PRINTED:	08/31/2021
FORM AP	PROVED
OMB NO. ()938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION		E SURVEY PLETED
		155580	B. WING		08/0	2/2021
	PROVIDER OR SUPPLIER		2350 T/	ADDRESS, CITY, STATE, ZIP AFT ST IN 46404	CODE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
E 0000						
Bldg	conducted by the In Health in accordance Survey Date: 08/02 Facility Number: 0 Provider Number: 2000 At this Emergency I Care Tolleston Park compliance with En Requirements for M	08505 155580 064830 Preparedness survey, Aperion c, was found in substantial nergency Preparedness Iedicare and Medicaid	E 0000			
E 0041 SS=C Bldg	483.73 The facility has 180 dually certified for 1 beds are certified for of the survey, the co Quality Review con 482.15(e), 483.73 Hospital CAH and §482.15(e) Condit (e) Emergency an The hospital must standby power sys emergency plan so this section and in procedures plan so (1)(i) and (ii) of this §483.73(e), §485.1	npleted on 08/05/21 (e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b) s section.				

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/02/2021	
	PROVIDER OR SUPPLIEI			2350 TA		DE	
APERIC	N CARE TOLLEST	ON PARK		GARY, I	N 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	The [LTC facility a implement emerg systems based or forth in paragraph §482.15(e)(1), §4 (1) Emergency gener generator must be with the location r Health Care Facil Tentative Interim 12-3, TIA 12-4, TI Safety Code (NFF Interim Amendme 12-3, and TIA 12- new structure is b structure or buildi 482.15(e)(2), §48 Emergency gener The [hospital, CA implement the em inspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §48	and the CAH] must ency and standby power in the emergency plan set in (a) of this section. 83.73(e)(1), §485.625(e) rator location. The e located in accordance equirements found in the ities Code (NFPA 99 and Amendments TIA 12-2, TIA A 12-5, and TIA 12-6), Life PA 101 and Tentative ents TIA 12-1, TIA 12-2, TIA 4), and NFPA 110, when a uilt or when an existing			DERCLEACE		DATE
	and LTC facilities fuel source to pov must have a plan emergency power	I that maintain an onsite ver emergency generators for how it will keep systems operational					
	*[For hospitals at §483.73(g), and C The standards inc	ency, unless it evacuates. §482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation					

	NT OF DEFICIENCIES				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			
	PROVIDER OR SUPPLIEF			2350 T/	address, city, state, zip cc AFT ST IN 46404	DDE		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETIC	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE	
	the Federal Regis U.S.C. 552(a) and obtain the materia below. You may in Information Reson Boulevard, Baltim Archives and Rec (NARA). For infort this material at N/ go to: http://www.archive e_of_federal_regu If any changes in incorporated by re a document in the announce the cha (1) National Fire F Batterymarch Par Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issu (ii) Technical inter to NFPA 99, issue (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012.	Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 ed August 11, 2011. FPA 99, issued August 9, FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued March 3, fe Safety Code, 2012						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	<u>`</u>	CONSTRUCTION	· /	E SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		155580	B. WING		08/02	2/2021	
NAME OF	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE				
	N CARE TOLLEST	ON PARK		TAFT ST Y, IN 46404			
						(1/5)	
X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOL			(X5) COMPLETION	
TAG	-	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE	
	22, 2013.						
	,	IFPA 101, issued October					
	22, 2013.						
	'	Standard for Emergency					
		ver Systems, 2010 edition,					
		chapter 7, issued August 6,					
	2009						
	Based on record re	eview and interview, the	E 0041	Aperion Care Tolleston Pa	ırk	08/19/2021	
	facility failed to in	nplement the emergency		E-041 Emergency			
	power system insp	pection, testing, and		Preparedness LTC emerge	ency		
	maintenance requi	rements found in the Health		power			
	Care Facilities Co	de, NFPA 110, and Life Safety		Compliance 08/19/2021			
	Code in accordance	e with 42 CFR 483.73(e)(2).		The facility requests pape			
	This deficient prac	ctice could affect all		compliance for this citation	n.		
	occupants.						
				This Plan of Correction is			
	Findings include:			center's credible allegatio	n of		
	Deseiten merentm	eview with the Maintenance		compliance.			
		21 at 09:34 a.m., the weekly		Preparation and/or execut	tion of		
		rator testing did not comply		this plan of correction do			
		PA 101. The generator testing		constitute admission or	-5 1101		
		"Weekly Emergency		agreement by the provide	r of		
	-	s - North" and "Weekly		the truth of the facts alleg			
		ator Records - PCU" (the		conclusions set forth in th			
	0,0	nerators) had missing weekly		statement of deficiencies.			
		tion on July 6th, July 13th,		plan of correction is prepa	ared		
	July 20th, and July	27th of 2021. The monthly		and/or executed solely be	cause		
		2021 was also not available		it is required by the provis	sions		
		for either generator. Based on		of federal and state law.			
		ne of record review, the					
		ctor agreed that the weekly and		1)Immediate actions taker			
		testing documentation for		those residents identified			
		l South generators was not					
		d review at the time of this		•No resident was found	to be		
		e exit conference with the		affected by this alleged			
		Director and the Maintenance		deficiency Weakly inspection of			
		21 at 1:40 p.m., no additional dence could be provided		·Weekly inspection of generator was conducted	and		
	contrary to this de	-	1	documented	anu		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KN3S21 Facility ID: 008505

If continuation sheet Page 4 of 31

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	(X2) MULTIPLE CO A. BUILDING B. WING	A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/02/2021	
NAME OF P	ROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP C	CODE		
				AFT ST			
APERION	I CARE TOLLEST	ON PARK	GARY,	IN 46404			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
				·A monthly inspecti			
				generator was condu	cted and		
				documented			
				2) How the facility ide	entified		
				other residents:			
				·Residents, staff an			
				have the potential to affected by the allege			
				practice.			
				3) Measures put into	place/		
				System changes:			
				•The Maintenance D	irector		
				will be re-educated or	n the		
				Preventative Mainten	ance		
				Program by the Exec			
				Director/designee by			
				•The Executive Dire			
				monitor routine main			
				and operational week	-		
				month testing to ensu			
					с.		
				4) How the corrective	actions		
				will be monitored:			
				·An Environmental	QAPI tool		
				will be utilized month	ly to		
				monitor compliance.			
				·The results of thes	e audits		
				will be reviewed in Qu			
				Assurance Meeting m	•		
				6 months or until 100			
				compliance is achiev			
				QA Committee will id			
				trends or patterns an			
				recommendations to			
				plan of correction as	indicated		
				5) Date of complianc	e:		
				08/19/2021			

