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	08/17/2017

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 Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/17/17 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 At this Life Safety Code survey, Aperion Care Valparaiso 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 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 sprinklered. The facility has a fire alarm system with smoke detection in the	K 0000	**The facility request 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 for 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.	

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

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	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 96 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 08/24/17 - DA			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 Lower Manor smoke barrier doors per 4.6.12.3. LSC 4.6.12.3	K 0100	**K100** **The facility request paper compliance for this citation.**	09/16/2017

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	requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and at least 32 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 10:15 a.m., the Lower Manor smoke barrier doors did not fully close because one of the doors was caught on the coordinating device. Based on interview at the time of observation, the Administrator and the Maintenance Director confirmed one of the two cross-corridor doors failed to latch. 3.1-19(b)		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 for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All residents on the Lower Manor had the potential to be affected by this alleged deficient practice. **3. Measures put into place/ System changes:** 1. Lower Manner smoke barrier doors were repaired to ensure that they fully close	

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			2 An Audit was completed throughout to whole house to help identify any other doors not properly latching. 3. Maintenance Director or Designee will complete an audit of five random rooms which includes common areas twice per week to ensure facility doors are properly latching. Maintenance Director or Designee will submit these audits for review by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **Date of compliance: 9/16/2017**	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally,			

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	the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 Based on observation and interview, the facility failed to ensure 1 of 3 Pines Lower exit discharge were constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect staff and up to 13 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 11:35 a.m., the South Pines Lower exterior door was marked as an exit. The exit discharged on to a concrete path but there was 14 feet of missing sidewalk, a grassy area, between the path and the gate and gate exit discharge which was provided with a cement path. Based on interview at the time of observation, the Executive Director and the Maintenance Director provide the measurement and acknowledged the lack of a hard clearable surface that led to a public way. 3.1-19(b)	K 0271	**K271** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All residents on the South Pines lower had the potential to be affected by this alleged deficient practice.	09/16/2017

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			3. Measures put into place/ System changes: Facility revised signage of the identified door on the South Pines lower unit to advise Residents that it is not an approved Exit route. **4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. . **5. Date of compliance:** **9/16/2017**	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating			

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	of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.			
	Based on observation and interview, the facility failed to maintain protection of 2 of 4 stairways in accordance of 19.3.1. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect staff and at least 48 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 between 2:43 p.m. and 3:05 p.m., the following was discovered; a) the Manor Lower south stairwell contained a three inch by five inch penetration above the drop ceiling. Additionally the penetration demonstrated that only one piece of five eighths inch drywall was installed making the stairwell a half an hour construction b) the Manor Center stairwell drywall did not continue all the way to the roof decking Based on interview at the time of each observation, the Executive Director and	K 0311	**K311** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All residents on Manor had the potential to be affected by this alleged deficient practice.	09/16/2017

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	the Maintenance Director acknowledged the incomplete enclosure of the aforementioned stairwells and provided the measurements. Additionally, the Maintenance Director was unable to confirm if the other stairwells contained only one layer of five eights inch drywall.		**3. Measures put into place/ System changes:** Manor Lower south stairwell and Manor Center stairwell penetrations will be repaired and an additional layer of five eighths drywall will be applied to meet the 1-hour fire resistant guideline. **4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **5. Date of compliance:** **9/16/2017**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an			

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	automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 Upper Manor Soiled Utility room in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect staff and up to 15 residents. Findings include:	K 0321	**K321** **The facility request 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	09/16/2017

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	Based on observation with the Executive Director and the Maintenance Director on 05/17/17 at 10:45 a.m., the Upper Manor Soiled Utility room contained multiple containers for soiled linen and trash adding up to more than sixty four gallons. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the hazardous room did not contain self-closing hardware. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain protection of 1 of 1 Boiler in accordance of 19.3.2. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 1:08 p.m., the Boiler room contained fuel-fired equipment. The Boiler room contained double corridor doors. One of the doors had an astragal, but no coordinating device installed. Centers for Medicare & Medicaid Services (CMS) requires sets of doors which swing in the same direction and		facts alleged or conclusions set for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All residents on the Upper and Lower Manor have the potential to be affected by this alleged deficient practice. **3. Measures put into place/ System changes:** 1. Self-closing devices was ordered and will be installed on the Manor Upper soiled utility room 2. A coordinating device will be installed on the Manor Lower boiler room double doors to ensure proper closure.	

