CENTERS FOR	R MEDICARE & MEDIC					AB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155580	B. WING		09/12	2/2023
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	O BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 09/12 Facility Number: 0 Provider Number: 2000 At this Emergency Care Tolleston Park with Emergency Promotes and Mediand Suppliers, 42 C The facility has 180 dually certified for beds are certified for of the survey, the conductive of the survey, the conductive of the survey in th	2/2023 08505 155580 064830 Preparedness survey, Aperion and a survey, Aperion and a survey, Aperion and a survey, Aperion and Participating Providers and Participating Providers FR 483.73. Ocertified beds. 152 beds are and Medicare and Medicare, At the time ansus was 126. f 42 CFR, Subpart 483.73 is Not by:	E 0000	Tag number: K-000 I. What corrective ac will be accomplished for the residents found to have be affected by the deficient proposed for the residents were affected by this alleged depractice. II. How other residents the potential to be affected same deficient practice will identified and what correct action(s) will be taken; 10 residents have a potential to be affected by alleged deficient practice. Battery-operated smoke allower 10 years old were republicated with the deficient practice of the the the deficient practice of the	ractice; ficient s having I by the II be tive the this All arms blaced II be put nic nsure does not will be urer date sted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Jennifer Helfrich Executive Director 09/28/2023

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	A. BUILDING C		(X3) DATE SURVEY COMPLETED 09/12/2023
	PROVIDER OR SUPPLIE		2350	T ADDRESS, CITY, STATE, ZIP COD TAFT ST Y, IN 46404	•
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
E 0004 SS=F Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan Annually §403.748(a), §41 §441.184(a), §46 §483.73(a), §485 §485.68(a), §485 §494.62(a). The [facility] must Federal, State an preparedness rec must develop est comprehensive e program that mee section. The eme	5(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 920(a), 486.360(a),		The administrator or desginee will audit the battery-operated smoke log weekly to ensure they are replaced timely. The results of these audits wereviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achiful x3 consecutive months. The Committee will identify any troor patterns and make recommendations to revise the plan of correction as indicate. Compliance Date: 10/13/2023	ee or eved QA ends

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/12/2023	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	(a) Emergency Pladevelop and main preparedness pla and updated at leamust do all of the * [For hospitals at §485.625(a):] Emor CAH] must con Federal, State, an preparedness req CAH] must develocomprehensive en program that mees section, utilizing at the form of the for	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable and local emergency uirements. The [hospital or op and maintain a mergency preparedness at the requirements of this in all-hazards approach. Les at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. Lities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], and the properties of the plant in the pla			
	failed to review and Preparedness Plan (view and interview, the facility dupdate the Emergency (EPP) at least annually in CFR 483.73(a). This deficient et all occupants.	E 0004	Tag number: E004 I. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice; No residents were affected by	
	Based on records re	eview with the Executive		alleged deficient practice	

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP: 09/12	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP CO AFT ST , IN 46404	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE PROPRIATE	(X5) COMPLETION DATE
	between 09:12 a.m. a packet listed as the procedures were probinder had a revision binder provided had A packet listed as the had no revision date confirmed the inforcupdated annually, of record review, the packet, as of then, with the facility used unaware of the other preparedness binded. The Maintenance of the emergency preprocess of revisions and Maintenance of the everything had been.	enance Director on 09/12/23 and 1:25 p.m., two binders and e disaster policies and ovided at the survey. The first on date of 11/2017. The second d a revision date of 09/02/22. The designated disaster manual e or documentation that mation and plans had been Based on interview at the time the Administrator stated the was the disaster preparedness s. However, they were therefore two emergency and had not reviewed them. Director further stated that all of the aredness manuals were in the s. Both the Executive Director director could not confirm if an updated within the past year. Viewed with the Executive tenance Director during the exit		II. How other having the potential to be by the same deficient probe identified and what caction(s) will be taken; All residents have the potential to be affected by this alleg deficient practice. The Ill reviewed and updated to complete emergency problem. III. What measure be put into place and what systemic changes will be ensure that the deficient does not recur; The IDT was inserviced emergency management requirements. A complet of the emergency plan who to the QAPI calendar exponents. IV. How the contaction(s) will be monitor ensure the deficient pranot recur i.e., what quality assurance program will place; The admin or designee the QAPI calendar montals ocheck the date of the update of the emergency preparedness plan to enterviewed at least every. The results of these audience is achieved to compliance is achieved.	the affected ractice will corrective otential to ed DT he ogram ares will nat e made to t practice on the ent ete review was added very 12 rective ed to ctice will eity be put into will review thly and the last eyes are it is 12 months. His will be urance onths or %	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 	COMP	(X3) DATE SURVEY COMPLETED 09/12/2023	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP AFT ST IN 46404	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
				consecutive months. Committee will identif or patterns and make recommendations to plan of correction as	revise the	
E 0013 SS=F Bldg	484.102(b), 485.6. 485.727(b), 485.9. 491.12(b), 494.62 Development of E §403.748(b), §416. §441.184(b), §466. §483.73(b), §485. §485.68(b), §485. §485.920(b), §486. §494.62(b). (b) Policies and pridevelop and implered preparedness polition the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and unique preparedness polition to the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and unique preparedness polition the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible preparedness polition the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible preparedness polition the politic plasection.	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 2.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 3.360(b), §491.12(b), 2.360(b),				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	l í	JILDING	NSTRUCTION	(X3) DATE COMPI 09/12	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E IATE	(X5) COMPLETION DATE
	*Additional Requi ESRD Facilities:	rements for PACE and					
	procedures. The develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The polic address manager nonmedical emergimited to: Fire; edialure; care-related disasters likely to safety of the partic The policies and previewed and upd	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be lated at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must					
	preparedness pol on the emergency (a) of this section, paragraph (a)(1) of	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this					
	section. The police be reviewed and understanding years. These emeritarian not limited to, fire, failures, care-relations supply interruption	cies and procedures must updated at least every 2 ergencies include, but are equipment or power ted emergencies, water n, and natural disasters he facility's geographic					
	Based on record rev	view and interview, the facility I update the Emergency	E 00	013	Tag number: E013 I. What corrective	е	10/13/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	r í	JILDING	ONSTRUCTION	(X3) DATE COMPL 09/12/	ETED
	PROVIDER OR SUPPLIEI		•	2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) action(s) will be accomplished those residents found to have been affected by the deficient practice; No residents were affected by alleged deficient practice. II. How other reside having the potential to be affe by the same deficient practice be identified and what correct action(s) will be taken; All residents have the potential be affected by this alleged deficient practice. The emerg preparedness policies and procedures were reviewed an updated.	this this ents exted e will eive	(X5) COMPLETION DATE
	unaware of the other preparedness binded. The Maintenance Experience the emergency prepared and Maintenance Experience available EPP binded dates and could not been updated within This finding was re-	rs and had not reviewed them. Director further stated that all of paredness manuals were in the s. Both the Executive Director director confirmed that all of the ers had issues with revision confirm if everything had			III. What measures we be put into place and what systemic changes will be made ensure that the deficient practices on the emergency management requirements. A review and use of the emergency preparednes policies and procedures was added to the QAPI calendar of 12 months. IV. How the correctice action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality	de to tice e pdate ess every	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/12/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0029	403 748(c) 416 5	4(c) 418 113(c)		assurance program will be puplace; The admin or designee will rethe QAPI calendar monthly a also check the date of the last update of the emergency preparedness policies and procedures to ensure it is revat least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months until an average of 100% compliance is achieved x12 consecutive months. The QAC Committee will identify any tror patterns and make recommendations to revise the plan of correction as indicate.	eview nd iewed e e or		
SS=F Bldg	484.102(c), 485.6. 485.727(c), 485.9. 491.12(c), 494.62. Development of C §403.748(c), §416. §441.184(c), §460. §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					

