I		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING		COMPLETED	
		155572	B. WING		10/24/2024
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
				N 600 E COUNTY LINE RD	
APERIO	N CARE DEMOTTE	: 	DEMO	TTE, IN 46310	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg					
	An Emergency Prep	paredness Recertification and	E 0000		
		vey was conducted by the			
	_	t of Health in accordance with			
	42 CFR 483.73.				
	Surryay Data: 10/2/	1/24			
	Survey Date: 10/24	t/ <del>/ ' '</del>			
	Facility Number: 0	00471			
	Provider Number:				
	AIM Number: 100	290390			
		Preparedness survey, Aperion			
		s found in compliance with			
		dness Requirements for caid Participating Providers			
		FR Subpart 483.73.			
	and Suppliers, 12 C	111 Support 1001/01			
	The facility is certif	fied for 93 dual certified beds.			
	At the time of the si	urvey, the census was 83.			
		1 . 1 . 10/00/01			
	Quality Review con	npleted on 10/29/24			
K 0000					
Bldg. 01					
	•	Recertification and State	K 0000		
	_	as conducted by the Indiana			
	_	th in accordance with 42 CFR			
	483.90(a).				
	Survey Date: 10/24	1/24			
	Survey Date. 10/24	<i>⊓                                    </i>			
	Facility Number: 0	00471			
	Provider Number:				
	AIM Number: 100	290390			
		a 1			
	At this Life Safety (	Code survey, Aperion Care -			
LADORATOR	NA DIDECTORIS OF PROS	WIDED CUIDDLIED DEDDECENTER THE TOP OF	CNATURE	TITLE	(VC DATE
LABORATOR	CY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE
Kelly DeYo	ouna		HFA		11/01/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/24/2024			
NAME OF PROVIDER OR SUPPLIER  APERION CARE DEMOTTE		10352	STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	Demotte was found Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one-story facil Type V (111) constructions sprinklered. The fact with smoke detection open to the corridor all resident sleeping capacity of 93 and hof this survey.  All areas where the access were sprinkle facility services were detached garage used detached generator facility storage.  Quality Review controls and the safety of the survey of the survey.	te, 42 CFR Subpart 483.70(a), re, and the 2012 edition of the ction Association (NFPA) 101, re. (SC), Chapter 19, Existing ancies and 410 IAC 16.2.  The rection and was fully rection and was fully reliable to the corridors, spaces and hard-wired detectors in rooms. The facility has a fire alarm system and a census of 83 at the time residents have customary ered. All areas providing re sprinklered except for one and for storage and one shed which also provided	TAG	DEFICIENCY	DATE		
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lightin	ng on and interview, the facility	K 0291	K- 291	11/10/2024		
	failed to ensure 1 of tested monthly for 3 minutes over the pa would provide light outages and a writte and tests was provide requires functional to monthly, with a minute maximum of 5 week	10 battery backup lights were 10 seconds and annually for 90 set year to ensure the light sing during periods of power on record of visual inspections ded. Section 7.9.3.1.1 (1) testing shall be conducted simum of 3 weeks and a set between tests, for not less of Functional testing shall be	K 0271	The facility requests desk revision this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not	of		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QF3L21

Facility ID: 000471

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/24/2024				
	ROVIDER OR SUPPLIER		10352	STREET ADDRESS, CITY, STATE, ZIP COD 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310				
	SUMMARY:  (EACH DEFICIEN  REGULATORY OR  conducted annually if the emergency lig powered and (5) We inspections and test for inspection by the jurisdiction. This de- residents, staff, and  Findings include:  Based on record rev Director on 10/24/2 Battery-Operated E- 2024 indicated one at the outside emerg Based on an intervice the Maintenance Di had a battery-operate aforementioned loca Battery-Operated E- 2024 had a missed i second testing. Furt test could not be loca documented within Emergency Light T- monthly and annual one battery operated by the Maintenance review who added t Maintenance man d  This item was discust	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION for a minimum of 1 1/2 hours thing system is battery ritten records of visual s shall be kept by the owner the authority having efficient practice could affect all visitors in the facility.  The mergency Light Test Log for the battery operated light located tency generator location. There was a gap in the mergency Light Test Log for the ation. There was a gap in the mergency Light Test Log for month (March of 2024) in the 30 thermore, a 90-minute annual the Battery-Operated test Log for 2024. The lack of testing documentation for the demergency light was verified Director at the time of record that the facility was without a turing most of that time.			or ed tte .			
				Light Testing.				