CENTERS FOR MEDICARE & MEDICAID SERVICES						(FORM APPROVE	
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	î î	JILDING	NSTRUCTION	(X3) DA COM	(X3) DATE SURVEY COMPLETED 08/02/2021	
NAME OF	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP C	CODE		
APERIO	N CARE TOLLEST	ON PARK		2350 TA GARY,	AFT ST IN 46404			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S	HOULD BE	COMPLETIO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE	
0000								
Bldg. 01	Licensure Survey w	Recertification and State ras conducted by the Indiana f Health in accordance with	К 0	000				
	Survey Date: 08/02	2/2021						
	Tolleston Park was Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protect 101, Life Safety Co	155580 064830 Code survey, Aperion Care found not in compliance with						
	was determined to be construction and ful has a fire alarm syst the corridors, space Battery powered sur the North and South	lly sprinklered. The facility tem with smoke detection in s open to the corridors. hoke detectors are located in a wing resident rooms; the s are equipped with hard						
	generator and a 45-	cted by a 30-kW natural gas kW diesel generator.						
	dually certified for) certified beds. 152 beds are Medicare and Medicaid; 28 or Medicare only. At the time						

		X1) PROVIDER/SUPPLIER/CLIA	ICATION NUMBER: A. BUILDING <u>01</u>			(X3) DATE SURVEY COMPLETED
					<u>01</u>	08/02/2021
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE	
APERIO	N CARE TOLLEST	ON PARK		2350 TA GARY,	AFT ST IN 46404	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETIO DATE
IAG	of the survey, the			IAG		
	All areas where th	e residents have customary				
		lered. A detached wood				
	-	shed was unsprinklered.				
	Quality Review co	ompleted on 08/05/21				
C 0211	NFPA 101					
SS=E	Means of Egress					
Bldg. 01	Means of Egress					
		vays, corridors, exit				
	-	ocations, and accesses are				
		th Chapter 7, and the				
	•	is continuously maintained ctions to full use in case of				
		ss modified by 18/19.2.2				
	through 18/19.2.	-				
	18.2.1, 19.2.1, 7.					
	Based on observat	ion and staff interview, the	K 02	11	Aperion Care Tolleston Park	08/19/202
	facility failed to m	aintain the means of egress				
		ions in 2 of 9 corridors within			K-211 Means of	
	-	9.2.3.4(4) states, projections			Egress	
	-	vidth shall be permitted for			a	
		it, provided that all of the			Compliance	
	following conditio	ns are met: quipment does not reduce the			08/19/2021	
		corridor width to less than 60			The facility requests paper	
	in. (1525 mm.)				compliance for this citation.	
		e occupancy fire safety plan				
		am address the relocation of			This Plan of Correction is the	ڊ ڊ
	the wheeled equip	ment during a fire or similar			center's credible allegation o	f
	emergency.				compliance.	
		quipment is limited to the				.
	following:	1			Preparation and/or execution	
	i. Equipment in us				this plan of correction does n	ΙΟΪ
	-	ency equipment not in use transport equipment			constitute admission or agreement by the provider of	,
	This deficient prac				the truth of the facts alleged	
	-	residents, 3 staff and 1 visitor.			conclusions set forth in the	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 08/02/2021	
	PROVIDER OR SUPPLIE		2350 T	ADDRESS, CITY, STATE, ZIP CODE AFT ST IN 46404		
(X4) ID	APERION CARE TOLLESTON PARK x4) ID SUMMARY STATEMENT OF DEFICIENCIES				(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETI	
	Maintenance Direct the facility from 1 following was note 1) two delivery pai the corridor outsid each containing ap supplies. These ite of the corridor to c 2) a small 3 drawe corridor immediate #310 and was not Based on interview observation, the M acknowledged the added that he has f corridor before and nursing staff, but t storage. During the facility Executive Director on 08/02/	llets were sitting unattended in e of Resident room #316, proximately 40 to 50 boxes of ms obstructed the clear width only 44 inches. r desk was sitting in the ely outside resident room on wheels. v at the time of each faintenance Director items in the corridor and found these items in the d that he has mentioned it to hey still use the area for e exit conference with the Director and the Maintenance 21 at 1:40 p.m., no additional dence could be provided		statement of deficiencies. The plan of correction is prepared and/or executed solely becau- it is required by the provision of federal and state law. 1. Immediate actions take for those residents identified: Facility staff removed Pallets and central supply staff was educated on leave DME and other supplies unattended an obstructing clear egress in the corridor The small 3 dresser drawer we removed from hallway and replace with one that has wheels. No resident or staff was found to be affected by this alleged deficiency 2) How the facility identified other residents: The facility observed all other hallway and egresses to ensu- that the same deficient practi- did not occur in other areas ·Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficien- practice. 3) Measures put into place/ System changes: ·All staff was educated on leave DME and other supplies	d e as fure ce s ent	