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Facility ID: 008505

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155580	B. W	ING		09/12/	/2023
			I	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			AFT ST		
\ \DEDI∩\	N CARE TOLLESTO	JNI DADK					
AFERIO	N CARE TULLEST			GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ust develop and maintain					
		eparedness communication					
		s with Federal, State and					
		st be reviewed and updated					
		ears [annually for LTC					
	facilities].						
		view and interview, the failed	E 00	029			10/13/2023
	to review and update				Tag number: E029		
	*	(EPP) Communication Plan at			I. What corrective action		
	-	cordance with 42 CFR			will be accomplished for those	;	
	` ′	icient practice could affect all			residents found to have been		
	occupants.				affected by the deficient practi	ce;	
					No residents were		
	Findings include:				affected by this alleged deficie	ent	
					practice		
		eview with the Executive					
		enance Director on 09/12/23			II. How other residents ha	_	
		and 1:25 p.m., two binders and			the potential to be affected by		
	-	e disaster policies and			same deficient practice will be	!	
	-	ovided at the survey. The first			identified and what corrective		
		on date of 11/2017. The second			action(s) will be taken;		
	_	d a revision date of 09/02/22.			All residents have the		
	-	he designated disaster manual			potential to be affected by this		
		e or documentation that			alleged deficient practice. The	!	
		mation and plans had been			entire emergency plan was	IDT	
		Based on interview at the time			reviewed and updated by the	וטו.	
	·	e Administrator stated the					
		was the disaster preparedness					
	_	s. However, they were			III What we are suite to	nut.	
	unaware of the othe				III. What measures will be	put	
		rs and had not reviewed them. Director further stated that all of			into place and what systemic	ro	
		paredness manuals were in the			changes will be made to ensu		
		s. Both the Executive Director			that the deficient practice does	S HOL	
	-	irector could not confirm if the			recur; The IDT was inservice	d on	
		an had been reviewed and				u OII	
	updated within the				the emergency preparedness	ω.v.	
	upuateu witiiii tile	past 12 months.			requirements. A complete revi		
	This finding was ra	viewed with the Executive			of the emergency plan was ad to the QAPI calendar every 12		
		enance Director during the exit	1		months.	-	
	Director and iviallity	chance Director during the exit	1		monus.		I

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	OF CORRECTION	IDENTIFICATION NUMBER 155580	A. BUILDING B. WING		COMP 09/12	LETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 0036 SS=F Bldg	484.102(d), 485.62 485.727(d), 485.92 491.12(d), 494.62(EP Training and T §403.748(d), §416	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) esting .54(d), §418.113(d),		IV. How the corrective action(s) will be monitored ensure the deficient practic not recur i.e., what quality assurance program will be place; How the corrective action(s) will be monitored ensure the deficient practic not recur i.e., what quality assurance program will be place; The admin or designee will review the Qualendar monthly and also the date of the last update emergency preparedness ensure it is reviewed at least 12 months. The results of audits will be reviewed in Quality will be reviewed in Quality will an average 100% compliance is comp	to to te will put into put into API check of the plan to list every these Quality ly x12 e of		
	§483.73(d), §483.4 §485.68(d), §485.6 §485.920(d), §486 §494.62(d). *[For RNCHIs at §	.84(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), .360(d), §491.12(d), 403.748, ASCs at §416.54, 13, PRTFs at §441.184,					
		Hospitals at §482.15,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		 ILDING	NSTRUCTION	COMPL 09/12/	ETED	
	F PROVIDER OR SUPPLIEF		2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	CAHs at §486.628 485.727, CMHCs §486.360, and RH Training and testin develop and main preparedness train that is based on the in paragraph (a) of assessment at passection, policies and (b) of this section, plan at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The land maintain an entraining and testing the emergency plan of this section, risi (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plan section, risk and testing programe emergency plan section, risk and (a)(1) of this section at paragraph (b) of communication plasection. The train	P., CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at IC/FHQs at §491.12:] (d) and The [facility] must tain an emergency pring and testing program are emergency plan set forth and procedures at paragraph and the communication (c) of this section. The grogram must be ated at least every 2 years. Seat §483.73(d):] (d) Training TC facility must develop mergency preparedness grogram that is based on an set forth in paragraph (a) assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every and procedures of this section, and the gency preparedness training and the testing program and updated at least every and the early procedures of this section, and the early procedures of this section and the early program and updated at least every early fine program and updated at least every early fine program and updated at least every early program and updated at least every				

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Event ID:

