STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING -- B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/12/2023 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 At this Emergency Preparedness survey, Aperion Care Tolleston Park, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 180 certified beds. 152 beds are dually certified for Medicare and Medicaid; 28 beds are certified for Medicare only. At the time of the survey, the census was 126. The requirements of 42 CFR, Subpart 483.73 is Not Met as evidenced by: Quality Review completed on 09/14/23	E 0000	Tag number: K-000 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 having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 10 residents have the potential to be affected by this alleged deficient practice. All battery-operated smoke alarms over 10 years old were replaced III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A log of all battery operated smoke detectors will be created with the manufacturer date and date to be replaced listed. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Helfrich	Executive Director	09/28/2023

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

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			The administrator or desginee will audit the battery-operated smoke log weekly to ensure they are replaced timely. 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. Compliance Date:10/13/2023	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to,			

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	155580	A. BUILDING -- B. WING	09/12/2023

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	the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Executive	E 0004	**Tag number: E004** 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	10/13/2023

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	Director and Maintenance Director on 09/12/23 between 09:12 a.m. and 1:25 p.m., two binders and a packet listed as the disaster policies and procedures were provided at the survey. The first binder had a revision date of 11/2017. The second binder provided had a revision date of 09/02/22. A packet listed as the designated disaster manual had no revision date or documentation that confirmed the information and plans had been updated annually. Based on interview at the time of record review, the Administrator stated the packet, as of then, was the disaster preparedness that the facility uses. However, they were unaware of the other two emergency preparedness binders and had not reviewed them. The Maintenance Director further stated that all of the emergency preparedness manuals were in the process of revisions. Both the Executive Director and Maintenance Director could not confirm if everything had been updated within the past year. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		II. How other residents having 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 IDT reviewed and updated the complete emergency program III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The IDT was inserviced on the emergency management requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12	

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			consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.			

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	*Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency	E 0013	Tag number: E013 I. What corrective	10/13/2023

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	Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Executive Director and Maintenance Director on 09/12/23 between 09:12 a.m. and 1:25 p.m., two binders and a packet listed as the disaster policies and procedures were provided at the survey. The first binder had a revision date of 11/2017. The second binder provided had a revision date of 09/02/22. A packet listed as the designated disaster manual had no revision date or documentation that confirmed the information and plans had been updated annually. Based on interview at the time of record review, the Administrator stated the packet, as of then, was the disaster preparedness that the facility uses. However, they were unaware of the other two emergency preparedness binders and had not reviewed them. The Maintenance Director further stated that all of the emergency preparedness manuals were in the process of revisions. Both the Executive Director and Maintenance Director confirmed that all of the available EPP binders had issues with revision dates and could not confirm if everything had been updated within the past year. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		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 having 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 emergency preparedness policies and procedures were reviewed and updated. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The IDT was inserviced on the emergency management requirements. A review and update of the emergency preparedness policies and procedures was added to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality	

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			assurance program will be put into place; The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness policies and procedures to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).			

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	(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Executive Director and Maintenance Director on 09/12/23 between 09:12 a.m. and 1:25 p.m., two binders and a packet listed as the disaster policies and procedures were provided at the survey. The first binder had a revision date of 11/2017. The second binder provided had a revision date of 09/02/22. A packet listed as the designated disaster manual had no revision date or documentation that confirmed the information and plans had been updated annually. Based on interview at the time of record review, the Administrator stated the packet, as of then, was the disaster preparedness that the facility uses. However, they were unaware of the other two emergency preparedness binders and had not reviewed them. The Maintenance Director further stated that all of the emergency preparedness manuals were in the process of revisions. Both the Executive Director and Maintenance Director could not confirm if the Communication Plan had been reviewed and updated within the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit	E 0029	Tag number: E029 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 having 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 entire emergency plan was reviewed and updated by the IDT. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The IDT was inserviced on the emergency preparedness requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months.	10/13/2023