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	IB NO. 0938-0391 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	r í	ILDING	01	COMPL	LETED
		155580	D. WI			08/02/	/2021
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
APERIO	N CARE TOLLES	ON PARK			AFT ST IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	1		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP	N BE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
					unattended and obstructin	-	
					clear egress in the corrido	r	
					1. How the corrective actions will be monitored:		
					actions will be monitored.		
					·The Executive Director/		
					Designee will review the da	-	
					egress audit Worksheets		
					monthly basis and random check egress. The Execut	-	
					Director/ Designees will		
					observe staff's knowledge	on	
					keeping the corridor free f		
					obstructed areas by means return demonstration.	s of	
					return demonstration.		
					·The results of these aud	lits	
					will be reviewed in Quality		
					Assurance Meeting month	ly for	
					6 months or until 100%	'h e	
					compliance is achieved. T QA Committee will identify		
					trends or patterns and mal	-	
					recommendations to revise		
					plan of correction as indic	ated.	
					5) Date of compliance: 08/19/2021		
(0014							
< 0311 SS=E	NFPA 101 Vertical Opening	s - Enclosure					
Bldg. 01	Vertical Opening						
Ŭ	2012 EXISTING						
	-	tor shafts, light and					
		, chutes, and other vertical					
		en floors are enclosed with ing a fire resistance rating of					
		a atrium may be used in					
	accordance with						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE C	ONSTRUCTION	(X3) DATE	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		01	COMPLETED		
		155580	B. WING			08/02	2/2021	
	PROVIDER OR SUPPLIE	D D	STREET ADDRESS, CITY, STATE, ZIP CODE					
					AFT ST			
APERIO	PERION CARE TOLLESTON PARK			GARY,	IN 46404			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	ERIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	19.3.1.1 through	nings are properly enclosed						
		providing at least a 2-hour						
		ting, also check this						
	box.							
		ions and interview, the facility	K 03	11	Aperion Care Tolleston Par	·k	08/19/2021	
		of 1 ceiling barriers in the data	K 05	11	K311 Vertical Openings		00/17/2021	
		ight in accordance with 19.3.1.			Compliance 08/19/2021			
		es protection of a vertical			The facility requests paper			
	-	3.1 requires a vertical opening			compliance for this citation			
		or protected in accordance						
		SC 8.6.1 requires every floor			This Plan of Correction is t	Correction is the		
		es in a building shall be			center's credible allegation of			
	constructed as a sr	noke barrier. LSC 19.3.1.1			compliance.			
	requires where an	enclosure is provided, the						
	construction shall	have not less than a 1-hour fire			Preparation and/or executi	on of		
	rating. This deficie	ent practice could affect			this plan of correction doe.	s not		
	approximately 20	residents, 3 employees, and 1			constitute admission or			
	staff.				agreement by the provider	of		
					the truth of the facts allege	d or		
	Findings include:				conclusions set forth in the	9		
					statement of deficiencies.			
		ions made with the			plan of correction is prepa			
		ctor on 08/02/21 during a tour			and/or executed solely bec			
	2	2 p.m., the electrical closet on			it is required by the provisi	ions		
		a white two inch in diameter			of federal and state law.			
		s a conduit for 15 white data						
		nrough the ceiling and into the			·Immediate actions taken	tor		
	<u>^</u>	The fire caulk that was applied			those residents identified:			
	-	the around the wires had fallen			The Meintenence Direct			
		leaving a hole up into the attic			•The Maintenance Director ensured that the two inch i			
	-	d on interview at the time of e Maintenance Director			diameter PVC pipe passing			
		ceiling penetrations and			though the ceiling was cau			
	-	ling was not smoke tight.			with fire barrier caulking. T			
	-	nference with the facility			ensured that the annular sp			
	-	r and the Maintenance			around the wire was smoke			
		21 at 1:40 p.m., no additional			tight and prevented the	-		
		dence could be provided			passage of smoke to ensur	е		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K

KN3S21 Facility

Facility ID: 008505

If continuation sheet

Page 10 of 31

	R MEDICARE & MEDI- VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	ì í	ILDING	DNSTRUCTION 01	COMF	e survey pleted 2/2021
NAME OF 1	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP CODE		
APERIO	N CARE TOLLEST	ON PARK			AFT ST IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP	BE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	RIATE	DATE
	3.1-19(b)				2) How the facility identifie other residents:	d	
					·All visitors, staff and residents that reside at the community have the poten to be affected by the allege deficient practice.	itial ed	
					3) Measures put into place System changes: •The Maintenance Direct		
					Designee will inspect verti openings in the facility mo	cal	
					to ensure that annular area are smoke tight and will document on the Preventa Maintenance Worksheet. T	tive	
					Maintenance Director will re-educated on the Preventative Maintenance	be	
					Program by the Executive Director/designee by 08/01 •The Maintenance Direct responsible for complianc	or is	
					4. How the corrective action will be monitored:		
					•The Executive Director v review the Preventative Maintenance Worksheets monthly.	will	
0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	î î	JILDING	DNSTRUCTION 01	CON	(X3) DATE SURVEY COMPLETED 08/02/2021	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CO	DDE		
				2350 TA				
AFERIO	N CARE TOLLEST			GART,	IN 46404			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE PPROPRIATE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		corridor openings in other						
		closures of vertical						
		or hazardous areas resist						
		moke and are made of 1 3/4						
		d core wood or other						
		of resisting fire for at least						
		rs in fully sprinklered smoke						
		re only required to resist the						
		ke. Corridor doors and doors						
		ing flammable or						
		erials have positive latching						
		latches are prohibited by						
	-	These requirements do not						
		spaces that do not contain						
		mbustible material.						
		en bottom of door and floor						
	•	xceeding 1 inch. Powered						
		with 7.2.1.9 are permissible						
		a device capable of keeping						
		when a force of 5 lbf is						
		s no impediment to the						
	-	ors. Hold open devices that e door is pushed or pulled						
		onrated protective plates of						
		are permitted. Dutch doors						
		8.6 are permitted. Door						
	•	abeled and made of steel or						
		n compliance with 8.3,						
		e compartment is						
		d fire window assemblies						
		3.3. In sprinklered						
		ere are no restrictions in						
		tance of glass or frames in						
	window assembl	-						
	19.3.6.3 42 CEE	R Parts 403, 418, 460, 482,						
	483, and 485							
		KS details of doors such as						
		tings, automatics closing						
	devices, etc.							
			1					

DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICADE & MEDICAD CEDUC

TATEMENT OF DEFI	IENCIES (X1) P	ROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF CORRE	. ,	TIFICATION NUMBER:	A. BUILDING	<u>01</u>	COMPLETED
		5580	B. WING	<u></u>	08/02/2021
	155				00/02/2021
AME OF PROVIDER	R SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
			2350 T	AFT ST	
APERION CARE	OLLESTON P	ARK	GARY,	IN 46404	
X4) ID	UMMARY STATE	MENT OF DEFICIENCIES	ID		(X5)
REFIX (EA	H DEFICIENCY M	JST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	BE COMPLETION
TAG REGU	LATORY OR LSC I	DENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE
Based o	observation and	l interview, the facility	K 0363	Aperion Care Tolleston Pa	rk 08/19/202
failed to	ensure 3 of over	100 doors within the		K363 Corridor Doors	
		ould completely resist		Date Compliance 08/19/202	21
		is deficient practice			
-	-	ly 34 residents, 3 staff,		The facility requests paper	r
and 1 vi		, , ,,		compliance for this citation	
Finding	include:			This Plan of Correction is	the
				center's credible allegation	n of
Based o	observations m	ade with the		compliance.	
Mainter	nce Director on	08/02/21 during a tour			
the facil	ty from 11:25 a.	m. to 1:30 p.m., the		Preparation and/or execut	ion of
followir	g was noted:			this plan of correction doe	es not
1) the C	ntral Supply doo	or in the basement of the		constitute admission or	
facility	eading to the cor	ridor had a		agreement by the provider	r of
three-ei	hths inch hole al	ove the door handle.		the truth of the facts allege	ed or
2) the S	orage room door	in the Central Supply		conclusions set forth in th	e
room lo	ated within the b	basement of the facility		statement of deficiencies.	The
leading	ad a three-eight	ns inch hole above the		plan of correction is prepa	nred
door ha	dle.			and/or executed solely be	cause
3) Resid	ent room #324 co	orridor door had a		it is required by the provis	ions
three-ei	hths inch hole al	pove the door handle.		of federal and state law.	
Based o	an interview at	the time of each			
	on, the Mainten			 Immediate actions taker 	-
	-	ove mentioned doors		those residents identified:	
	•	ige of smoke. During		•The Central Supply door	
		he facility Executive		the basement was repaired	
		ance Director on		no longer has a hole above	e the
	-	additional information		door handle.	
	-	vided contrary to this		•The storage room door	
deficien	finding.			the basement was repaired	
				no longer has a hole above	e the
3.1-19(8)			door handle	
				•The Room 324 in the	
				corridor on PCU was repai	
				and no longer has a hole a	bove
				the door handle	
					.
				2) How the facility identifie	d
			I	other residents:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KN3S21 Facility ID: 008505

If continuation sheet

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	MEDICARE & MEDI T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(3) DATE S	B NO. 0938-0 . Survey
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER: 155580	A. BU B. WI	JILDING NG	01 COMPLETED 08/02/2021		
NAME OF PI	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	CARE TOLLEST	ON PARK			AFT ST IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
					•Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. All Facilities door were audited to ensure the alleged deficient practice does not occur.	nt d	
					3) Measures put into place/ System changes:		
					·The Maintenance Director o Designee will inspect doors monthly and will document on		
					the Preventative Maintenance Worksheet. The Maintenance Director and Assistant will be		
					re-educated on the Preventative Maintenance Program by the Executive		
					Director/designee by 08/01/202 •The Maintenance Director is responsible for compliance.		
					4. How the corrective actions will be monitored:		
					•The Executive Director will review the Preventative Maintenance Worksheets monthly.		
					•The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any		

	R MEDICARE & MEDI					-	IB NO. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	JLTIPLE C	ONSTRUCTION 01	(X3) DATE COMPI	
11.012.11.	or conduction	155580	B. WING 08/02/20				
			_	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIE	ER			AFT ST		
APERIO	N CARE TOLLEST	ON PARK		GARY,	, IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'RIATE	DATE
					trends or patterns and ma	ke	
					recommendations to revis		
					plan of correction as indic	ated.	
					5) Date of compliance:		
					08/19/2021		
K 0374	NFPA 101						
SS=E	-	uilding Spaces - Smoke					
Bldg. 01	Barrie						
C C	Subdivision of B	uilding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
		barriers are 1-3/4-inch thick od-core doors or of					
		resists fire for 20 minutes.					
		tive plates of unlimited height					
		pors are permitted to have					
		assemblies per 8.5. Doors					
		or automatic-closing, do not					
		and are not required to					
	-	ction of egress travel. Door s a minimum clear width of					
		inging or horizontal doors.					
	19.3.7.6, 19.3.7.	0 0					
		ion and interview, the facility	K 0.	374	Aperion Care Tollestor	ı	08/19/202
		of 6 sets of smoke barrier			Park		
		ct the movement of smoke for			K 274 Duildi		
		s. LSC, Section 19.3.7.8 s in smoke barriers shall			K-374 Buildin Spaces	ng	
		, Section 8.5.4. LSC, Section					
		pors in smoke barriers to close			Compliance Dat	e	
	the opening leaving	g only the minimum clearance			08/19/2021		
		er operation which is defined					
		rict the movement of smoke.			The facility requests pape		
	This deficient practice well as 3 staff and	ctice affects 25 residents, as			compliance for this citatio	n.	
	wen as 5 starr and	2 VISIWIS.			This Plan of Correction is	the	
	Findings include:				center's credible allegatio		
	Ĭ			compliance.			

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
	or conduction	155580	B. WING	<u>01</u>	08/02/2021	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AME OF	PROVIDER OR SUPPLIE	CR	2350 T	AFT ST		
PERIO	N CARE TOLLEST	ON PARK	GARY,	IN 46404		
(4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X	(5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPL	ETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DAT	ГE
	Based on observat	ions made with the				
	Maintenance Direct	ctor on 08/02/21 during a tour		Preparation and/or execution	on of	
	the facility from 1	1:25 a.m. to 1:30 p.m., the		this plan of correction does	not	
	following was note	ed:		constitute admission or		
	1) the smoke barri	er doors in the Lobby area		agreement by the provider	of	
	leading to the Sout	th unit failed to fully close		the truth of the facts alleged	1 or	
	when tested on thr	ee separate attempts leaving a		conclusions set forth in the		
	one-inch gap when	n closed at the fullest.		statement of deficiencies.	Гhe	
2) the smoke barrier doors near Resident rooms #111 and #122 on the North unit failed to fully		plan of correction is prepar	ed			
	the North unit failed to fully		and/or executed solely beca	ause		
	close when tested	on three separate attempts		it is required by the provision	ons	
	leaving a one-inch gap when cl	gap when closed at the fullest.		of federal and state law.		
	Based on an interv	riew at the time of each				
	observation, the Maintenance Direct	laintenance Director		1. Immediate actions tak	en	
	acknowledged that	t the aforementioned doors		for those residents identifie	d:	
	failed to fully close	e after being tested on three		·No resident or staff was		
	separate occasions	. During the exit conference		found to be affected by this		
	with the facility Ex	xecutive Director and the		alleged deficiency		
	Maintenance Direc	ctor on 08/02/21 at 1:40 p.m.,		•The Maintenance Directo	r	
	no additional infor	mation or evidence could be		inspected and repaired the		
	provided contrary	to this deficient finding.		following doors to ensure the	nat	
				the smoke barrier doors wo	uld	
	3.1-19(b)			restrict the movement of sm	loke	
				for at least 20 minutes.		
				·Smoke Barrier Door 111		
				·Smoke Barrier Door 122		
				2) How the facility identified	1	
				other residents visitor and s	staff	
				:		
				·Visitors, staff and resider	nts	
				that reside at the communit		
				have the potential to be	′	
				affected by the alleged defic	ient	
				practice.		
				·Maintenance Director		
				inspected all facility doors t	0	
				ensure that the smoke barri		
				doors would restrict the	~ .	
				movement of smoke for at l	east	
	1		1	in all all all all all all all all all al		