5Z4Q21

Facility ID: 008505

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155580	B. W	ING		09/12/	/2023
NAME OF I	PROVIDER OR SUPPLIEF	₹	•		ADDRESS, CITY, STATE, ZIP COD	•	
APERIO	N CARE TOLLEST	ON PARK	2350 TAFT ST GARY, IN 46404				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	requirements for eat §483.470(i).	IID must meet the evacuation drills and training ties at §494.62(d):]					
	_	and orientation. The					
		ist develop and maintain an					
	1 .	redness training, testing					
	and patient orient	ation program that is based					
		/ plan set forth in paragraph					
	(a) of this section, risk assessment at						
	paragraph (a)(1) of this section, policies and						
	1 '	agraph (b) of this section,					
		cation plan at paragraph (c) ne training, testing and					
		m must be evaluated and					
	updated at every						
		view and interview, the facility	E 00	036	Tag number: E0036		10/13/2023
		l updated the Emergency			I. What corrective action	(s)	10/13/2023
	Preparedness Plan's	s (EPP) Training and Testing			will be accomplished for those	` '	
	Plan at least annual	ly in accordance with 42 CFR			residents found to have been		
	483.73(a). This det	ficient practice could affect all			affected by the deficient pract	ice;	
	occupants.				No residents were		
	Findings include:				affected by this alleged deficiently practice	ent	
	Based on records re	eview with the Executive			II. How other residents ha	avina	
		enance Director on 09/12/23			the potential to be affected by	•	
		and 1:25 p.m., two binders and			same deficient practice will be		
		e disaster policies and			identified and what corrective		
		ovided at the survey. The first			action(s) will be taken;		
		on date of 11/2017. The second			All residents have the		
	_	d a revision date of 09/02/22.			potential to be affected by this		
	_	he designated disaster manual			alleged deficient practice. The	;	
		e or documentation that			entire emergency plan was		
		mation and plans had been			reviewed and updated by the	IDT.	
		Based on interview at the time					
	· ·	ne Administrator stated the					
	_	was the disaster preparedness			III What measures will be	nut	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/12/2023	
	PROVIDER OR SUPPLIEF		2350 1	TADDRESS, CITY, STATE, ZIP COD TAFT ST 7, IN 46404	-
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF unaware of the other preparedness binder The Maintenance Defined the emergency preparedness of revisions and Maintenance Defining and Testing and updated within This finding was re	rs and had not reviewed them. Firector further stated that all of aredness manuals were in the second by the Executive Director irector could not confirm if the g Plans had been reviewed	ID PREFIX TAG	into place and what systemic changes will be made to ensure the emergency preparedness requirements. A complete revof the emergency plan was a to the QAPI calendar every 1 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice on trecur; assurance program will be puplace; The admin or designed will review the QAPI calendar monthly and also check the dof the last update of the emergency preparedness requirements. The results of the ensure it is reviewed at least 12 months. The results of the audits will be reviewed in Qual Assurance Meeting monthly of months or until an average of 100% compliance is	DATE Ure es not ed on s view dded 2 will ut into ee r late an to every ese ality k12
Bldg. 01	Licensure Survey w		K 0000	Tag number: K-000 I. What corrective action will be accomplished for thos residents found to have been affected by the deficient praction in the complex series where affected by this alleged deficients.	e tice;

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155580	B. W	TNG	_	09/12/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	(AFT ST		
APERIO	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	Provider Number:				practice.		
	AIM Number: 200	064830					
	At this Life Cofety	Code aumier America Cone			II. How other residents ha	-	
	· ·	Code survey, Aperion Care			the potential to be affected by		
		found not in compliance with			same deficient practice will be	!	
	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a),				identified and what corrective		
	Life Safety from Fire and the 2012 edition of the				action(s) will be taken; 10 residents have the		
	National Fire Protection Association (NFPA) 101,				potential to be affected by this		
		* * * * * * * * * * * * * * * * * * * *			alleged deficient practice. All	•	
	Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.				battery-operated smoke alarm	ie	
	Treatur Care Occupancies and 410 IAC 10.2.				over 10 years old were replace		
	This one story facil	ity with a partial basement was			over 10 years old were replac	cu	
	determined to be of Type V (111) construction and				III. What measures will be	nut	
	fully sprinklered. The facility has a fire alarm				into place and what systemic	P 4.1	
		detection in the corridors,			changes will be made to ensu	re	
	1 -	corridors. Battery powered			that the deficient practice does		
		c located in the North and			recur;		
		t rooms; the PCU resident			A log of all battery		
		with hard wired smoke			operated smoke detectors will	be	
	detectors.				created with the manufacturer	date	
					and date to be replaced listed		
	The facility is prote	cted by a 30-kW and 45 kW					
	natural gas generato	ors.			IV. How the corrective		
					action(s) will be monitored to		
	I -	certified beds. 152 beds are			ensure the deficient practice v	vill	
		Medicare and Medicaid; 28			not recur i.e., what quality		
		or Medicare only. At the time of			assurance program will be put	tinto	
	the survey, the cens	sus was 126.			place;		
					The administrator or		
		residents have customary			desginee will audit the		
	1	ered. A detached wood			battery-operated smoke log		
	equipment storage s	shed was unsprinklered.			weekly to ensure they are		
	O 1'4 P '	1 4 1 00/14/22			replaced timely.		
	Quality Review cor	mpleted on 09/14/23			The results of these audits wil		
					reviewed in Quality Assurance		
					Meeting monthly x6 months of	Γ	
					until an average of 90%		
					compliance or greater is achie		
					x3 consecutive months. The	JΑ	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155580	B. W	ING	.=	09/12/	/2023
						33,12	
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
				2350 TA			
APERION	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Committee will identify any tre	nds	
					or patterns and make		
					recommendations to revise the		
					plan of correction as indicated		
				Compliance Date:10/13/2023			
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
Diag. 01	•	d means of egress shall not					
	1	a latch or a lock that					
		of a tool or key from the					
	•	s using one of the following					
	special locking an	-					
		OR SECURITY THREAT					
	LOCKING	or observer miner					
		king arrangements for the					
	I -	eeds of the patient are					
	1	cking device shall be					
	I -	door and provisions shall					
	1 '	apid removal of occupants					
		l of locks; keying of all					
	1 -	ied by staff at all times; or					
	I -	e means available to the					
	staff at all times.	o means available to the					
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6	.2.2.0, 10.2.2.2.0.1,					
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENT						
		king arrangements for the					
	I -	e patient are used, all of					
	· ·	curity Locking requirements					
		addition, the locks must be					
		at fail safely so as to					
		of power to the device; the					
	1						
		ed by a supervised					
		er system and the locked					
	space is protected	d by a complete smoke					

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detection system (or is constantly monitored

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Facility ID: 008505

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/12/2023
	PROVIDER OR SUPPLIEI		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, supdetection system automatic sprinkled 18.2.2.2.4, 19.2.2 ACCESS-CONTELOCKING ARRAI Access-Controlled installed in according be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBI LOCKING ARRAI Elevator lobby exaccordance with a condition of conditions and conditions assemblication of conditions are assemblications.	SS LOCKING S delayed-egress locking in accordance with permitted on door ag low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 ROLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall 3.2.4 BY EXIT ACCESS			
	approved, superv system.	ised automatic sprinkler			
	failed to ensure the 1 exit door in the maccessible for resid diagnosis requiring Doors within a requ	on and interview, the facility means of egress through 1 of main lobby were readily ents without a clinical specialized security measures. uired means of egress shall not latch or lock that requires the	K 0222	I. What corrective action(will be accomplished for those residents found to have been affected by the deficient practic No residents were	
		from the egress side unless		affected by this alleged deficien	nt