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	conference.		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is completed.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15,			

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	HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every			

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	2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed reviewed and updated the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Executive Director and Maintenance Director on 09/12/23 between 09:12 a.m. and 1:25 p.m., two binders and a packet listed as the disaster policies and procedures were provided at the survey. The first binder had a revision date of 11/2017. The second binder provided had a revision date of 09/02/22. A packet listed as the designated disaster manual had no revision date or documentation that confirmed the information and plans had been updated annually. Based on interview at the time of record review, the Administrator stated the packet, as of then, was the disaster preparedness that the facility uses. However, they were	E 0036	Tag number: E0036 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 having 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 entire emergency plan was reviewed and updated by the IDT. III. What measures will be put	10/13/2023

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	unaware of the other two emergency preparedness binders and had not reviewed them. The Maintenance Director further stated that all of the emergency preparedness manuals were in the process of revisions. Both the Executive Director and Maintenance Director could not confirm if the Training and Testing Plans had been reviewed and updated within the past 12 months. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.		into place and what systemic changes will be made to ensure that the deficient practice does not recur; The IDT was inserviced on the emergency preparedness requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/12/2023 Facility Number: 008505	K 0000	Tag number: K-000 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	

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	155580	A. BUILDING 01 B. WING	09/12/2023

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	Provider Number: 155580 AIM Number: 200064830 At this Life Safety Code survey, Aperion Care Tolleston Park was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors. Battery powered smoke detectors are located in the North and South wing resident rooms; the PCU resident rooms are equipped with hard wired smoke detectors. The facility is protected by a 30-kW and 45 kW natural gas generators. The facility has 180 certified beds. 152 beds are dually certified for Medicare and Medicaid; 28 beds are certified for Medicare only. At the time of the survey, the census was 126. All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered. Quality Review completed on 09/14/23		practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 10 residents have the potential to be affected by this alleged deficient practice. All battery-operated smoke alarms over 10 years old were replaced III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A log of all battery operated smoke detectors will be created with the manufacturer date and date to be replaced listed. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality 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 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	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Compliance Date:10/13/2023	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored			

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	at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 exit door in the main lobby were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless	K 0222	K-0222 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	10/14/2023

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	otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. LSC 7.2.1.5.3 requires if provided, locks shall not require of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Maintenance Director on 09/12/23 between 9:42 a.m. and 1:25 p.m., the exit door leading outside from the main lobby was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, that had a code posted on the keypad. However, when the code was put in the door did not release. Based on interview at the time of observation, the Maintenance Director stated that the code posted at the door was not the correct code to open up the door and had not had time to put the new code back on the door and agreed the door would not open with the posted code. The findings were reviewed with Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		practice II. How other residents having 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. All egress doors well be check weekly for appropriate code and recorded on log which will be reviewed and updated by the IDT. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The IDT was inserviced on egress door requirements. A complete review of the egress door requirements will be added to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every	

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			12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is	
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, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain 1 of 7 Exit Discharges in accordance with NFPA 101 Section 7.7 as required by Section 19.2.7. Section 7.7.1.1 state that the exit discharge shall be of the required width and size to provide all occupants with a safe access to a public way. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Maintenance Director on 09/12/23 during a tour of the facility from 1:43 p.m. to 3:34 p.m., the Exit Discharge from the North Wing near resident room 127 was blocked by a passenger car. The car was parked in the painted hashed out area in front of the exit door. Based on interview at the time of observation, the Maintenance Director agreed that the door was blocked by a car and the exit discharge was blocked. The Plant Operations Director had the car owner notified upon observation.	K 0271	Tag number: K271 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 having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 15 residents had the potential to be affected deficient practice. The vehicle blocking the exit was moved. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	10/13/2023