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	equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. Additionally, one of the double corridor doors caught on the floor and failed to self-close. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged lack of the coordinating device and the door that was caught on the floor not self-closing. 3.1-19(b)		**4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **5. Date of compliance:** **9/16/2017**	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1			

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	through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 1:05 p.m., the Kitchen contained a UL 300 hood system. Based on interview, a staff member was asked what she would do if there was a fire underneath the hood. She replied she would go behind the appliance and shut the gas valve, then go get some baking soda, then call Maintenance. She failed to indicate pulling the hood pull station. Based on interview, the Maintenance Director acknowledged her response and confirmed that he will instruct all kitchen staff on proper response. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 UL300	K 0324	**K324** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All Kitchen staff have the potential to be affected by this alleged deficient practice. **3. Measures put into place/ System changes:**	09/16/2017

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	manual activation pull station was readily accessible. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition at 10.5.1 states, a readily accessible means for manual activation shall be located between 42 inches and 48 inches above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. This deficient practice was not in a resident area but could affect kitchen staff. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 1:06 p.m., a cooking appliance was directly in front of the UL300 manual activation pull station. Based on interview at the time of observation, the Executive Director and the Maintenance Director confirmed the pull station was obstructed from sight and would be difficult to activate with the appliance in front of the pull station. 3.1-19(b)		1. Maintenance Director or designee will re- in service all kitchen staff on the proper protocol for manually operating the fire extinguishing system. Maintenance Director or Designee will conduct random interviews of a minimum of 5 kitchen staff members two times per week for 90 days, or until 100% compliance is achieved. 2. Kitchen was re-organized to ensure that the UL300 Manual activation pull station was not obstructed from sight and easily able to be activated. . Maintenance Director or Designee will conduct random interviews of a minimum of 5 kitchen staff members two times per week to ensure knowledge of keeping the pull station unobstructed from sight and easily obtainable for 90 days, or until 100% compliance is achieved. **4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved.	

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			5. Date of compliance: **9/16/2017**	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 08/17/17 at 12:05 p.m., the facility provided fire watch documentation but it was incomplete.	K 0346	**K346** **The facility request 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 for 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 take for those residents identified:**	09/16/2017

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(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
	The plan failed to include contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Executive Director and the Maintenance Director acknowledged fire watch policy failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)		No residents were identified in this citation. **2. How the facility identified other residents:** All residents within the facility have the potential to be affected by this alleged deficient practice. **3. Measures put into place/ System changes:** 1. The facility will revise the written Fire Watch policy to include in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period the Indiana State department of health will be notified via the web portal **4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved.	

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	155277	A. BUILDING 01 B. WING	08/17/2017

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APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

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			5. Date of compliance: **9/16/2017**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required 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 Pines Dining room. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of	K 0351	**K351** **The facility request paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this	09/16/2017

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	sprinkler and the type of construction. This deficient practice could affect staff and up to 34 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 1:30 p.m., the Pines Dining room contained a sprinkler head with a missing escutcheon. Based on interview at the time of observation, the Executive Director and the Maintenance Director were unaware of the missing escutcheon. 3.1-19(b)		plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for 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 take for those residents identified:** No residents were identified in this citation. **1. How the facility identified other residents:** All residents on the Pines North who have access to the dining room have the potential to be affected by this alleged deficient practice. **2. Measures put into place/ System changes:** 1. Sprinkler head with a missing escutcheon was repaired. **3. How the corrective actions will be monitored:** The results of these audits if	

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			necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **4. Date of compliance: 9/16/2017**	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Pines IT closet. The ceiling tiles trap hot air and gases around the sprinkler and cause the	K 0353	**K353** **The facility request paper compliance for this citation.** This Plan of Correction is the	09/16/2017

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	sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 11:49 a.m., the Pines IT closet was missing a ceiling tile. Based on interview at the time of observation, the Executive Director and the Maintenance Director was unaware of the missing ceiling tile. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could		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 for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All residents in the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** 1. Missing ceiling tile in the Pines Lower IT closet was replaced.	

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	affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 08/17/17 at 9:45 a.m., the sprinkler system was inspected quarterly. No documentation was available for the monthly control valves, weekly dry system gauge and monthly wet system gauge inspection. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the lack of documentation. 3.1-19(b)		2. Facility is to add a monthly control valve inspection, weekly dry system gauge inspection and monthly wet system gauge inspections to the routine maintenance schedule. Maintenance Director or Designee will report findings of these audits monthly in the Quality Assurance Committee meeting for 90 days, or until 100% compliance is achieved. **4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **5. Date of compliance: 9/16/2017**	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and			

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	other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director and the Maintenance Director on 08/17/17 at 12:05 p.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via	K 0354	**K354** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All residents within the facility have	09/16/2017