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPI	LETED	
		155580	B. WI	NG	<u> </u>	09/12	/2023	
			<u> </u>		_			
NAME OF	PROVIDER OR SUPPLIEI	8			ADDRESS, CITY, STATE, ZIP COD			
THIND OF	ing (ibbit on boll bib			2350 T	AFT ST			
APERIO	N CARE TOLLEST	ON PARK		GARY,	IN 46404			
(VA) ID	CURALARY	CTATEMENT OF DEFICIENCIE		ID	T		(7/5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, i	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	otherwise permitted	d by LSC 19.2.2.2.4.			practice			
	Door-locking arran	gements shall be permitted in						
	accordance with 19	2.2.2.2.5.2. LSC 7.2.1.5.3 requires			II. How other residents ha	aving		
	if provided, locks shall not require of a key, a tool,				the potential to be affected by	_		
	_	ge or effort for operation from			same deficient practice will be			
	_	is deficient practice could			identified and what corrective			
	-	ly 15 residents and staff.			action(s) will be taken;			
	arreet approximates	1) 10 residents and stair.			All residents have the			
	Findings in alud-							
	Findings include:				potential to be affected by this	•		
				alleged deficient practice. All				
		on with the Maintenance			egress doors well be check			
	Director on 09/12/23 between 9:42 a.m. and 1:25				weekly for appropriate code a	nd		
	p.m., the exit door leading outside from the main				recorded on log which will be			
	lobby was marked	as a facility exit, was			reviewed and updated by the	IDT.		
	magnetically locked	d, and could be opened by						
	entering a four-digi	it code on the access control						
	pad, that had a code	e posted on the keypad.						
	_	e code was put in the door did			III. What measures will be	put		
		on interview at the time of			into place and what systemic	•		
		aintenance Director stated that			changes will be made to ensu	re		
		the door was not the correct			that the deficient practice doe			
	_	e door and had not had time to			recur;	3 1101		
		ack on the door and agreed the			The IDT was inservice	d on		
	1 -	_				u on		
	aooi would not ope	en with the posted code.			egress door requirements. A			
	TEL (* 1'	· · · · · · · · · · · · · · · · · · ·			complete review of the egress			
	_	reviewed with Maintenance			requirements will be added to			
		tive Director during the exit			QAPI calendar every 12 mont	hs.		
	conference.							
					IV. How the corrective			
	3.1-19(b)				action(s) will be monitored to			
					ensure the deficient practice v	vill		
					not recur i.e., what quality			
					assurance program will be pu	t into		
					place;			
					The admin or designe	е		
					will review the QAPI calendar			
					monthly and also check the da			
					1	ai C		
					of the last update of the			
					emergency preparedness plan	า to		

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ensure it is reviewed at least every

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155580	B. WING		09/12/2023
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	L		AFT ST	
APFRION	N CARE TOLLESTO	ON PARK		IN 46404	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				12 months. The results of thes	
				audits will be reviewed in Qua	•
				Assurance Meeting monthly x	12
				months or until an average of	
				100% compliance is	
K 0271	NFPA 101				
SS=E	Discharge from Ex				
Bldg. 01	Discharge from Ex				
	Exit discharge is a	arranged in accordance with			
	7.7, provides a lev	el walking surface meeting			
	the provisions of 7	'.1.7 with respect to			
changes in elevation and shall be maintained free of obstructions. Additionally, the exit					
	discharge shall be	a hard packed all-weather			
	travel surface.				
	18.2.7, 19.2.7				
	Based on observation	on and interview, the facility	K 0271	Tag number: K271	10/13/2023
	failed to maintain 1	of 7 Exit Discharges in		What corrective action	(s)
	accordance with NF	FPA 101 Section 7.7 as required		will be accomplished for those	
	by Section 19.2.7.	Section 7.7.1.1 state that the		residents found to have been	
	exit discharge shall	be of the required width and		affected by the deficient practi	ce;
	size to provide all o	ccupants with a safe access to		No residents were	
	a public way. This	deficient practice could affect		affected by this alleged deficie	nt
	approximately 15 re	esidents and staff.		practice.	
				l ·	
	Findings include:			II. How other residents ha	ving
	-			the potential to be affected by	the
	Based on observation	on with the Maintenance		same deficient practice will be	
	Director on 09/12/2	3 during a tour of the facility		identified and what corrective	
		:34 p.m., the Exit Discharge from		action(s) will be taken;	
	_	r resident room 127 was		15 residents had the	
	_	nger car. The car was parked		potential to be affected deficie	nt
		ed out area in front of the exit		practice. The vehicle blocking	
	_	erview at the time of		exit was moved.	
		intenance Director agreed			
	· ·	ocked by a car and the exit		III. What measures will be	put
		ked. The Plant Operations		into place and what systemic	F = -
		owner notified upon		changes will be made to ensur	re l
1		T	1	1	-

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observation.

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that the deficient practice does not

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS CITY STATE ZIE			(X3) DATE SURVEY COMPLETED 09/12/2023	
	PROVIDER OR SUPPLIEF		•	2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION viewed with the Executive enance Director at the exit		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) recur; All staff will be inservic on exit discharge requirement IV. How the corrective action(s) will be monitored to ensure the deficient practice was not recur i.e., what quality assurance program will be purplace; The maintenance director or designee will check the existence or designee will check the existence or discharge space 5 times weekly. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved and the complete will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	ced ds. will t into ctor ts for es ll be e r eved QA ends	(X5) COMPLETION DATE
K 0300 SS=E Bldg. 01	Section 18.3 and requirements that provided K-tags, k information, along Safety Code or NI should be include Based on observation failed to ensure 4 or	RKS section any LSC	K 03	300	Tag number: K300 I. What corrective action will be accomplished for those	. ,	10/13/2023

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were not over ten years old in accordance with

NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1

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If continuation sheet

residents found to have been

affected by the deficient practice;