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	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		recur; All staff will be inserviced on exit discharge requirements. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The maintenance director or designee will check the exits for proper discharge space 5 times 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 achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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 ensure 4 of over 20 battery operated smoke alarms installed in resident sleeping rooms were not over ten years old in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1	K 0300	Tag number: K300 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/13/2023

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	states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observations with the Maintenance Director on 09/12/23 during a tour of the facility from 1:43 p.m. to 3:34 p.m., manufacturer's documentation affixed to the battery operated smoke alarms installed above the doors in resident sleeping rooms 217, 215, 209, and 112 indicated each device was manufactured 02/2009, 03/2012, 03/2011 and 02/2009 respectively. Based on interview at the time of each observation, the Maintenance Director agreed the aforementioned smoke alarms were more than ten years old and stated that he was aware of only one battery smoke detector being replaced, but was unaware if any others had been replaced due to being over 10 years old. These findings were reviewed with the Executive Director and Maintenance Director during the exit conference.		No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 10 residents have the potential to be affected by this alleged deficient practice. All battery-operated smoke alarms over 10 years old were replaced III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A log of all battery operated smoke detectors will be created with the manufacturer date and date to be replaced listed. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality 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 be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90%	

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			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.	
K 0346 SS=F 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 records review with the Maintenance Director and Executive Director on 09/12/23 between 09:42 a.m. and 1:25 p.m., the fire watch plan provided failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on	K 0346	Tag number: K0346 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 having 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. III. What measures will be put into place and what systemic changes will be made to ensure	10/14/2023

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	interview during the record review, the Executive Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		that the deficient practice does not recur; The administrator or designee will fire watch policy with updated required information. The IDT team will be in serviced in regards to updated policy. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; 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.	
K 0354 SS=F 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 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			

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	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 1 of 1 correct written policies 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 9.7.6 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. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and Executive Director on 09/12/23 between 09:42 a.m. and 1:25 p.m., the fire watch plan provided failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and	K 0354	Tag number: K0354 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 having 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. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The administrator or designee will fire watch policy with updated required information. The IDT team will be in serviced in regards to updated policy. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;	10/13/2023

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	e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Executive Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		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.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of			

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	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 ensure 4 of 30 resident room corridor doors on the 100 wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 406. Findings include: Based on observation with the Maintenance Director on 09/12/23 between 1:43 p.m. and 3:34 p.m., the corridor door to resident room 113 did not latch into the frame when tested. Furthermore, the doors to resident rooms 112, 116 and 122 had trash cans placed in front of the door which impedes closure in an event of an emergency. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame and acknowledged the trash cans impeding door closings for the three resident rooms. The finding was reviewed with the Executive	K 0363	Tag number: K-0363 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 having 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. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator and or	10/13/2023

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APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	Director and the Maintenance Director during the exit conference. 3.1-19(b)		designee will audit 100% of resident doors ensure means are suitable for keeping doors closed specifically latching. A weekly audit form will be utilized. IDT team educated on importance of suitable door closing and latching protocol. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator will 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 achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0531 SS=C 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			

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	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 Based on record review and interview, the facility failed to maintain testing of 1 of 1 elevator 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 all occupants. Findings include: Based on record review with the Maintenance Director and Executive Director on 09/12/23 between 09:42 a.m. and 1:25 p.m., the monthly testing for the elevator firefighter recall for the memory care elevator was missing testing for 6 of 12 months from September 2022 to August 2023. Based on interview at the time of record review, the Maintenance Director confirmed there were missing recall testing from documentation located in the elevator service room. The finding was reviewed with the Executive Director and Maintenance Director during the exit	K 0531	Tag number: K531 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 having 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 elevator firefighter recall was tested. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director was inserived on the monthly	10/13/2023

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	conference. 3.1-19(b)		requirement for the elevator firefighter monthly recall testing. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator or designee will audit the elevator monthly firefighter recall testing log monthly. 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.	
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 expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility	K 0712	I. What corrective action(s)	10/13/2023

