STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 01 B. WING	08/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/12-13/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/18/16 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 At this PSR survey, Aperion Care Valparaiso was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 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 facility is located in two, two story buildings with walk out lower levels and connected by the "tunnel", a one story corridor. The two buildings, identified as the Pines and the Manor were determined to be of Type II (111) construction, built prior to March 1, 2003 and fully	K 0000		

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

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in resident sleeping Rooms #1 through #37 on the Pines upper level and hard wired smoke detectors supervised by the fire alarm system in rooms 38 through 43 on the Pines lower level. Smoke detectors in resident sleeping rooms on the upper and lower level are hard wired. The facility has the capacity for 150 and had a census of 86 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/19/16 - DA			
K 0029 SS=A Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the			

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	door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 fuel fired Manor Boiler room, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Supervisor and Administrator on 08/18/16 at at 2:58 p.m., the Manor Boiler room contained a set of double doors with an astragal without a coordinating device. One of the double doors had two slide bolts and no self-closing device. Based on interview at the time of observation, the Maintenance Supervisor and Administrator said that a contractor worked on the door but the work had not be completed. 3.1-19(b) This deficiency was cited on 07/12/16. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0029	**The facility requests paper compliance 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:** No residents were identified in this citation. **2) How the facility identified other residents:** These areas were not in resident common areas and would have the potential to affect staff only.	09/10/2016

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			2) Measures put into place/ System changes: Facility has ordered an internal mount slide lock to secure one door, when installed the surface mount slide locks will be removed. An automatic closure for the second door was installed and a coordinating closure was ordered. When installed the double doors will have automatic closures for both doors, a coordinating closure device and one door will be secured with a slide lock that secures into the door frame. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 9/10/2016**	