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Event ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/24/2024	
	PROVIDER OR SUPPLIE			10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	(X5) MPLETION DATE
					4) How the corrective action will be monitored:	s	
					Maintenance Director /HFA value perform monthly and annual audits times 6 months to ensitesting in completed per NFI 25 standards.	l sure	
					The results of these audits version be reviewed in Quality Assurance Meeting monthly months or until an average of 100 % compliance The QA Committee will identify any trends or patterns and make recommendations to revise a plan of correction as indicated.	x6 of the	
					5) Date of compliance: 11-10-24		
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities	:					
	failed to provide ar returning cooking a when the kitchen h was designed and i extinguishing syste Ventilation Contro Commercial Cooki Edition Section 12 requiring protection or rearranged with	on and interview, the facility approved method for appliances to where they were ood extinguishing equipment anstalled for 1 of 1 kitchen hood an. NFPA 96, Standard for and Fire Protection of and Operations Section 2011 1.2.2, states cooking appliances a shall not be moved, modified, but prior re-evaluation of the system by the system installer	K 0.	324	K- 324  The facility requests desk revision this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agree	of ot	/10/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QF3L21

Facility ID: 000471

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155572		B. WING 10/24/2024			10/24/2024		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
4050101	LOADE DEMOTTE				N 600 E COUNTY LINE RD		
APERIOI	N CARE DEMOTTE	<u>:</u>		DEMO	ΓΤΕ, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	or servicing agent,	unless otherwise allowed by			by the provider of the truth of	the	
	the design of the fir	e extinguishing system.			facts alleged or conclusions so	et	
	Section 12.1.2.3 sta	tes the fire-extinguishing			forth in the statement of		
	system shall not rec	quire reevaluation where the			deficiencies. The plan of		
	cooking appliances	are moved for the purposes of			correction is prepared and/or		
	maintenance and cl	eaning, provided the			executed solely because it is		
	appliances are retur	ned to approved design			required by the provisions of		
	location prior to co	oking operations, and any			federal and state law.		
	disconnected fire-ex	xtinguishing system nozzles					
	attached to the appl	iances are reconnected in			1)Immediate actions taken fo	or	
	accordance with the	e manufacturer's listed design			those residents identified:		
	manual. Section 12	.1.2.3.1 states an approved					
	method shall be pro	vided that will ensure that the			HFA notified company		
	appliance is returne	d to an approved design			purchasing department to		
	location. The defic	ient practice could affect as			order wheel chalks and will		
	many as residents a	nd staff.	install on the kitchen floor as			5	
					soon as possible.		
	Findings include:				-		
					2) How the facility identified		
	Based on observation	on during a tour of the facility			other residents:		
	with the Maintenan	ce Director on 10/24/24 at					
	11:36 a.m., the four	(4) burner flat grill which was			All residents and staff may b	e	
	located on the cook	ing line under the hood in the			affected by this alleged		
	kitchen was not pro	vided with an approved			deficient practice.		
	method that would	ensure that the appliance was					
		oved design location after it					
		r maintenance and cleaning.			3) Measures put into place/		
		at the time of the observation,			System changes:		
	the Maintenance Di	rector stated that he was not					
		method should be provided to			Maintenance Director educat	ted	
	ensure that the appl	iance was returned to an		on NFPA 96 , Standard for			
	approved design lo	cation after maintenance or	Ventilation Control and Fire				
	cleaning and that he	e would order a "wheel chalk"			Protection of Commercial		
	and have it installed	d on the kitchen floor as soon			Cooking Operations .		
	as possible.						
					4) How the corrective actions	s	
	This item was discu	ssed with the Administrator			will be monitored:		
	and the Maintenance	ee Director at the exit					
	conference on 10/2	4/24.			Maintenance Director/HFAwi	II	
					perform a weekly audit to		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/24/2024
	ROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			ensure the wheel chalks are place and are in proper working order for 6 months.	in
				The results of these audits was be reviewed in Quality Assurance Meeting monthly months or until an average of 100% compliance or greater achieved. The QA Committe will identify any trends or patterns and make recommendations to revise plan of correction as indicated.  5) Date of compliance: 11-10-24	x6 of is ee
K 0353 SS=F Bldg. 01	Based on record rev failed to ensure the maintained in accor requires all sprinkle tested, and maintain	iew and interview, the facility sprinkler system was dance with NFPA 25. LSC 9.7.5 r systems shall be inspected, ed in accordance with NFPA Inspection, Testing, and	K 0353	K- 353  The facility requests desk revifor this citation.  This Plan of Correction is the	11/10/2024 iew
	Maintenance of Wa Systems. NFPA 25 states Chapter 8 sha and maintenance red Section 8.2.2 states shall be performed velectric motor-drive monthly. Section 4. or designated repres	ter-Based Fire Protection , 2011 Edition, Section 10.2.9 Il be followed for inspection quirements for fire pumps. pertinent visual observations weekly. Section 8.3.1.2 states in fire pumps shall be operated 1.4.1 states the property owner tentative shall correct or repair forments that are found during		center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of	of ot ment the

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Event ID:

