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	08/02/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/02/21 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 At this Emergency Preparedness survey, Aperion Care Tolleston Park, was found in substantial 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 103. Quality Review completed on 08/05/21	E 0000		
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

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.

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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation			

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	by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 08/02/21 at 09:34 a.m., the weekly and monthly generator testing did not comply with testing in NFPA 101. The generator testing log forms entitled "Weekly Emergency Generator Records - North" and "Weekly Emergency Generator Records - PCU" (the facility has two generators) had missing weekly testing documentation on July 6th, July 13th, July 20th, and July 27th of 2021. The monthly testing for July of 2021 was also not available for record review for either generator. Based on interview at the time of record review, the Maintenance Director agreed that the weekly and monthly generator testing documentation for both the North and South generators was not available for record review at the time of this survey. 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.	E 0041	**Aperion Care Tolleston Park** **E-041 Emergency Preparedness LTC emergency power** **Compliance 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **·No resident was found to be affected by this alleged deficiency** **·Weekly inspection of generator was conducted and documented**	08/19/2021

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			·A monthly inspection of generator was conducted and documented **2) How the facility identified other residents:** **·Residents, staff and visitors have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **·The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 08/3/2021.** **·The Executive Director will monitor routine maintenance and operational weekly and month testing to ensure continued compliance.** **4) How the corrective actions will be monitored:** **·An Environmental QAPI tool will be utilized monthly to monitor compliance.** **·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 trends or patterns and make recommendations to revise the plan of correction as indicated** **5) Date of compliance: 08/19/2021**	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/02/2021 Facility Number: 008505 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 natural gas generator and a 45-kW diesel generator. 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	K 0000		

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	of the survey, the census was 103. All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered. Quality Review completed on 08/05/21			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 2 of 9 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 25 residents, 3 staff and 1 visitor.	K 0211	**Aperion Care Tolleston Park** **K-211 Means of Egress** **Compliance 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the***	08/19/2021

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	Findings include: Based on observations made with the Maintenance Director on 08/02/21 during a tour the facility from 11:25 a.m. to 1:30 p.m., the following was noted: 1) two delivery pallets were sitting unattended in the corridor outside of Resident room #316, each containing approximately 40 to 50 boxes of supplies. These items obstructed the clear width of the corridor to only 44 inches. 2) a small 3 drawer desk was sitting in the corridor immediately outside resident room #310 and was not on wheels. Based on interview at the time of each observation, the Maintenance Director acknowledged the items in the corridor and added that he has found these items in the corridor before and that he has mentioned it to nursing staff, but they still use the area for storage. 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)		***statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1. Immediate actions taken for those residents identified: Facility staff removed Pallets and central supply staff was educated on leave DME and other supplies unattended and obstructing clear egress in the corridor** **The small 3 dresser drawer was 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 ensure that the same deficient practice did not occur in other areas** **·Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **·All staff was educated on leave DME and other supplies**	

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			unattended and obstructing clear egress in the corridor **1. How the corrective actions will be monitored:** **·The Executive Director/ Designee will review the daily egress audit Worksheets on a monthly basis and randomly check egress. The Executive Director/ Designees will observe staff's knowledge on keeping the corridor free from obstructed areas by means of return demonstration.** **·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 trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 08/19/2021**	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.			

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	19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.			
	Based on observations and interview, the facility failed to ensure 1 of 1 ceiling barriers in the data room was smoke tight in accordance with 19.3.1. LSC 19.3.1 requires protection of a vertical opening. LSC 19.3.1 requires a vertical opening shall be enclosed or protected in accordance with section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire rating. This deficient practice could affect approximately 20 residents, 3 employees, and 1 staff. Findings include: Based on observations made with the Maintenance Director on 08/02/21 during a tour the facility at 12:22 p.m., the electrical closet on the South unit had a white two inch in diameter PVC pipe acting as a conduit for 15 white data wires passing up through the ceiling and into the attic space above. The fire caulk that was applied in the annular space around the wires had fallen out of the conduit leaving a hole up into the attic space above. Based on interview at the time of the observation, the Maintenance Director acknowledged the ceiling penetrations and agreed that the ceiling was not smoke tight. 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.	K 0311	**Aperion Care Tolleston Park K311 Vertical Openings Compliance 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **·Immediate actions taken for those residents identified:** **·The Maintenance Director ensured that the two inch in diameter PVC pipe passing though the ceiling was caulked with fire barrier caulking. This ensured that the annular space around the wire was smoke tight and prevented the passage of smoke to ensure continued compliance.**	08/19/2021

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	3.1-19(b)		**2) How the facility identified other residents:** **·All visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **·The Maintenance Director or Designee will inspect vertical openings in the facility monthly to ensure that annular areas are smoke tight and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 08/01/2021** **·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.**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

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	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 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.			