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLI	ETED
		155580	B. W	ING		09/12/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L					
ADEDION	LOADE TOLLEGE	ON DADIC		2350 TA			
APERIO	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	states unless otherw	vise recommended by the			No residents were		
	manufacturer's publ	ished instructions, single- and			affected by this alleged deficie	ent	
	multiple-station sm	oke alarms shall be replaced			practice.		
	when they fail to re	spond to operability tests but			•		
	shall not remain in	service longer than 10 years			II. How other residents ha	ving	
	from the date of ma	nufacture. This deficient			the potential to be affected by	-	
	practice could affect approximately 10 residents				same deficient practice will be	<u> </u>	
	and staff.				identified and what corrective		
	Findings include: Based on observations with the Maintenance Director on 09/12/23 during a tour of the facility				action(s) will be taken;		
					10 residents have the		
					potential to be affected by this	;	
					alleged deficient practice. All		
					battery-operated smoke alarm	ıs	
	from 1:43 p.m. to 3:34 p.m., manufacturer's				over 10 years old were replace	ed	
	documentation affix	xed to the battery operated					
	smoke alarms instal	led above the doors in resident			III. What measures will be	put	
	sleeping rooms 217	, 215, 209, and 112 indicated			into place and what systemic		
	each device was ma	nufactured 02/2009, 03/2012,			changes will be made to ensu	re	
		9 respectively. Based on			that the deficient practice does	s not	
		e of each observation, the			recur;		
		or agreed the aforementioned			A log of all battery		
		more than ten years old and			operated smoke detectors will		
		ware of only one battery			created with the manufacturer		
		ng replaced, but was unaware if			and date to be replaced listed.		
		replaced due to being over					
	10 years old.				IV. How the corrective		
					action(s) will be monitored to		
	_	e reviewed with the Executive			ensure the deficient practice w	√III	
		enance Director during the exit			not recur i.e., what quality		
	conference.				assurance program will be put	into	
					place;		
					The administrator or		
					desginee will audit the		
					battery-operated smoke log		
					weekly to ensure they are		
					replaced timely.		
					The results of these audits will		
					reviewed in Quality Assurance		
					Meeting monthly x6 months or	ſ	
					until an average of 90%		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPL	LETED
		155580	B. WIN	lG		09/12	/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE		ιΤΕ	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	SS=F Fire Alarm System - Out of Service				compliance or greater is achie x3 consecutive months. The 0 Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	QA ends e	
K 0346 SS=F Bldg. 01							
	Based on record reversal failed to provide a conformation of procedures to be for alarm system has to four hours or more accordance with LS deficient practice at Findings include: Based on records reduced between 09:42 a.m. plan provided failed Indiana Department Gateway link at htt primary method or	wiew and interview, the facility complete 1 of 1 written policy f residents indicating llowed in the event the fire of the placed out of service for in a twenty four hour period in SC, Section 9.6.1.6. This ffects all occupants. Eview with the Maintenance tive Director on 09/12/23 and 1:25 p.m., the fire watch d to include contacting the tof Health via the IDOH ps://gateway.isdh.in.gov as the by the secondary method when is nonoperational by	K 03	46	Tag number: K0346 I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. II. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice.	ent ent eving the	10/14/2023

completing the Incident Reporting form and

e-mailing it to incidents@isdh.in.gov. Based on

into place and what systemic

changes will be made to ensure

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMP	E SURVEY PLETED 2/2023
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP AFT ST IN 46404	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF interview during the Director acknowled documentation prov IDOH but not via th e-mail address listed This finding was re	rided stated to contact the are IDOH Gateway link or at the	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) that the deficient practice of the designee will fire water updated required information (IDT team will be in second to updated points). How the corresponding to updated points are the deficient proton recur i.e., what quassurance program will provide the proton of the complete of the second to update of the second to the second to update of the second to the second to update of the second to the s	ctice does not ator or ch policy with branation. The erviced in olicy. ctive itored to bractice will uality vill be put into audits will be assurance months or 10% er is achieved ths. The QA fy any trends er revise the	(X5) COMPLETION DATE
K 0354 SS=F Bldg. 01	extent and duration been determined, are inspected and recommendations management or durand the fire depart having jurisdiction the sprinkler systems.	Out of Service er system is impaired, the n of the impairment has areas or buildings involved risks are determined,				

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155580	B. Wl	NG		09/12	/2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEI	3			AFT ST		
APERIO	N CARE TOLLEST	ON PARK		GARY, IN 46404			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	building or portion	of the building affected are					
		approved fire watch is					
	1 3	sprinkler system has been					
	returned to servic						
		, 9.7.5, 15.5.2 (NFPA 25)					
		view and interview, the facility	K 0	354	Tag number: K0354		10/13/2023
	•	of 1 correct written policies in			I. What corrective action		
		natic sprinkler system has to be			will be accomplished for those	•	
	_	ce for 10 hours or more in a			residents found to have been		
	_	ccordance with LSC, Section			affected by the deficient pract	ice;	
		quires sprinkler impairment			No residents were		
		with NFPA 25, 2011 Edition,			affected by this alleged deficie	ent	
	the Standard for the Inspection, Testing and				practice.		
	Maintenance of Water-Based Fire Protection						
		5, 15.5.2 requires nine			II. How other residents ha	_	
	_	impairment coordinator shall			the potential to be affected by		
) (b) states a fire watch should			same deficient practice will be		
	_	ersonnel who continuously			identified and what corrective		
	_	area. Ready access to fire			action(s) will be taken;		
	_	he ability to promptly notify			All residents have the		
	_	are important items to			potential to be affected by this	3	
	_	e patrol of the area, the person			alleged deficient practice.		
		looking for fire, but making ire protection features of the			III. What measures will be	put	
		ress routes and alarm systems			III. What measures will be into place and what systemic	ρuι	
		inctioning properly. This			changes will be made to ensu	ro	
		ould affect all occupants in the			that the deficient practice doe		
	facility.	oura arreet arr occupants in the			recur;	3 1101	
	1301111,				The administrator or		
	Findings include:				designee will fire watch policy	with	
					updated required information.		
	Based on records re	eview with the Maintenance			IDT team will be in serviced in		
		tive Director on 09/12/23			regards to updated policy.	-	
	between 09:42 a.m.	and 1:25 p.m., the fire watch					
		d to include contacting the			IV. How the corrective		
		t of Health via the IDOH			action(s) will be monitored to		
		ps://gateway.isdh.in.gov as the			ensure the deficient practice v	vill	
		by the secondary method when			not recur i.e., what quality		
		is nonoperational by			assurance program will be pu	t into	
		dent Reporting form and			place:		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		 JILDING	01	COMPL 09/12/	ETED	
	PROVIDER OR SUPPLIER		2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	interview during the Director acknowled documentation prov IDOH but not via th e-mail address listed This finding was rev	ided stated to contact the e IDOH Gateway link or at the		The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any trei or patterns and make recommendations to revise the plan of correction as indicated.	ved QA nds	
K 0363 SS=D Bldg. 01	than required enclexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combustible or combustible mater hardware in the covering is not except to a complying with the door closed with a polied. There is closing of the door release when the	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	meeting 19.3.6.3. frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratic devices, etc. Based on observation failed to ensure 4 or doors on the 100 with means suitable for no impediment to corresist the passage of practice could affect. Findings include: Based on observation birector on 09/12/2 p.m., the corridor donot latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in Based on interview Maintenance Direct would not latch into the fronthe doors to resident trash cans placed in impedes closure in the fronthe doors to resident trash cans placed in impedes closure in the fronthe doors to resident trash cans placed in impedes closure in the fronthe doors to resident trash cans placed in impedes closure in the fronthe doors to resident trash cans placed in impedes closure in the fronthe doors to resident trash cans	fire window assemblies are a sprinklered compartments of tions in area or fire as or frames in window Parts 403, 418, 460, 482, So details of doors such as angs, automatics closing on and interview, the facility and an additional and would are smoke. This deficient are resident room 406. The window with a description of the door which an event of an emergency, at the time of observation, the for stated the corridor door of the door frame and trash cans impeding door	K 0363	Tag number: K-0363 I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract No residents were affected by this alleged deficient practice II. How other residents hat the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. III. What measures will be into place and what systemic changes will be made to ensut that the deficient practice doe recur:	ice; ent aving the e		