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	the Web Portal. Based on an interview record review, the Executive Director and the Maintenance Director acknowledged fire watch policy failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)		the potential to be affected by this alleged deficient practice. **3. Measures put into place/ System changes:** 1. The facility will revise the written Fire Watch policy to include in the event the Automatic Sprinkler system has to be placed out of service for ten hours or more in a twenty four hour period the Indiana State department of health will be notified via the web portal **4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **Date of compliance: 9/16/2017**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20			

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	minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to maintain protection of corridor doors in 1 of 4 corridors in accordance of 19.3.6.3. This deficient practice could affect staff only. Findings include: Based on observation with the Executive	K 0363	**K363** **The facility request 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	09/16/2017

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	Director and the Maintenance Director on 08/17/17 at 10:22 a.m., room 172 corridor door failed to latch when tested. The wing was shut down and prevented from unauthorized use. Based on interview at the time of observation, the Administrator and the Maintenance Assistant #1 acknowledged the door not positively latching into the frame. 3.1-19(b)		constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** No resident in the Manor Lower had the potential to be affected by this alleged deficient practice as no resident was residing in room 172 due to the wing being shut down at this present time. This deficient practice could affect staff only. **3. Measures put into place/ System changes:** 1. Room 172 corridor door was repaired to ensure proper latching when closing. 2. Maintenance Director or	

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			Designee will complete an audit of 5 corridor doors two times per week to ensure proper latching when closing. Findings of the audits will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.			

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	19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 69 residents. Findings include: Based on observations with the Executive Director and the Maintenance Director on 08/17/17 between 2:30 p.m. and 2:55 p.m., the following unsealed penetrations were discovered: a) a one inch penetration and a two inch penetration above the ceiling tile in the Manor Rehab Dining room smoke barrier. Additionally, a two and a half inch by two and a half inch penetration around sprinkler pipe above the ceiling tile b) a two inch by two inch and a three inch by three inch penetration above the ceiling tile in the resident room 266	K 0372	**K372** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation. **2. How the facility identified other residents:** All staff and residents within the facility have the potential to be affected by this alleged deficient practice.	09/16/2017

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	smoke barrier Based on interview at the time of each observation, the Executive Director and the Maintenance Director acknowledged each aforementioned penetration and provided the measurements. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain at least 1 of 1 smoke damper per 8.5.5.4.2. LSC 8.5.5.4.2 requires smoke dampers and the combination smoke and fire dampers shall be inspected, tested, and maintained in accordance with 2010 edition of NFPA 105. NFPA 105 6.5.2 states each damper shall be tested and inspected on year after installation. The test frequency shall then be every 4 years. This deficient practice could affect staff and up to 32 residents. Findings include: Based on observations with the Executive Director and the Maintenance Director on 08/17/17 at 2:13 p.m., a damper was discovered in the Pines Upper smoke barrier above the drop ceiling. Based on interview at the time of observation, the Executive Director and the Maintenance Director was unaware of any dampers in the facility and could not provide any documentation of inspection, testing or		**3. Measures put into place/ System changes:** 1. a) one inch penetration and a two inch penetration above the ceiling tile in the Manor Rehab Dining room smoke barrier along with the two and a half by two and a half inch penetration around the sprinkler pipe above the ceiling tile were repaired with fire rated ASTM-814 fire rated caulk b) two inch by two inch and a three inch by three inch penetration above the ceiling tile in the resident room 266 smoke barrier was repaired and caulked with fire rated ASTM-814 fire caulk. 2. Damper discovered in the Pines Upper smoke barrier above the drop ceiling was identified and the facility will complete an inspection of the entire facility to identify and inspect any and all other dampers. Maintenance Director or Designee will review findings monthly in the Quality Assurance Committee meeting for 90 days, or until 100% compliance is achieved.	

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	maintenance. 3.1-19(b)		**4. How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **5. Date of compliance: 9/16/2017**	
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected * takes air for combustion from outside * provides for a combustion system separate from occupied area atmosphere 18.5.2.2, 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 Laundry room was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could affect staff only. Findings include: Based on observation with the Executive	K 0522	**K522** **The facility request 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	09/16/2017

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	Director and the Maintenance Director on 08/17/17 at 11:48 a.m., the laundry room had fuel-fired dryers. Based on interview at the time of observation, the Maintenance Director was unable to locate the fresh air intake source. 3.1-19(b)		constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for 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 take for those residents identified:** No residents were identified in this citation. **1.How the facility identified other residents:** All staff within the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** Maintenance Director or designee will identify the fresh air intake source within the facility laundry room and label it accordingly. **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the	

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	155277	A. BUILDING 01 B. WING	08/17/2017

