STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155702	A. BUILDING -- B. WING	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/25/22 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Emergency Preparedness survey, Aperion Care - Peru was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 92 certified beds. At the time of the survey, the census was 90. Quality Review completed on 08/31/22	E 0000	We have submitted pictures, Angel rounds and inservices We are asking for paper compliance if you have any further question or need any further information please let me know.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/25/22 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Life Safety Code survey, Aperion Care - Peru was not found in compliance with	K 0000	We have submitted pictures, Angel rounds and inservices We are asking for paper compliance if you have any further question or need any further information please let me know.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a), Life Safety from Fire, the 2012 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. This one-story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in all resident rooms. The facility has a capacity of 92 and had a census of 90 at the time of this survey. All areas where the residents have customary access were sprinklered with exception of two window recesses in the therapy room. All areas providing facility services were sprinklered. Quality Review completed on 08/31/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 9 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 32 residents, 4 staff and 2 visitors if needing to exit the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/25/22 from 10:11 a.m. to 11:41 p.m., the following exit doors were marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code, but the code was not posted at the exit: A. the main entrance to the facility B. the employee entrance to the service hall / clock in room Based on an interview at the time of each observation, the Maintenance Director explained that the codes were not posted by the door to prevent residents from eloping. At the time of the observations the Maintenance Director did acknowledge that the code was not posted by the aforementioned exits. During the exit conference with the facility Maintenance Director and the	K 0222	1. Immediate actions taken for those residents identified: Facility maintenance director placed protected code at each appropriate exit immediately upon receipt of the letter addressing the inadequate previous POC. 2. How the facility identified other residents, staff and visitors who may be affected: Maintenance director did an audit of all appropriate facility exits to ensure code was reposted and did not require special knowledge or effort for operation. 3. Measures put into place/system changes: Monthly inspections per preventative maintenance check list will be completed to ensure all doors have access code to ensure anyone is able to exit safely. 4. How the corrective action will be monitored: Maintenance director/designee will conduct an audit through his preventative maintenance to ensure compliance and report results to QAA meetings to ensure on going compliance. ="" b=""> ="" b3.="">	09/22/2022

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	Administrator at 12:35 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		=”” b4.=””> =”” b=””> =”” b=””> =”” b=””> =”” b=””> =”” b=””> =”” b=””> **=”” p=””>** =”” b4.=””> =”” b=””> =”” span=””> **=”” p=””>** =”” b=””> =”” b=””> =”” b=””> =”” b=””> =”” b=””	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure	K 0345	=”” b=””	08/26/2022

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	that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/25/22 from 11:06 a.m., the time on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the time to be 6:58 a.m. at 11:06 a.m. This control panel also did not display the date on it. Based on interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the time updated on the fire alarm control panel as soon as possible. During the exit conference with the facility Maintenance Director and the Administrator at 12:35 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		1. Immediate actions taken for those residents identified: The date and time has been corrected on the main fire panel. 2. How the facility identified other residents: An audit was completed on all fire panels by Maintenance director to ensure all other fire panels displayed correct time and date with no other concerns found. 3. Measures put into place / system changes: Monthly inspections per preventative maintenance check list will be completed to ensure all fire extinguishers are accessible. 4. How the corrective actions will be monitored: Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance. ="" b=""> ="" b=""> **b="">** ="" b="">	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required			

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	by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 clock-in-room in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 43 residents in the Garden smoke compartment. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/25/22 from 11:21 a.m., the "clock-in-room off the service hall sprinkler had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheon was missing, found it sitting on top of the	K 0351	1) Immediate actions taken for those residents identified: Facility Maintenance Director ensured escutcheons was immediately put back on the sprinkler in the time clock room. 2) How the facility identified other residents who could be affected. Maintenance Director did a complete audit of all sprinklers throughout the facility to ensure all escutcheons were present and appropriately placed. 3) Measures put into place / system changes: Monthly inspections per preventative maintenance check list will be completed to ensure all escutcheons are present and appropriately placed.	08/26/2022

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	employee mailboxes, and replaced it in the sprinkler located in the ceiling of the room. This deficiency was fixed prior to my exiting of the facility. 3.1-19(b)		4) How the corrective actions will be monitored: Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance. ="" b=""> **b="">** ="" b="">="" b=""> **b="">** ="" b="">	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the laundry room were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice would affect all staff only in the laundry and service hall areas. Findings include: Based on observation with the Maintenance	K 0355	1. Immediate actions taken for those residents identified: The medication cart was removed from obstructing fire extinguisher immediately. 2. How the facility identified other residents: A walk through of the facility was done by the Maintenance director to ensure all other fire extinguishers were accessible. with no other concerns found. 3. Measures put into place / system changes: Monthly inspections per preventative maintenance check list will be	08/29/2022

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	Director during a tour of the facility on 08/25/22 from 10:50 a.m., the ABC portable fire extinguisher located at the Dementia Unit nurses station was obstructed by a Med cart. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned portable fire extinguisher located at the Dementia Unit was obstructed, and not readily accessible. During the exit conference with the facility Maintenance Director and the Administrator at 12:35 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		completed to ensure all fire extinguishers are accessible. 4) How the corrective actions will be monitored: Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving	K 0374	1. Immediate actions taken for those residents identified: The Maintenance director placed a coordinator on the smoke barrier door coordinating the door appropriately. 2. How the facility identified other	08/29/2022

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	only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 24 residents, 4 staff and 2 visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/25/22 from 10:50 a.m., the set of smoke barrier doors nearest to resident rooms #102 and #104 contained an astragal between the set of barrier doors. These doors both swung in the same direction, but when tested on three separate occasions, had a two inch gap along the center where the doors came together in the closed position because the door with the astragal closed before the other door did. It was then determined that the barrier door set did not contain a coordinator. This was verified by the Maintenance Director or at the time of observation. During the exit conference with the facility Maintenance Director and the Administrator at 12:35 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		residents who could have been affected: A walk through of the facility was done by the Maintenance director to ensure all fire doors had appropriate coordinators to ensure doors closed properly. 3. Measures put into place / system changes: Monthly inspections per preventative maintenance check list will be completed to ensure all fire doors close properly. 4) How the corrective actions will be monitored: Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with			

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	capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure 2 of 2 soiled linen receptacles in the corridor did not exceed 32 gallons in capacity within a 64 square foot area. This deficient practice could affect staff and up to 18 residents, 4 staff, and 1 visitor in the smoke compartment. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/25/22 from 10:50 a.m., there were two full large 55-gallon soiled linen containers in the corridor near resident room #135. Based on interview at the time of the observation, the Maintenance Director confirmed the capacity of the receptacles. During the exit conference with the facility Maintenance Director and the Administrator at 12:35 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	K 0754	=”” span=””>1. Immediate actions taken for those residents identified: The Maintenance director immediately removed the 55-gallon soiled linen containers from the corridor. 2. How the facility identified other residents who could have been affected: A walk through of the facility was done by the Maintenance director to ensure all corridors did not contain any receptacles greater than 32 gallons within 64 square feet. 3. Measures put into place / system changes: Weekly inspections per Angel Rounds by department heads will be completed to ensure the corridors are free from receptacles. 4) How the corrective actions will be monitored: Administrator will conduct and audit of Angel Rounds weekly to ensure compliance and report results to QAA meeting.	08/29/2022