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The finding was reviewed with the Executive

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Administrator and or

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	î í	ЛLDING	01	COMPL	
		155580	B. W			09/12/	
			1	_	_	1	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
				2350 TA			
APERION	N CARE TOLLEST	UN PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		aintenance Director during the			designee will audit 100% of		
	exit conference.				resident doors ensure means		
					suitable for keeping doors clos		
	3.1-19(b)				specifically latching. A weekly	/	
					audit form will be utilized. IDT		
					team educated on importance		
					suitable door closing and latch	ning	
					protocol.		
					IV. How the corrective		
					IV. How the corrective action(s) will be monitored to		
					ensure the deficient practice v	vill	
					not recur i.e., what quality	V 161	
					assurance program will be pu	t into	
					place;		
					The administrator will		
					audit form weekly.		
					The results of these audits wil	l be	
					reviewed in Quality Assurance		
					Meeting monthly x6 months o		
					until an average of 90%		
					compliance or greater is achie	eved	
					x3 consecutive months. The	QA	
					Committee will identify any tre	ends	
					or patterns and make		
					recommendations to revise th		
					plan of correction as indicated	l.	
IV 0524	NEDA 404						
K 0531 SS=C	NFPA 101						
SS=C Bldg. 01	Elevators Elevators						
Diug. 01	2012 EXISTING						
	-	with the provision of 9.4.					
		pected and tested as					
	·	E A17.1, Safety Code for					
	•	calators. Firefighter's					
		ed monthly with a written					
	record.	54 monthly with a written					
		conform to ASME/ANSI					
	-	de for Existing Elevators					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/12/2023
	PROVIDER OR SUPPLIEI		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST , IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	a travel distance of below the level the emergency person purposes, conformed Requirements of a (Includes firefighter recall and smoke firefighter's service key operation, madetectors, and electectors.) 19.5.3, 9.4.2, 9.4. Based on record refailed to maintain the firefighter recall in Testing. LSC 9.4.6 fire fighters' emerge with 9.4.3 shall be with a written record kept on the premise A17.1/CSA B44, SE Escalators. This deconcupants. Findings include: Based on record refined between 09:42 a.m. testing for the elevation memory care elevants. Based on interview the Maintenance Demissing recall testing in the elevator service.	wiew and interview, the facility esting of 1 of 1 elevator accordance with 9.4.6, Elevator 5.2 states that all elevators with ency operations in accordance subject to a monthly operation of of the findings made and es as required by ASME afety Code for Elevators and efficient practice would affect all eview with the Maintenance tive Director on 09/12/23 and 1:25 p.m., the monthly ator firefighter recall for the tor was missing testing for 6 of ptember 2022 to August 2023. The time of record review, irector confirmed there were ag from documentation located	K 0531	Tag number: K531 I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. II. How other residents has the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. The elevator firefighter recall was tested. III. What measures will be into place and what systemic changes will be made to ensuthat the deficient practice doe recur;	e tice; ent aving / the e s e put ure es not

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Director and Maintenance Director during the exit

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was inserived on the monthly

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	OF CORRECTION	IDENTIFICATION NUMBER 155580	A. BUILDING B. WING	01	COMPLETED 09/12/2023
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	conference. 3.1-19(b)			requirement for the elevator firefighter monthly recall testin IV. How the corrective action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality assurance program will be purplace; The administrator or designee will audit the elevator monthly firefighter recall testing monthly. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achied x3 consecutive months. The example of patterns and make	vill t into or og Il be ee r eved QA ends
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills ar routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1	ay be used instead of	K 0712	recommendations to revise the plan of correction as indicated.	1.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155580	B. W	ING		09/12/	/2023
		ı	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R		2350 TA			
ΔPERI∩N	N CARE TOLLESTO	ON PARK			IN 46404		
AI ENIOI	V OAKL TOLLEST	ON LAIM		GART,	114 70404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		re drills on each shift for 2 of 4			will be accomplished for those	;	
	quarters. LSC 19.7.1.6 states drills shall be				residents found to have been		
		y on each shift to familiarize			affected by the deficient practi	ce;	
		nurses, interns, maintenance			No residents were		
	_	inistrative staff) with the			affected by this alleged deficie	ent	
		ncy action required under			practice		
	varied conditions. This deficient practice affects						
	all staff and residen	nts.			II. How other residents ha	•	
	E. 1				the potential to be affected by		
	Findings include:				same deficient practice will be	!	
					identified and what corrective		
	Based on records review with the Maintenance				action(s) will be taken;		
	Director and Executive Director on 09/12/23 between 9:42 a.m. and 1:25 p.m., the following				All residents have the		
					potential to be affected by this		
	fire drill:	documentation of a completed			alleged deficient practice. A fir	е	
		re drill in the first quarter of			drill with all the required	ı	
	2023.	re drift in the first quarter of			components will be conducted	1.	
		second shift fire drill in the			III. What measures will be	nut	
	fourth quarter of 20				into place and what systemic	put	
	_	at the time of record review,			changes will be made to ensu	rΔ	
		irector acknowledged the			that the deficient practice does		
		e drills missing and stated that			recur;	3 1100	
		ation they could find and had			The maintenance direc	ctor	
	1	was provided and agreed there			was inserviced on all the requ		
	were three fire drill				components of a fire drill. The		
		8			drill log was revised to include		
	Findings were discu	ussed with the Maintenance			the required components.		
	Director and Execu						
					IV. How the corrective		
	3.1-19(b)				action(s) will be monitored to		
	3.1-51(c)				ensure the deficient practice v	vill	
					not recur i.e., what quality		
					assurance program will be put	tinto	
					place;		
					The administrator or		
					designee will audit the fire drill	l log	
					month to ensure all required	-	
					components of a fire drill are		
			1		followed		