QF3L21

Facility ID: 000471

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	î í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLE			
155572			B. WING 10/24/2024				
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>	-		ADDRESS, CITY, STATE, ZIP COD		
					N 600 E COUNTY LINE RD		
APERION	N CARE DEMOTTE	·		DEMOT	TTE, IN 46310		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
	-	and maintenance required by on 4.3.1 states records shall be			correction is prepared and/or executed solely because it is		
		tions, tests, and maintenance of			required by the provisions of		
	•	omponents and shall be made			federal and state law.		
	-	nority having jurisdiction upon					
	request. This defici	ent practice could affect all			1)Immediate actions taken fo	or	
	residents, staff, and	visitors.			those residents identified:		
	Findings include:				Maintenance Director and H	-Δ	
	1 manigo merade.				ensured that documentation		
	Based on record rev	view with the Maintenance			monthly testing of the fire		
	Director on 10/24/2	4 at 9:20 a.m., it was noted that			pump was current.		
		electric fire pump. The					
		he monthly testing of the fire			2) How the facility identified		
		the testing of approximately six			other residents:		
	-	of 2024 through September of					
		interview at the time of record nance Director acknowledged			All residents, staff and visito		
		pump had not been inspected			may be affected by this alleg deficient practice.	<sub>l</sub> ea	
	-	s as the facility did not have a			delicient practice.		
	-	uring that time period and					
		siting and assisting with the			3) Measures put into place/		
	buildings upkeep at	these times did not know that			System changes:		
	facility had a fire pu	amp or the need to test it.					
					Maintenance Director educat		
		issed with the Administrator			on NFPA 25, Standard for the	9	
	and the Maintenanc conference on 10/24	e Director at the exit			Inspection, Testing and		
	conference on 10/22	4/24.			Maintenance of Water-Based	i	
	3.1-19(b)				Fire Protection Systems.		
					4) How the corrective actions	s	
					will be monitored:		
					Maintenance Director/ HFA v	will	
					perform a monthly audit to	7111	
					ensure that fire pump testing	ı is	
					performed timely for 6 month		

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PRINTED: 11/13/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 09	38-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/24/2024	
	PROVIDER OR SUPPLIER		10352	ADDRESS, CITY, STATE, ZIP COD N 600 E COUNTY LINE RD TTE, IN 46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPI	X5) LETION ATE
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Storag Based on observation of the storag state of the storage of the state	Cylinder and Container on and interview, the facility f 10 cylinders of nonflammable en were properly secured from Health Care Facilities Code, 2012 .3.2 states storage for se greater than 8.5 cubic meters tall comply with 11.3.2.1 IFPA 99, Section 11.3.2.6 states er restraints shall comply with 1.6.2.3(11) states freestanding roperly chained or supported er stand or cart. This deficient ext 14 residents, 4 staff, and 2	K 0923	The results of these audits wibe reviewed in Quality Assurance Meeting monthly x months or until an average of 100% compliance or greater is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.  5) Date of compliance: 11-10-24  K-923  The facility requests desk reviet for this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	II  26 S S The d.  11/10 W	0/2024
	Findings include:			deficiencies. The plan of correction is prepared and/or executed solely because it is		

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Based on observation during a tour of the facility

with the Maintenance Director on 10/24/24 at

11:35 a.m., three of ten small 'E' type oxygen

Event ID:

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required by the provisions of

federal and state law.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155572		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/24/2024	
	PROVIDER OR SUPPLIER		10352	T ADDRESS, CITY, STATE, ZIP COD 2 N 600 E COUNTY LINE RD OTTE, IN 46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	shelf in the oxygen This shelf was attac	ng on their sides sitting on a storage and transfilling room. hed to the wall in the oxygen		1)Immediate actions taken those residents identified:	for
	feet above the floor time of observation acknowledged the t in the oxygen storag not properly chaine cylinder stand or ca	ing room approximately five . Based on interview at the , the Maintenance Director hree 'E' type oxygen cylinders ge and transfilling room were d or supported in a proper rt stating that nursing staff place these items in such		Cylinder's identified were properly secured at time of observation in the cylinder stand. The shelf was removed immediately in the oxygen storage and transfilling room 2) How the facility identified other residents:	ved m.
		e Director at the exit 4/24.		All residents may be affected by this alleged deficient practice.	ed
				3) Measures put into place/ System changes:	
				Nursing staff was In-Servic regarding proper oxygen storage.	ed
				4) How the corrective action will be monitored:	ns
				Maintenance Director/Design will perform weekly audits to assure all oxygen cylinders properly secured at all time for 6 months.	to s are
				The results of these audits be reviewed in Quality	will

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155572	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION G 01	co	ATE SURVEY MPLETED /24/2024
	ROVIDER OR SUPPLIER		103	EET ADDRESS, CITY 52 N 600 E COI MOTTE, IN 4631	UNTY LINE RD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	X (EACH CORR CROSS-REFER	ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				months or 100% com achieved x months. T will identify patterns ar recommen plan of con	Meeting monthly x6 until an average of pliance or greater is 3 consecutive The QA Committee y any trends or nd make dations to revise the rection as indicated.  compliance:	

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