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	failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director and Executive Director on 09/12/23 between 9:42 a.m. and 1:25 p.m., the following shifts were missing documentation of a completed fire drill: a) A second shift fire drill in the first quarter of 2023. b) A third shift and second shift fire drill in the fourth quarter of 2022. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned fire drills missing and stated that the only documentation they could find and had available was what was provided and agreed there were three fire drills missing. Findings were discussed with the Maintenance Director and Executive Director. 3.1-19(b) 3.1-51(c)		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 having 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. A fire drill with all the required components will be conducted. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director was inserviced on all the required components of a fire drill. The fire drill log was revised to include all the required components. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator or designee will audit the fire drill log month to ensure all required components of a fire drill are followed.	

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			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	
K 0741 SS=E 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 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	K 0741		10/13/2023

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	failed to ensure 1 of 2 smoking areas was maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 12 residents and staff. 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., in the courtyard resident smoking area there were over 40 cigarette butts disposed on the ground in and around the smoking area in the grass and mulch coverings. Based on interview at the time of observation, the Maintenance Director stated that they do clean the smoking areas periodically and agreed that there were multiple spots within the designated area that had discarded cigarette butts on the ground. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		Tag number: 741 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 having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 12 residents have the potential to be affected by this alleged deficient practice. All the cigarette butts were picked up and placed in the proper container. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 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. IV. How the corrective action(s) will be monitored to ensure the deficient practice will	

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			not recur i.e., what quality assurance program will be put into 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 achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0761 SS=F Bldg. 01	Based on records review and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified 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 having 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 fire door inspections have occurred	10/13/2023

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	states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director and Executive Director on 09/12/23		weekly which will be recorded on a log. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The administrator and or designee will the inspect the log weekly IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; 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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	between 9:42 a.m. and 1:25 p.m., no documentation of an annual inspection for the (5) fire door assemblies was available for review. Based on interview at the time of records review, the Maintenance Director stated they were unaware if fire door inspections were ever conducted within the past 12 months and stated the only documentation they had documented was given to the surveyor. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)			
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications,			

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	containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview; the facility failed to ensure non-hospital grade electrical receptacles in 61 of 61 resident sleeping rooms within the 100 and 200-wings were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect approximately 80 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/12/23 between 1:43 p.m. and 3:34 p.m., the facility's 61 resident sleeping rooms within the 100 and 200-Halls contained four to eight non-hospital-grade electrical receptacles. Based on records review between 9:12 a.m. and 1:25 p.m., documentation of electrical receptacles was available, but the documentation only had recorded testing for the 300-Hall resident rooms. Documentation for the 100 and 200-Hall testing could not be found. Based on interview at the	K 0914	Tag number: K914 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 having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 80 residents the potential to be affected by this alleged deficient practice. All outlets were tested as for polarity and retention with all outlets passing and the form showing the room, location, and pass/fail. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director was inserviced on outlet testing and the form changed to add date, room, location, and pass/fail. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into	10/13/2023

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	time of record review, the Executive Director stated that the only documentation that the facility has is the one provided and was unsure if any other records could be found. The Maintenance Director could not confirm whether the testing had been done for all three halls had been completed within the past 12 months. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		place;	
K 0920 SS=B 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			

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	(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 09/12/23 between 1:43 p.m. and 3:34 p.m., in the Medical Records Office had a power strip that was plugged into and supplied power by another power strip. Based on interview at the time of observation, the Maintenance Director agreed a power strip was daisy chained to another power strip. The power strip was removed upon observation. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 4 staff and an unknown number of residents.	K 0920	Tag number: 920 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 having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An unknown number of residents could be affected by this alleged deficient practice. The 2 power cord daisy chains were removed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff will be inserviced on the proper use of power strips and cords. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The maintenance director or designee will round the building 5 times a week to ensure no extension cords are used and	10/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 01 B. WING	09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	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. 3.1-19(b)		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.	