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	ì í	JILDING	ONSTRUCTION 01	(X3) DATE COMPI 08/02	LETED
NAME OF PI	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE TOLLEST	ON PARK			AFT ST , IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	DATE
					20 minutes.		
					3) Measures put into place/ System changes: ·All staff instructed to noti maintenance via work order ensure that the same alleged deficient practice does not occur. Maintenance will continue to observe the doo during a fire drill and annual per policy.	to d	
					 ·Maintenance Director or Designee will conduct mont audits to identify any potent problems How the corrective actions will be monitored: 	-	
					•The Maintenance Director will review door audit Worksheets monthly and randomly check doors and staff's knowledge on door closures the door by means return demonstration.		
					•The results of these audit will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise plan of correction as indicat	for e iny the	

	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V 2) M		ONSTRUCTION	(X3) DATE	1B NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER: 155580	ì í	JILDING	<u>01</u>	COMPLETED 08/02/2021	
NAME OF	PROVIDER OR SUPPLIE	UR			ADDRESS, CITY, STATE, ZIP CODE		
APERIO	N CARE TOLLEST	ON PARK			AFT ST IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
					5) Date of compliance: 08/19/2021		
K 0511 SS=F Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1. 1) Based on record facility failed to en generator had a rel accordance with th 2012 edition, Sect NFPA 110, 2010 I 9.1.3.1 states emen installed, tested, an with NFPA 110, S Standby Power Sy 5.1.1 states the fol be permitted to be supply (EPS): (1) Liquid petroleu pressure (2) Liquefied petrol withdrawal) (3) Natural or synt Exception: For Le where the probabil fuel supplies is hig alternate energy sc output of the EPSS	d Electric gas or related gas piping FPA 54, National Fuel Gas wiring and equipment FPA 70, National Electric stallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 d review and interview the asure that the emergency diable source of fuel in the requirements of NFPA 101 - tion 19.5.1.1, 9.1, 9.1.3.1 and Edition, 5.1. LSC section regency generators shall be nd maintained in accordance tandard for Emergency and stems, 2010 Edition. Section lowing energy sources shall used for the emergency power am products at atmospheric	KO	511	Aperion Care Tolleston Pa K -511 Gas and Electric Compliance 08/19/2021 The facility requests paper compliance for this citation This Plan of Correction is center's credible allegation compliance. Preparation and/or execut this plan of correction doe constitute admission or agreement by the providen the truth of the facts allege conclusions set forth in the statement of deficiencies. plan of correction is prepara and/or executed solely bea it is required by the proviss of federal and state law. 1)Immediate actions taken those residents identified:	n. the n of ion of is not of ed or e The ired cause ions	08/19/202
	automatic transfer	from the primary energy nate energy source.			The facility called local gas company (Nipsco) (Mike F		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	e construction G 01		TE SURVEY MPLETED
		155580	B. WING		08/02/202	
NAME OF	PROVIDER OR SUPPLIE	ER		EET ADDRESS, CITY, STATE, ZIP C	ODE	
APERIO	N CARE TOLLEST	ON PARK		0 TAFT ST RY, IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		mples of probability of		and requested an upd		
	-	include the following:		letter indicating that t		
	-	damage, or a demonstrated		source for the facility		
		y. This deficient practice had		emergency generator	is a	
	the potential to aff visitors within the	fect all residents, staff, and facility.		reliable source.		
	Findings include:			2) The facility install		
				(GFCI) ground fault ci		
	Based on record review with the Maintenance Director on 08/02/21 at 11:29 a.m.,			interrupter at the sink		
				protect against electri	ical	
		monthly generator testing		shock.		
	-	Emergency Generator Record -				
		tly Emergency Generator		2) How the facility ide	ntified	
		ne facility has two generators)		other residents:		
	the fuel source for	the North generator was		·Residents, staff and	d visitors	
	determined to be r	natural gas. Additionally, based		have the potential to I	be	
	on interview, the f	facility did have a letter from		affected by the allege	d deficient	
	their natural gas p	rovider indicating the natural		practice.		
	gas was from a rel	iable source, but it was dated		·Maintenance Direct	tor	
	December 5th, 20	14. The facility not having an		observed All areas are	ound	
	up-to-date letter st	tating that the fuel source for		water including the ki	tchens,	
		nerator was from a reliable		bathrooms and other	areas that	
		wledged by the Maintenance		require a (GFCI) to en		
	Director who stated that he would request a more			the alleged deficient p	oractice	
		diately. During the exit		does not occur.		
		ne facility Executive Director				
		nce Director on 08/02/21 at		4) How the corrective	actions	
	1:40 p.m., no addi	tional information or evidence		will be monitored:		
	could be provided	contrary to this deficient		·An Environmental (QAPI tool	
	finding.			will be utilized month	ly to	
				monitor compliance.		
	3.1-19(b)			observed with any ele		
				service and annually		
		vation and interview, the		the same alleged defi		
		nsure 1 of 1 sink areas was		practice does not occ	ur.	
	provided with a gr	round fault circuit interrupter				
	(GFCI) protection	against electric shock. LSC		·The results of these	e audits	
	sections 9.1.2 requ	ires all electrical wiring and		will be reviewed in Qu	uality	
	· · · · · · · · · · · ·	e in accordance with NFPA 70,	1	Assurance Meeting m	a mála le c fa n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KN3S21 Facility ID: 008505