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	Based on observation and interview, the facility failed to ensure 3 of over 100 doors within the facility to the corridor would completely resist the passage of smoke. This deficient practice could affect approximately 34 residents, 3 staff, and 1 visitor. Findings include: Based on observations made with the Maintenance Director on 08/02/21 during a tour the facility from 11:25 a.m. to 1:30 p.m., the following was noted: 1) the Central Supply door in the basement of the facility leading to the corridor had a three-eighths inch hole above the door handle. 2) the Storage room door in the Central Supply room located within the basement of the facility leading had a three-eighths inch hole above the door handle. 3) Resident room #324 corridor door had a three-eighths inch hole above the door handle. Based on an interview at the time of each observation, the Maintenance Director acknowledged that all above mentioned doors would not resist the passage of smoke. 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 0363	**Aperion Care Tolleston Park** **K363 Corridor Doors** **Date Compliance 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **·Immediate actions taken for those residents identified:** **·The Central Supply door in the basement was repaired and no longer has a hole above the door handle.** **·The storage room door in the basement was repaired and no longer has a hole above the door handle** **·The Room 324 in the corridor on PCU was repaired and no longer has a hole above the door handle** · **2) How the facility identified other residents:**	08/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			·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.** **3) Measures put into place/ System changes:** **·The Maintenance Director or 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 08/01/2021** **·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**	

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			trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 08/19/2021**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 2 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 25 residents, as well as 3 staff and 2 visitors. Findings include:	K 0374	**Aperion Care Tolleston Park** **K-374 Building Spaces** **Compliance Date 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	08/19/2021

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	Based on observations made with the Maintenance Director on 08/02/21 during a tour the facility from 11:25 a.m. to 1:30 p.m., the following was noted: 1) the smoke barrier doors in the Lobby area leading to the South unit failed to fully close when tested on three separate attempts leaving a one-inch gap when closed at the fullest. 2) the smoke barrier doors near Resident rooms #111 and #122 on the North unit failed to fully close when tested on three separate attempts leaving a one-inch gap when closed at the fullest. Based on an interview at the time of each observation, the Maintenance Director acknowledged that the aforementioned doors failed to fully close after being tested on three separate occasions. 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)		***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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1. Immediate actions taken for those residents identified:** **·No resident or staff was found to be affected by this alleged deficiency** **·The Maintenance Director inspected and repaired the following doors to ensure that the smoke barrier doors would restrict the movement of smoke for at least 20 minutes.** **·Smoke Barrier Door 111** **·Smoke Barrier Door 122** **2) How the facility identified other residents visitor and staff :** **·Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice.** **·Maintenance Director inspected all facility doors to ensure that the smoke barrier doors would restrict the movement of smoke for at least**	

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			20 minutes. **3) Measures put into place/ System changes:** **·All staff instructed to notify maintenance via work order to ensure that the same alleged deficient practice does not occur. Maintenance will continue to observe the doors during a fire drill and annually per policy.** **·Maintenance Director or Designee will conduct monthly audits to identify any potential problems** **1. 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 of return demonstration.** **·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 trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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			5) Date of compliance: 08/19/2021	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1) Based on record review and interview the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.	K 0511	**Aperion Care Tolleston Park K -511 Gas and Electric Compliance 08/19/2021 The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified: The facility called local gas company (Nipsco) (Mike Figg)**	08/19/2021

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	A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice had the potential to affect all residents, staff, and visitors within the facility. Findings include: Based on record review with the Maintenance Director on 08/02/21 at 11:29 a.m., documentation for monthly generator testing entitled "Weekly Emergency Generator Record - North" and "Weekly Emergency Generator Record - PCU" (the facility has two generators) the fuel source for the North generator was determined to be natural gas. Additionally, based on interview, the facility did have a letter from their natural gas provider indicating the natural gas was from a reliable source, but it was dated December 5th, 2014. The facility not having an up-to-date letter stating that the fuel source for the emergency generator was from a reliable source was acknowledged by the Maintenance Director who stated that he would request a more recent letter 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) 2) Based on observation and interview, the facility failed to ensure 1 of 1 sink areas was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70,		**and requested an updated letter indicating that the fuel source for the facility's emergency generator is a reliable source.** **2) The facility installed a (GFCI) ground fault circuit interrupter at the sink area to protect against electrical shock.** **2) How the facility identified other residents:** **·Residents, staff and visitors have the potential to be affected by the alleged deficient practice.** **·Maintenance Director observed All areas around water including the kitchens, bathrooms and other areas that require a (GFCI) to ensure that the alleged deficient practice does not occur.** **4) How the corrective actions will be monitored:** **·An Environmental QAPI tool will be utilized monthly to monitor compliance. Audits observed with any electrical service and annually to ensure the same alleged deficient practice does not occur.** **·The results of these audits will be reviewed in Quality Assurance Meeting monthly for**	