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			Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	
K 0531 SS=D Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3			
	1. Based on observation and interview, the facility failed to ensure 2 of 2 elevator	K 0531		09/16/2017

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	equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage in accordance with 19.5.3. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice would affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 10:32 a.m. then again at 12:13 p.m., the Manor elevator equipment room contained 1 sprinkler head. Then again, the Pines elevator equipment room contained 1 sprinkler head. Based on interview at the time of observation, the Executive Director and the Maintenance Director did not know what an elevator shunt trip was and was unable to confirm the elevator equipment rooms were provided with an elevator shunt trip. 3.1-19(b) 2. Based on interview and observation, the facility failed to maintain testing of 2		**K531** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation. **1.How the facility identified other residents:** All staff within the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** 1. Maintenance Director and	

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	of 2 elevators provided with firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 between 10:00 a.m. and 4:31 p.m., there were two elevators located in the health care portion of the building equipped with elevator firefighter recall. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged the elevators were equipped with elevator firefighter recall; no monthly inspection documentation was available for review and were unaware of the monthly inspection requirement. 3.1-19(b)		Executive Director were educated on the purpose of an elevator shunt trip and the location of such devices within the facility. 2. Maintenance Director or Designee will obtain a firefighter recall key from the local fire department and implement monthly elevator fire fighter recall inspections which are to be recorded within the facility. Maintenance Director or Designee will review inspections monthly with the Quality Assurance Committee for 90 days, or 100% compliance is achieved. **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	
K 0711	NFPA 101			

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SS=F Bldg. 01	Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on observation, interview, and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all	K 0711	**K711** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation.	09/16/2017

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	occupants. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 3:00 p.m., the facility provided information indicating locations of smoke/fire barriers. There were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on interview, the Executive Director and the Maintenance Director acknowledged the cross corridor doors near the Pines Lower Laundry and the Manor Tunnel Entrance was not part of a complete smoke barrier, specifically they did not have construction continuous in the attic. 3.1-19(b)		**1.How the facility identified other residents:** All residents and staff within the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** Facility is to revise facility fire evacuation policy to ensure proper evacuation procedure is listed in regards to the cross corridor doors near the Pines Lower Laundry and Manor Tunnel Entrance. Maintenance Director or Designee will then re- in service facility staff on proper evacuation procedures within that given area. Revision of evacuation procedures and in-servicing will be reviewed at the Quality Assurance Committee meeting. **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee	

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			monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff	K 0712	**K712** **The facility request paper compliance for this citation.** This Plan of Correction is the	09/16/2017

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	and residents. Findings include: Based on record review of the "Fire Drill Procedure" form with the Executive Director and the Maintenance Director on 08/17/17 at 9:36 a.m., there was no documentation for a second shift fire drill in the second quarter of 2017. Additionally, there was no documentation for a third shift fire drill in the fourth quarter of 2016. Based on interview at the time of record review, the Executive Director and the Maintenance Director were unable to provide further documentation. 3.1-19(b) 3.1-51(c)		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 for 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. **1.How the facility identified other residents:** All staff and residents within the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** 1. Maintenance Director or Designee will complete a fire drill on 2nd shift and 3rdshift by 9/16/2017. 2. Maintenance Department was re-in serviced on expectations related	

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			to conducting quarterly fire drills. 3. Maintenance Director or Designee will be required to submit review of Fire Drills monthly indicating variation between all three shifts to the Quality Assurance Committee for 90 days, or until 100% compliance is achieved **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are			

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	prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents was maintained in accordance with 19.7.4. LSC 19.7.4 requires ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with a self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas were smoking is permitted. This deficient practice could affect staff only. Findings include: Based on observations with the Executive Director and the Maintenance Director on 08/17/17 at 11:36 a.m., there were at least 30 cigarette butts in a can in the Staff smoking area. The can was part of a long	K 0741	**K741** **The facility request 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 for 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:**	09/16/2017

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	neck approved smoking container, but the container was melted. Based on interview at the time of observation, the Executive Director and the Maintenance Director confirmed that the container was melted so cigarette butts cannot be placed inside and staff must have removed the container and used it in an unapproved manner. 3.1-19(b)		No residents were identified in this citation. **1.How the facility identified other residents:** All staff within the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** 1. The long neck smoking container and can was removed. 2. All other long neck smoking containers on the facility grounds were inspected to ensure proper structural status. Smoking containers found to be defective will be immediately removed. 3.. Maintenance Director or Designee will re- in service facility staff on the facility smoking procedures which have been revised to include instruction on necessary actions required when facility approved smoking containers become defective. Maintenance Director or Designee will randomly interview 5 staff members twice a week for	