If continuation sheet Page 19 of 31

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		· · ·	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155580	A. BUILDING B. WING	<u>01</u>		ipleted 02/2021
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP	CODE	
APERIO	N CARE TOLLEST	ON PARK		AFT ST , IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO DATE
	National Electrica	l Code. NFPA 70, Article		6 months or until 100)%	
	210.8 Ground-Fau	It Circuit-Interrupter		compliance is achiev	ed. The	
		sonnel, in 210.8(A), Dwelling		QA Committee will id		
		ound-fault circuit-interrupter		trends or patterns an		
		for all personnel in bathrooms		recommendations to		
		the receptacles are intended		plan of correction as	indicated	
		ertop surfaces. (7) Sinks -		5) Data of compliance		
		ther than kitchens where tailed within 1.8 m. (6 ft.) of		5) Date of compliant 08/19/2021	e:	
		f the sink. This deficient		00/19/2021		
		to 24 residents, 3 staff and 1				
	visitor.					
	Findings include:					
		tions made with the				
		ctor on 08/02/21 during a tour				
		2 p.m., the North unit Supply				
		vith an electrical outlet within				
		c. This outlet was not a GFCI When tested, this outlet did not				
	-	ter in the nearby circuit box				
		n interview at the time of the				
		faintenance Director stated that				
		t the outlet being tested was not				
	GFCI protected or	protected at a nearby breaker.				
	-	nference with the facility				
		r and the Maintenance				
		/21 at 1:40 p.m., no additional				
	contrary to this de	dence could be provided ficient finding.				
	3.1-19(b)					
0712	NFPA 101					
SS=F	Fire Drills					
Bldg. 01	Fire Drills					
		the transmission of a fire				
	-	simulation of emergency ire drills are held at				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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 155580 08/02/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE 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 Aperion Care Tolleston Park Based on record review and interview, the K 0712 08/19/2021 facility failed to conduct quarterly fire drills for K -712 Fire Drill Compliance 08/19/2021 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied The facility requests paper conditions. This deficient practice affects all compliance for this citation. staff and residents. This Plan of Correction is the Findings include: center's credible allegation of compliance. Based on record review of the documents entitled "Fire Drill Evaluation Worksheet" form Preparation and/or execution of with the Maintenance Director on 08/02/21 at this plan of correction does not 9:27 a.m., there was no documentation for a constitute admission or second or third shift fire drill in the third quarter agreement by the provider of of 2020. Based on interview at the time of the truth of the facts alleged or record review, the Maintenance Director stated conclusions set forth in the that he was not working at this facility during that statement of deficiencies. The time and noted that the pervious Maintenance plan of correction is prepared Director must have missed doing or documenting and/or executed solely because them. During the exit conference with the it is required by the provisions facility Executive Director and the Maintenance of federal and state law. Director on 08/02/21 at 1:40 p.m., no additional information or evidence could be provided 1)Immediate actions taken for contrary to this deficient finding. those residents identified: The Facility completed second 3.1-19(b) shift fire drill and documented 3.1-51(c) The Facility completed a third shift fire drill documented 2) How the facility identified FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KN3S21 Facility ID: 008505 If continuation sheet Page 21 of 31

PRINTED:

08/31/2021

	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		MB NO. 0938-039 E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155580	B. WING		08/0	2/2021
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE		
	N CARE TOLLEST			TAFT ST Y, IN 46404		
	1			T, IN 40404		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				other residents:		
				·Residents, staff, and vis	sitors	
				have the potential to be	ficient	
				affected by the alleged de practice.	licient	
				4) How the corrective acti	ons	
				will be monitored:		
				•An Environmental QAP		
				will be utilized monthly to monitor compliance.		
				·The results of these au	dits	
				will be reviewed in Quality	/	
				Assurance Meeting month	nly for	
				6 months or until 100%	F 1	
				compliance is achieved. QA Committee will identif		
				trends or patterns and ma		
				recommendations to revis plan of correction as indic		
					alca	
				5) Date of compliance: 08/19/2021		
K 0911	NFPA 101					
SS=E	Electrical System					
Bldg. 01	Electrical System	is - Other RKS section any NFPA 99				
		cal Systems requirements				
		essed by the provided				
	-	deficient. This information,				
		plicable Life Safety Code or				
	on Form CMS-25	sitation, should be included				
	Chapter 6 (NFPA					
	Based on observat	ion and interview, the facility	K 0911	Aperion Care Tolleston Pa	ark	08/19/202
		cess and working space was		K911 Electrical System		
		osures housing electrical		Compliance 08/19/2021		
		Maintenance shop. NFPA 99,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING	(X3) DATE SURVEY COMPLETED 08/02/2021
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STAT 2350 TAFT ST GARY, IN 46404	E, ZIP CODE
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE A CROSS-REFERENCED	A OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE
TAG	Health Care Facilit Section 6.3.2.1 sta be in accordance w Electric Code. NF 110.26 states work operating at 600 v to require examinal maintenance while the dimensions of Distances shall be if such parts are ex front or opening if 110.26(B) states th this section shall n deficient practice of Findings include: Based on observat Maintenance Direct the facility at 11:2? were noted on the located in the base by 48-inch steel m 3 binders and clean immediately in fro Based on interview observations, the M acknowledged the stored within three front of electrical p shop advising that immediately. Durin facility Executive Director on 08/02/	Aaintenance Director aforementioned items were feet of the working space in banels in the Maintenance he would have the items moved ng the exit conference with the Director and the Maintenance 21 at 1:40 p.m., no additional dence could be provided	TAGDEFICIThe facility requ compliance forThis Plan of Con center's credible compliance.Preparation and this plan of corrective agreement by the the truth of the conclusions set statement of de plan of corrective and/or executed it is required by of federal and s	DATE Jests paper this citation. rrection is the le allegation of d/or execution of rection does not ission or he provider of facts alleged or t forth in the efficiencies. The on is prepared d solely because v the provisions state law. etions taken for identified: nir, 3 binders upplies were ont of the s ity identified : taff and eside at the e the potential y the alleged ce. t into place/
	3.1-19(b)		·The Maintena Designee will in weekly to ensur	-

