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	10/30/2023

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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E 0000 Bldg. --	A Post Survey Revisit (PSR) for the Emergency Prepardness Survey that exited on 09/12/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73 Survey Date: 10/30/2023 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 At this Emergency Preparedness PSR, Aperion Care Tolleston Park, was found 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 137. Quality Review completed on 10/31/23	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/12/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 10/30/2023 Facility Number: 008505 Provider Number: 155580	K 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Attinger	RVP of Operations	11/13/2023

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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	AIM Number: 200064830 At this Life Safety Code PSR, 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 137. All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered. Quality Review completed on 10/31/23		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review*	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,			

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	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 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 1 of 30 resident room corridor	K 0363	**I. What corrective action(s) will be accomplished**	11/14/2023

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	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 approximately 2 residents in room 113. Findings include: Based on observation with the Maintenance Director on 10/30/23 between 11:30 a.m. and 12:15 p.m., the corridor door to resident room 113 did not latch into the frame when tested approximately five times. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame when tested and would fix the deficiency before the end of the day. The resident room door was able to be fixed during the survey. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. This deficiency was cited on 09/12/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**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 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.** The facility will ensure doors protecting corridor openings will be smoke resistive; have no	

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			impediments to closing; are self-latching and provided with positive latching hardware **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;** Ongoing, the Administrator or designee will monitor corridor doors to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.	
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,			

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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 2 smoking areas were 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 10/30/23 between 11:30 a.m. and 12:15 p.m., in the courtyard resident smoking area there were approximately over 50 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 observations, the Maintenance Director stated that they implemented a program to clean the area every 3-4 hours, but did acknowledge that there were multiple spots within the designated area that had an excessive amount of discarded cigarette butts on the ground. This finding was reviewed with the Executive Director and Maintenance Director during the exit	K 0741	**. 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.**	11/14/2023

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	conference. This deficiency was cited on 09/12/23. The facility failed to implement a systemic plan of correction to prevent recurrence 3.1-19(b)		**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 s 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.** The facility will ensure smoking materials are discarded properly in areas where smoking is permitted **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 audit the smoking area audit form weekly.** Ongoing, the Administrator or designee will monitor smoking areas to ensure proper disposal of discarded smoking materials to ensure	

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			continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.	