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			90 days on the proper facility smoking procedures. Findings of the interviews will be brought to the Quality Assurance Committee Meetings monthly for 90 days for review, or until 100% compliance is achieved. **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	
K 0781 SS=D Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 space heater was in accordance with 19.7.8.	K 0781		09/16/2017

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	This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 10:23 a.m., a space heater was discovered in the Manor Unit Manager's office. Based on interview at the time of observation, the Executive Director and the Maintenance Director was unaware the space heater was in the building and confirmed no documentation was available to demonstrate the heating element does not exceed 212 degrees. 3.1-19(b)		**K781** **The facility request 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 for 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 take for those residents identified:** No residents were identified in this citation. **1.How the facility identified other residents:** All staff within the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:**	

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			1. Maintenance Director or Designee will complete a facility wide sweep to ensure no unapproved portable space heating devices were present. 2. Maintenance Director or Designee will re-in service staff on the LSC regulation 18.7.8 & 19.7.8 related to portable space heating devices within a facility. 3. Maintenance Director or Designee will audit 5 resident rooms which can include resident common areas twice a week for 90 days to ensure no unapproved portable space heating devices are present. Findings of the audits will be reviewed in the Quality Assurance Committee meeting monthly for 90 days, or until 100% compliance is achieved. **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved.	

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			1.Date of compliance: 9/16/2017	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	1. Based on observation, record review, and interview, the facility failed to install 1 of 1 power strip according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code.	K 0920	**K920** **The facility request paper compliance for this citation.** This Plan of Correction is the center's credible allegation of	09/16/2017

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	155277	A. BUILDING 01 B. WING	08/17/2017

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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
	NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 20 residents. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 1:50 p.m., a power strip was powering another surge protector powering an oxygen concentrator in resident room 05. Based on interview at the time of observation, the Executive Director and the Maintenance Director was unable to provide UL 60601-1 documentation for the permanently installed power strip in a patient care area and acknowledged the daisy-chained power strips. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8		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 for 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 take for those residents identified:** 1. Power strip powering another surge protector powering an oxygen concentrator in resident room 05 was immediately removed. 2. All Resident rooms were audited to ensure no other power strips were powering unapproved items. Any items found were corrected. 3. Surge protector powering an air conditioning unit in the pines it closet was revised immediately by Maintenance Director in the presence of the Survey Team and correctly plugged in the appropriate outlet. **1.How the facility identified other residents:**	

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	requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on 08/17/17 at 11:50 a.m., a surge protector was powering an air conditioning unit in the Pines IT closet. Based on interview at the time of observation, the Executive Director and the Maintenance Director acknowledged and immediately removed the surge protector. 3.1-19(b)		All staff and up to 20 residents within the facility have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** 1. Maintenance Director or designee will complete staff re- in serving to ensure staff members are aware and knowledgeable about the proper use of surge protectors based on LSC guidelines. 2. Maintenance Director or designee will audit five rooms which includes common areas twice a week for 90 days to ensure that there are in compliance with NFPA 70 electrical code regarding power strips and surge protectors. Maintenance Director or Designee will submit findings for review by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the	

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			Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	
K 0927 SS=D Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 Manor Shower oxygen transfill room was protected in accordance with 9.3.7.5.3.1. 2012 NFPA 99 9.3.7.5.3.1 requires oxygen transfill mechanical exhaust rooms to maintain a negative pressure continuously. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director and the Maintenance Director on	K 0927	**K927** **The facility request 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 for the statement of deficiencies. The plan of correction is prepared	09/16/2017

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	08/17/17 at 10:25 a.m., the Manor Shower oxygen transfill room fan was not running. The fan was checked with a piece of paper. Based on interview at the time of observation, the Executive Director and the Maintenance Director was unaware the fan was not working. 3.1-19(b)		and/or executed solely because it is required by the provisions of federal and state law. **1.Immediate actions take for those residents identified:** No residents were identified in this citation. **1.How the facility identified other residents:** All staff within the using the Manor Shower Oxygen room have the potential to be affected by this alleged deficient practice. **1.Measures put into place/ System changes:** 1. Manor Shower Oxygen transfill room fan was repaired. 2. All other Oxygen transfill room fans were checked for operational status. Any concerns noted were repaired. 3. Maintenance Director or designee is to inspect the Oxygen transfill room fans for functional status on a monthly basis as a routine monthly inspection. This	

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			inspection will be submitted for review by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.How the corrective actions will be monitored:** The results of these audits if necessary will be reviewed by the Quality Assurance Committee monthly for 90 days, or until 100% compliance is achieved. **1.Date of compliance: 9/16/2017**	