	R MEDICARE & MEDI						MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	Ì Í		ONSTRUCTION	î ź	E SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> B. WING			COMPLETED	
		155580	B. WIN			08/02	2/2021
NAME OF 1	PROVIDER OR SUPPLIE			STREET	ADDRESS, CITY, STATE, ZIP CODE		
TAME OF	ROVIDER OR SOLLER			2350 T	AFT ST		
APERIO	N CARE TOLLEST	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	I	REFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	N BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
					alleged deficient practice	does	
					not occur and will docume		
					the Preventative Maintena		
					Worksheet. The Maintena		
					Director and Assistant wil		
					re-educated on the		
					Preventative Maintenance		
					Program by the Executive		
					Director/designee by 08/0		
					•The Maintenance Direct		
					responsible for compliance	e.	
					4. How the corrective action	ons	
					will be monitored:		
					•The Executive Director	will	
					review the Preventative		
					Maintenance Worksheets monthly.		
					·The results of these au	dits	
					will be reviewed in Quality	,	
					Assurance Meeting month	nly for	
					6 months or until 100%		
					compliance is achieved.		
					QA Committee will identify		
					trends or patterns and ma		
					recommendations to revis		
					5) Date of compliance:		
					08/19/2021		
K 0918	NFPA 101						
SS=F	Electrical System	ns - Essential Electric Syste					
Bldg. 01		ns - Essential Electric					
-	System Maintena						
		r other alternate power					
		ciated equipment is capable					
	of supplying serv	ice within 10 seconds. If the					

	R MEDICARE & MEDI					_	B NO. 0938-03
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155580		· /	TIPLE CON	(X3) DATE SURVEY			
			A. BUILDING <u>01</u>			COMPL	
		B. WINC	G		08/02/2021		
NAME OF 1	PROVIDER OR SUPPLIE	R		STREET AI	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
			2350 TAFT ST				
APERIO	N CARE TOLLEST	ON PARK		GARY, II			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тг	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	10-second criteri	on is not met during the					
	monthly test, a p	rocess shall be provided to					
	annually confirm	this capability for the life					
	safety and critica	I branches. Maintenance					
	and testing of the	e generator and transfer					
	switches are per	formed in accordance with					
	NFPA 110.						
	Generator sets a	re inspected weekly,					
	exercised under	load 30 minutes 12 times a					
	year in 20-40 day	y intervals, and exercised					
		onths for 4 continuous					
		d test under load conditions					
		te simulated cold start and					
		c or manual transfer of all EES nd are conducted by competent					
		enance and testing of stored					
		urces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		are inspected annually, and					
		riodically exercising the					
		stablished according to					
		quirements. Written records					
		and testing are maintained					
	-	able. EES electrical panels					
		narked, readily identifiable,					
		m normal power circuits. ossibility of damage of the					
		er source is a design					
		new installations.					
		4 (NFPA 99), NFPA 110,					
	NFPA 111, 700.	. ,					
		d review and interview, the	K 091	10	Aperion Care Tolleston Park		08/19/20
		nsure a written record of	K 091	-	K918- LTC Electrical System		00/19/20
		s for the generator was			Compliance 08/19/2021		
	• •	of 52 weeks. NFPA 99,			The facility requests paper		
		onsite generators shall be			compliance for this citation.		
		ordance with NFPA 110,			semplation for this claubil.		
		gency and Standby Power			This Plan of Correction is the	e	
		10, 8.4.1 requires an			center's credible allegation of		
	-	Supply System (EPSS)			compliance.		

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
155580		155580	B. WING		- 08/02/2021	
			STREET	TADDRESS, CITY, STATE, ZIP CODE		
JAME OF	PROVIDER OR SUPPLIE	ER	2350	TAFT ST		
PERIO	N CARE TOLLEST	ON PARK	GARY	′, IN 46404		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	including all appu	rtenant components, shall be				
	inspected weekly a	and exercised monthly. NFPA		Preparation and/or execution	of	
	99, 6.4.4.2 require	s a written record of		this plan of correction does n	ot	
	inspection, perform	nance, exercising period, and		constitute admission or		
	repairs for the gen	erator to be regularly		agreement by the provider of		
		ailable for inspection by the		the truth of the facts alleged of	or	
		urisdiction. This deficient		conclusions set forth in the		
		ect all residents, staff, and		statement of deficiencies. The	e	
	visitors.			plan of correction is prepared		
				and/or executed solely becaus		
	Findings include:			it is required by the provision		
	8			of federal and state law.	-	
	Based on record re	eview with the Maintenance				
	Director on 08/02/	/21 at 11:29 a.m.,		1)Immediate actions taken for		
		weekly generator testing		those residents identified:		
		Emergency Generator Record -				
	-	ly Emergency Generator		·No resident was found to be	e	
		ne facility has two generators)		affected by this alleged		
		ly testing documentation on		deficiency		
	-	, July 20th, and July 27th of		·Weekly inspection of		
		interview at the time of		generator was conducted and		
		Maintenance Director		documented		
		generator testing during the		2) How the facility identified		
		eeks was not documented or		other residents:		
		w at the time of this survey.		·Residents, staff and visitors		
		nference with the facility		have the potential to be		
	-	r and the Maintenance		affected by the alleged deficie	nt	
		21 at 1:40 p.m., no additional		practice.	-	
		dence could be provided		3) Measures put into place/		
	contrary to this de	-		System changes:		
				•The Maintenance Director		
	3.1-19(b)			will be re-educated on the		
				Preventative Maintenance		
	2) Based on record	d review and interview, the		Program by the Executive		
		nsure a written record of		Director/designee by 08/3/202	1.	
		s for the generator was		•The Executive Director will		
		of 12 months. NFPA 99,		monitor routine maintenance		
		onsite generators shall be		and operational weekly to		
	-	ordance with NFPA 110,		ensure continued compliance		
		gency and Standby Power				
	Standard for Effer	gency and Standby I Owel	1			