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OF CORRECTION	IDENTIFICATION NUMBER 155580	A. BUILDING B. WING	01	COMPLETED 09/12/2023
		2350 T	AFT ST	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
			reviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achieved.	ieved
Smoking Regulations Smoking regulations shall include not be provisions: (1) Smoking shall ward, or compartmoliquids, combustible used or stored and location, and such signs that read NC posted with the interest smoking. (2) In health care of smoking is prohibited prominently placed secondary signs we smoking shall not a smoking shall not be secondary signs we smoking shall be the passible shall be supervision. (5) Ashtrays of nor safe design shall be where smoking is (6) Metal contained devices into which shall be readily avaismoking is permitted.	ons ons shall be adopted and less than the following be prohibited in any room, ment where flammable le gases, or oxygen is id in any other hazardous area shall be posted with o SMOKING or shall be ernational symbol for no occupancies where ted and signs are id at all major entrances, with language that prohibits be required. It is to the prohibited of 18.7.4(3) shall not extend at it is under direct incombustible material and the provided in all areas permitted. The with self-closing cover ashtrays can be emptied ailable to all areas where eed.	K 0741		10/13/2023
	NFPA 101 Smoking Regulation shall include not less provisions: (1) Smoking shall ward, or compartm liquids, combustible used or stored and location, and such signs that read NC posted with the interest smoking is prohibit prominently placed secondary signs ward, signs that read NC posted with the interest smoking. (2) In health care of smoking is prohibit prominently placed secondary signs was moking shall not (3) Smoking by paresponsible shall be (4) The requireme apply where the passible shall be supervision. (5) Ashtrays of not safe design shall be where smoking is (6) Metal contained devices into which shall be readily av smoking is permitting 18.7.4, 19.7.4	ROVIDER OR SUPPLIER I CARE TOLLESTON PARK SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 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.	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Smoking Regulations 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 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	ROVIDER OR SUPPLIER I CARE TOLLESTON PARK SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Smoking Regulations Smoking Regulations Smoking Regulations Smoking Regulations 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 signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with signs that read NO SMOKING or shall be posted with an average of smoking is prohibited and signs are 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.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/12/2023 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure 1 of 2 smoking areas was Tag number: 741 maintained by disposing cigarette butts in a metal What corrective action(s) or noncombustible container with self-closing will be accomplished for those residents found to have been cover devices. This deficient practice could affect approximately 12 residents and staff. affected by the deficient practice; No residents were Findings include: affected by this alleged deficient practice Based on observation during a tour of the facility with the Maintenance Director on 09/12/23 How other residents having between 1:43 p.m. and 3:34 p.m., in the courtyard the potential to be affected by the resident smoking area there were over 40 cigarette same deficient practice will be butts disposed on the ground in and around the identified and what corrective smoking area in the grass and mulch coverings. action(s) will be taken; Based on interview at the time of observation, the 12 residents have the Maintenance Director stated that they do clean potential to be affected by this the smoking areas periodically and agreed that alleged deficient practice. All the there were multiple spots within the designated cigarette butts were picked up and area that had discarded cigarette butts on the placed in the proper container. ground. What measures will be put III. This finding was reviewed with the Executive into place and what systemic Director and Maintenance Director during the exit changes will be made to ensure conference. that the deficient practice does not 3.1-19(b) All staff and residents that smoke will be re-educated on the proper disposal of cigarette butts. The housekeeping supervisor will the inspect the smoking area 5 times a week for 4 weeks then weekly and document the findings on the smoking area audit form to ensure all cigarette butts are properly disposed of.

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How the corrective action(s) will be monitored to ensure the deficient practice will

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (2) O1	c3) date survey completed 09/12/2023
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST , IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0761				not recur i.e., what quality assurance program will be put in place; The administrator audit the smoking area audit form weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieve x3 consecutive months. The QAC Committee will identify any trend or patterns and make recommendations to revise the plan of correction as indicated.	pe ed A
SS=F Bldg. 01	failed to ensure and of 5 fire door assen accordance of LSC openings in dividin 19.1.1.4.1 shall be protected be door assemblies. (S 8.3.3.1 Openings retaing by Table 8.3. approved, listed, labeling fire window assembliardware, including anchorage, and sills requirements of NF and Other Opening	eview and interview, the facility and inspection and testing of 5 ablies were completed in 19.1.1.4.1.1 communicating g fire barriers required by permitted only in corridors and by approved self-closing fire see also Section 8.3.) LSC equired to have a fire protection 4.2 shall be protected by beled fire door assemblies and oblies and their accompanying g all frames, closing devices, as in accordance with the PA 80, Standard for Fire Doors Protectives, except as in this Code. NFPA 80 5.2.1	K 0761	Tag number: 761 I. What corrective action(s will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. The fit door inspections have occurred	t ing ne

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	T OF HEALTH AND HUN R MEDICARE & MEDIC.						RM APPROVED B NO. 0938-039
STATEMEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	l í	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 09/12	SURVEY ETED
	PROVIDER OR SUPPLIER		-	2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR states fire door asse tested not less than	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION mblies shall be inspected and annually, and a written record		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) weekly which will be recorded log.	on a	(X5) COMPLETION DATE
	inspection by the Adoor assemblies shaboth sides to assess assembly. NFPA 80 the following items (1) No open holes of either the door or from the following items (2) Glazing, vision are intact and secure equipped. (3) The door, frame noncombustible through the same and the following interest and secure equipped.	r breaks exist in surfaces of			III. What measures will be into place and what systemic changes will be made to ensur that the deficient practice does recur; The administrator and or desi will the inspect the log weekly IV. How the corrective action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality assurance program will be put place;	re s not gnee	
	damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door com from the full open p (7) If a coordinator closes before the ac (8) Latching hardwa door when it is in th (9) Auxiliary hardwa prohibit operation a frame. (10) No field modif have been performe (11) Gasketing and inspected to verify the	sing or broken. do not exceed clearances 3.1.7. device is operational; that is, pletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the			The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	ved QA nds	

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Findings include:

Based on record review with the Maintenance Director and Executive Director on 09/12/23

