STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING -- B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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 Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/27/23 Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390 At this Emergency Preparedness survey, Aperion Care Demotte was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Subpart 483.73. The facility is certified for 93 dual certified beds. At the time of the survey, the census was 67. Quality Review completed on 11/29/23	E 0000		
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: 11/27/23 Facility Number: 000471 Provider Number: 155572 AIM Number: 100290390 At this Life Safety Code survey, Aperion Care	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly DeYoung	HFA	12/07/2023

Any defiencystatement 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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	Demotte was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) 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 detectors in all resident sleeping rooms. The facility has a capacity of 93 and had a census of 67 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage used for storage and one detached generator shed which also provided facility storage and was not sprinklered. Quality Review completed on 11/29/23			
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			

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	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 1 set of cross-corridor doors would close to form a smoke resistant barrier. This deficient practice could affect as many as 12 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Director of Maintenance during a tour of the facility on 11/27/23 at 1:30 p.m., the set of cross-corridor doors on the West Hall at the Therapy exit each swing in the same direction with the right-side door being equipped with an astragal. The door set was not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned cross-corridor door set was not equipped with a door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier and stated that he would contact a vendor and have a coordinator installed as soon as he could. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0374	**K- 374** The facility requests desk review 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** **Maintenance Director performed an audit of all cross -corridor doors to ensure they form a smoke resistant barrier.** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.**	12/11/2023

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			3) Measures put into place/ System changes: **A new Closing Coordinator was ordered and will be installed when it is delivered.** **4) How the corrective actions will be monitored:** **Maintenance Director/Designee will perform a weekly audit to ensure closing coordinators are in proper working order for 6 months.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 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: 12-11-23**	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing			

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	Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be	K 0914	**K- 914** The facility requests desk review 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 deficiencies. The plan of correction is prepared and/or*	12/11/2023

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	confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect as many as 12 residents, 4 staff, and 2 visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:50 a.m. to 2:33 p.m. on 11/27/23, the facility's 52 resident rooms had roughly 5 electrical receptacles in each room. Based on interview at the time of records review, the Director of Maintenance indicated all of the electrical receptacles in the resident rooms were all not hospital-grade. Furthermore, he added that he had completed the receptacle retention testing on the North Hall, the South Hall, and the A.C.U. Hall, but had not yet completed the testing on the West Hall. The last receptacle retention testing was completed on September 22nd of 2022 and therefore was more than 12 months' ago. Based on an interview at the time of records review, the Director of Maintenance agreed that his documentation of annual testing per NFPA 99, Receptacle Testing requirements was incomplete adding that he would finish the testing as soon as possible. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		*executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** **Maintenance Director completed testing on West Hall to ensure all nonhospital grade electrical receptacles in resident rooms was complete and all outlets were tested and in compliance.** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.** **3) Measures put into place/ System changes:** **Maintenance Director In-Serviced regarding Annual Testing of Hospital Grade Electrical Receptacles.** **4) How the corrective actions will be monitored:** **HFA will perform quarterly audits to ensure Annual testing**	

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			in completed per NFPA 25 standards. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12-11-23**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet			

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	In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 22 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect as many as 12 residents, 4 staff, and 2 visitors.	K 0923	**K- 923** The facility requests desk review 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 deficiencies. The plan of correction is prepared and/or*	12/11/2023

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	Findings include: Based on observations made with the Director of Maintenance during a tour of the facility on 11/27/23 at 1:30 p.m., one of twenty-two 'E' type oxygen cylinders was standing upright on the floor of the oxygen storage and transfilling room and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Director of Maintenance acknowledged the 'E' type oxygen cylinder in the aforementioned oxygen storage and transfilling room was not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		*executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** **Cylinder identified was properly secured at time of observation.** **2) How the facility identified other residents:** **All residents may be affected by this deficient practice.** **3) Measures put into place/ System changes:** **Nursing staff was In-Serviced regarding proper oxygen storage.** **4) How the corrective actions will be monitored:** **Maintenance Director/Designee will perform weekly audits to assure all oxygen cylinders are properly installed at all times for 6 months.** **The results of these audits will be reviewed in Quality**	

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			Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12-11-23**	