FORM CMS-2567(02-99) Previous Versions Obsolete

·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155580	B. WING		08/02/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
APERIC	N CARE TOLLEST	ON PARK		ΓΑΕΤ ST , IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
	Systems. NFPA 1	10, 8.4.1 requires an		4) How the corrective act	ions	
		Supply System (EPSS)		will be monitored:		
		rtenant components, shall be		·An Environmental QAF		
		and exercised monthly. NFPA		will be utilized monthly to	>	
	-	s a written record of		monitor compliance.		
		nance, exercising period, and				
		erator to be regularly		•The results of these au		
		ailable for inspection by the		will be reviewed in Qualit	-	
		urisdiction. This deficient ect all residents, staff, and		Assurance Meeting mont 6 months or until 100%	niy tor	
	visitors.	cet an residents, starr, and		compliance is achieved.	The	
	visitors.			QA Committee will identif		
	Findings include:			trends or patterns and ma		
	T mangs merade.			recommendations to revi		
	Based on record re	eview with the Maintenance		plan of correction as indi		
	Director on 08/02/	/21 at 11:29 a.m.,		1.		
		monthly generator testing		5) Date of compliance:		
	entitled "Weekly I	Emergency Generator Record -		08/19/2021		
	North" and "Week	tly Emergency Generator				
		e facility has two generators)				
	-	hly testing documentation for				
	-	ed on an interview at the time				
		the Maintenance Director				
		y generator testing for the				
		21 was not documented or				
		w at the time of this survey. nference with the facility				
		r and the Maintenance				
	Director on 08/02/21 at 1:40 p.m., no additional					
		dence could be provided				
	contrary to this de	-				
	3.1-19(b)					
	3) Based on record	d review and interview, the				
		nsure an annual fuel quality test				
	-	the facility's diesel-powered				
	-	99, Health Care Facilities				
		n Section 6.4.4.1.1.3 states				
	for Type 1 EES (E	Essential Electrical System)				

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155580 B. WING 08/02/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY, IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG generator sets, maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director on 08/02/21 at 11:29 a.m., documentation of an annual fuel quality test for the diesel generator was available for review but was dated June 13th, 2019, being over two years old. Based on an interview at the time of record review, the facility Maintenance Director acknowledged annual fuel quality testing as being over two years old and stated that he would have his vendor perform a new test immediately. During the exit conference with the facility Executive Director and the Maintenance Director on 08/02/21 at 1:40 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) K 0923 **NFPA 101** SS=E Gas Equipment - Cylinder and Container Bldg. 01 Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KN3S21 Facility ID: 008505 If continuation sheet Page 28 of 31

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APERION			A. BUILDING	(X3) DATE SURVEY COMPLETED	
APERION		155580	B. WING		08/02/2021
APERION	ROVIDER OR SUPPLIE	R	STREET	T ADDRESS, CITY, STATE, ZIP CODE	
				TAFT ST ′, IN 46404	
$(\mathbf{V}\mathbf{A})$ ID	CARE TOLLEST	UN PARK	GART	, IN 40404	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		in an enclosed interior			
		limited- combustible			
		n door (or gates outdoors)			
		red. Oxidizing gases are not			
		nables, and are separated			
		es by 20 feet (5 feet if			
	. ,	nclosed in a cabinet of			
		construction having a			
		fire protection rating.			
		al to 300 cubic feet			
	-	e compartment, individual			
	•	le for immediate use in			
		s with an aggregate volume			
		ual to 300 cubic feet are			
		e stored in an enclosure.			
	-	e handled with precautions			
	as specified in 11				
		sign readable from 5 feet is			
		gate of a cylinder storage			
		sign includes the wording as ITION: OXIDIZING GAS(ES)			
		N NO SMOKING."			
		ed so cylinders are used in			
		ey are received from the			
		cylinders are segregated			
		s. When facility employs			
		egral pressure gauge, a			
		re considered empty is			
	•	pty cylinders are marked to			
		Cylinders stored in the open			
	are protected from				
	•	1.3.3, 11.3.4, 11.6.5 (NFPA			
	99)				
	,	ion and interview, the facility	K 0923	Aperion Care Tolleston Park	08/19/20
	failed to ensure 2 of			K -923 Gas Equipment	
		es such as oxygen were		Compliance 08/19/2021	
	-	rom falling. NFPA 99, Health		The facility requests paper	
		de, 2012 Edition, Section		compliance for this citation.	
		ge for nonflammable gases			
		bic meters (300 cubic feet)		This Plan of Correction is th	e

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155580 B. WING 08/02/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) but less than 85 cubic meters (3000 cubic feet) center's credible allegation of shall comply with 11.3.2.1 through 11.3.2.3. compliance. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Preparation and/or execution of this plan of correction does not Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported constitute admission or in a proper cylinder stand or cart. This deficient agreement by the provider of practice could affect as many as 25 residents, 3 the truth of the facts alleged or staff, and 1 visitor. conclusions set forth in the statement of deficiencies. The Findings include: plan of correction is prepared and/or executed solely because Based on observations made with the it is required by the provisions Maintenance Director on 08/02/21 during a tour of federal and state law. the facility at 12:14 p.m., two of six green 'E' type oxygen cylinders was standing upright on 1)Immediate actions taken for the floor of the oxygen storage and transfilling those residents identified: ·The facility placed the "E" room and were not supported or in an approved carrier. Five liquid oxygen containers were also type oxygen cylinders 9in observed stored in the room. Based on interview approved carriers at the time of observation, the Maintenance •The five-oxygen containers Director advised that he has told staff numerous were removed and stored in proper area with in the times that the portable oxygen containers need to be placed in the holder, but that they do not listen approved carriers to him. During the exit conference with the facility Executive Director and the Maintenance 2.) How the facility identified Director on 08/02/21 at 1:40 p.m., no additional other residents: information or evidence could be provided ·Residents. staff and visitors contrary to this deficient finding. have the potential to be affected by the alleged deficient 3.1-19(b) practice. ·Maintenance Director observed All areas in the building to ensure that the same alleged deficient practice does not occur. 4) How the corrective actions will be monitored: ·An Environmental QAPI tool FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KN3S21 Facility ID: 008505 If continuation sheet Page 30 of 31

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DF	EPARTMENT	OF HEALTH AND HUN	AAN SERVICES				FOI	RM APPROVED
CF	ENTERS FOR	MEDICARE & MEDICA	AID SERVICES				ОМ	B NO. 0938-0391
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CO	NSTRUCTION	(X3) DATE SURVEY	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u>			COMPLETED		
			155580	B. WING			08/02/	2021
	155580 NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		235	0 ΤΑ ΥΥ,	ADDRESS, CITY, STATE, ZIP CODE AFT ST IN 46404 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) will be utilized monthly to monitor compliance. Audits created to observe weekly to ensure the same alleged deficient practice does not occur. •The results of these audits will be reviewed in Quality Assurance Meeting monthly 10%	TE for	(X5) COMPLETION DATE	
						compliance is achieved. The		
						QA Committee will identify an trends or patterns and make	ny	
						recommendations to revise t	he	
						plan of correction as indicate	əd	
						5) Date of compliance: 08/19/2021		

KN3S21 Facility ID: 008505

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