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X.		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER A. BUILDING <u>01</u> COM		COMPL	ETED		
		155580	B. W	ING		09/12/	/2023
NAME OF B	ROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
				2350 TA			
APERION	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ļ	(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		. LSC IDENTIFYING INFORMATION and 1:25 p.m., no documentation		TAG	DEFICIENCY (DATE
		tion for the (5) fire door					
	-	lable for review. Based on					
		e of records review, the					
		or stated they were unaware if					
		s were ever conducted within					
	the past 12 months a						
	_	had documented was given					
	to the surveyor.						
	Findings were discu	ssed with the Maintenance					
	-	tive Director at exit conference.					
	3.1-19(b)						
	3.1-17(0)						
K 0914	NFPA 101					ļ	
SS=E	Electrical Systems	s - Maintenance and					
Bldg. 01	Testing						
	_	s - Maintenance and					
	Testing						
		ceptacles at patient bed					
		re deep sedation or general					
		inistered, are tested after replacement or servicing.					
		is performed at intervals					
	_	ented performance data.					
	•	sted as hospital-grade at					
		e tested at intervals not					
		ths. Line isolation monitors					
	•	are tested at intervals of					
	less than or equal	to 1 month by actuating					
	the LIM test switch	n per 6.3.2.6.3.6, which					
		ıal and audible alarm. For					
		utomated self-testing, this					
		formed at intervals less					
	-	2 months. LIM circuits are					
	•	2 after any repair or					
		electric distribution system.					
		tained of required tests and					
	associated repairs	or modifications,					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155580	B. W	NG		09/12/2023		
			1	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			AFT ST			
APERIO	N CARE TOLLESTO	ON PARK		GARY, IN 46404				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE CONTILL TION	1	
TAG	 	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	_	oom or area tested, and						
	results.							
	6.3.4 (NFPA 99)					40/40/000		
		on, record review and	K 0	914	Tag number: K914	10/13/2023	3	
		ty failed to ensure non-hospital			I. What corrective action	` '		
	-	eptacles in 61 of 61 resident			will be accomplished for thos			
		hin the 100 and 200-wings were			residents found to have been			
		ally. NFPA 99, Health Care			affected by the deficient prac	cuce;		
	Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at				No residents were	iont		
	_				affected by this alleged defici	Herit		
	patient bed locations and in locations where deep				practice			
	sedation or general anesthesia is administered,				II. How other residents h	aving		
	shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle				the potential to be affected by	_		
		Care Rooms requires the			same deficient practice will be	· I		
	-	f each receptacle shall be			identified and what corrective			
		l inspection. The continuity of			action(s) will be taken;	·		
		it in each electrical receptacle			80 residents the poter	ntial		
		Forrect polarity of the hot and			to be affected by this alleged	•		
		in each electrical receptacle			deficient practice. All outlets			
		and retention force of the			tested as for polarity and rete			
	· ·	each electrical receptacle			with all outlets passing and th			
		e receptacles) shall be not less			form showing the room, locat	•		
		ounces). This deficient practice			and pass/fail.	, l		
		imately 80 residents and staff.			' '			
		-			III. What measures will be	e put		
	Findings include:				into place and what systemic			
					changes will be made to ensu			
	Based on observation	ons during a tour of the facility			that the deficient practice doe			
	with the Maintenan	ce Director on 09/12/23			recur;			
	between 1:43 p.m.	and 3:34 p.m., the facility's 61			The maintenance dire	ector		
	resident sleeping ro	oms within the 100 and			was inserviced on outlet testi	ing		
	200-Halls contained	d four to eight			and the form changed to add	date,		
		electrical receptacles. Based			room, location, and pass/fail.			
	on records review b	petween 9:12 a.m. and 1:25 p.m.,						
		lectrical receptacles was			IV. How the corrective			
	· ·	ocumentation only had			action(s) will be monitored to			
	_	the 300-Hall resident rooms.			ensure the deficient practice	will		
		the 100 and 200-Hall testing			not recur i.e., what quality			
	could not be found.	Based on interview at the			assurance program will be pu	ut into		

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	OF CORRECTION	IDENTIFICATION NUMBER 155580		ILDING	01	COMPL 09/12/	ETED
	PROVIDER OR SUPPLIER			2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	stated that the only of facility has is the on any other records community and the testing had been been completed with	w, the Executive Director documentation that the he provided and was unsure if hould be found. The hor could not confirm whether hone for all three halls had hin the past 12 months.			place;		
	_	tive Director at exit conference.					
K 0920 SS=B Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care virus non-PCREE (e.g., except in long-terredo not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re other UL standard used with general cords are not used wiring of a structur temporarily are rei completion of the installed and meet	d electrical equipment					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155580	B. WI	NG		09/12/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	R			AFT ST		
APERIO	N CARE TOLLESTO	ON PARK			IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		(D) (NFPA 70), TIA 12-5					
		ration and interview, the	K 0	920	Tag number: 920		10/13/2023
		sure 2 of 2 power cord daisy			 What corrective action 	ı(s)	
	chains were not used as and as a substitute for				will be accomplished for those)	
	fixed wiring. NFPA-70/2011, 400.8 state unless				residents found to have been		
	specifically permitted in 400.7 flexible cords and				affected by the deficient pract	ice;	
	cables shall not be used for (1) as a substitute for				No residents were		
	fixed wiring. Article 400.8 (1) prohibits daisy				affected by this alleged deficie	ent	
	chains, because the first extension cord (or power				practice		
	strip) is now acting as a substitute for the fixed						
	wiring of a structure. This deficient practice could				II. How other residents ha	aving	
	affect approximately 2 staff and an unknown				the potential to be affected by	the	
	number of residents.				same deficient practice will be	;	
					identified and what corrective		
	Findings include:				action(s) will be taken;		
					An unknown number of	of	
	Based on observation	ons during a tour of the facility			residents could be affected by	this	
	with the Maintenan	ce Director on 09/12/23			alleged deficient practice. The	2	
	between 1:43 p.m. a	and 3:34 p.m., in the Medical			power cord daisy chains were	;	
	Records Office had	a power strip that was			removed.		
	plugged into and su	applied power by another					
	power strip. Based	on interview at the time of			III. What measures will be	put	
	observation, the Ma	aintenance Director agreed a			into place and what systemic		
	power strip was dai	sy chained to another power			changes will be made to ensu	re	
	strip. The power st	rip was removed upon			that the deficient practice doe	s not	
	observation.				recur;		
					All staff will be inservi	ced	
	Findings were discu	ussed with the Maintenance			on the proper use of power st	rips	
	Director and Execu	tive Director at exit conference.			and cords.		
	3.1-19(b)				IV. How the corrective		
					action(s) will be monitored to		
	2. Based on observ	ration and interview, the			ensure the deficient practice v	vill	
	facility failed to ens	sure 2 of 2 flexible cords were			not recur i.e., what quality		
	not used as a substi	tute for fixed wiring.			assurance program will be pu	t into	
	NFPA-70/2011, 400	0.8 state unless specifically			place;		
	permitted in 400.7 f	flexible cords and cables shall			The maintenance dire	ctor	
	not be used for (1) a	as a substitute for fixed wiring.			or designee will round the bui	lding	
	1 1	ice could affect approximately			5 times a week to ensure no	-	
	-	own number of residents.			extension cords are used and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/12/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404			
(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 APPROPRIA DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
	Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/12/23 between 1:43 p.m. and 3:34 p.m., an extension cord was in use to power a ventilation fan in the medication room in 300 Hall. Furthermore, an extension cord was powered by daisy chained power strips in the House Keeping Managers office in the basement. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned issues and removed the extension cord at observation. The finding was reviewed with the Maintenance Director and the Executive Director during the exit conference.			power strips are used properly and record the results on the power strip log. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% 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.		

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