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	National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. (7) Sinks - Located in areas other than kitchens where receptacles are installed within 1.8 m. (6 ft.) of the outside edge of the sink. This deficient practice affects up to 24 residents, 3 staff and 1 visitor. Findings include: Based on observations made with the Maintenance Director on 08/02/21 during a tour the facility at 12:22 p.m., the North unit Supply room had a sink with an electrical outlet within six feet of the sink. This outlet was not a GFCI protected outlet. When tested, this outlet did not pop a circuit breaker in the nearby circuit box either. Based on an interview at the time of the observation, the Maintenance Director stated that he was certain that the outlet being tested was not GFCI protected or protected at a nearby breaker. 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)		**6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated** **5) Date of compliance: 08/19/2021**	
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			

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	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 failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the documents entitled "Fire Drill Evaluation Worksheet" form with the Maintenance Director on 08/02/21 at 9:27 a.m., there was no documentation for a second or third shift fire drill in the third quarter of 2020. Based on interview at the time of record review, the Maintenance Director stated that he was not working at this facility during that time and noted that the pervious Maintenance Director must have missed doing or documenting them. 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) 3.1-51(c)	K 0712	**Aperion Care Tolleston Park** **K -712 Fire Drill** **Compliance 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **The Facility completed second shift fire drill and documented The Facility completed a third shift fire drill documented** **2) How the facility identified**	08/19/2021

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			other residents: **·Residents, staff, and visitors have the potential to be affected by the alleged deficient practice.** **4) How the corrective actions will be monitored:** **·An Environmental QAPI tool will be utilized monthly to monitor compliance.** **·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 trends or patterns and make recommendations to revise the plan of correction as indicated** **5) Date of compliance: 08/19/2021**	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 Maintenance shop. NFPA 99,	K 0911	**Aperion Care Tolleston Park K911 Electrical System Compliance 08/19/2021**	08/19/2021

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	Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect as many as 4 staff. Findings include: Based on observations made with the Maintenance Director on 08/02/21 during a tour the facility at 11:29 a.m., three electrical panels were noted on the wall of the Maintenance shop located in the basement of the facility. A 24-inch by 48-inch steel mounting bracket, a desk chair, 3 binders and cleaning supplies were stored immediately in front of these electric panels. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned items were stored within three feet of the working space in front of electrical panels in the Maintenance shop advising that he would have the items moved 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)		**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **·Immediate actions taken for those residents identified:** **·The desk chair, 3 binders and cleaning supplies were roved from in front of the electrical panels** **2) How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **·The Maintenance Director or Designee will inspect audit weekly to ensure that the same**	

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			alleged deficient practice does not occur 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 08/01/2021 **·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 trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 08/19/2021**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the			

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	10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 4 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS)	K 0918	**Aperion Care Tolleston Park** **K918- LTC Electrical Systems** **Compliance 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	08/19/2021

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	including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. 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 for weekly generator testing entitled "Weekly Emergency Generator Record - North" and "Weekly Emergency Generator Record - PCU" (the facility has two generators) had missing weekly testing documentation on July 6th, July 13th, July 20th, and July 27th of 2021. Based on an interview at the time of record review, the Maintenance Director confirmed weekly generator testing during the aforementioned weeks was not documented or available for review at the time of this survey. 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) 2) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 1 of 12 months. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power		***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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **·No resident was found to be affected by this alleged deficiency** **·Weekly inspection of generator was conducted and documented** **2) How the facility identified other residents:** **·Residents, staff and visitors have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **·The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 08/3/2021.** **·The Executive Director will monitor routine maintenance and operational weekly to ensure continued compliance.**	

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	155580	A. BUILDING 01 B. WING	08/02/2021

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

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	Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. 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 for monthly generator testing entitled "Weekly Emergency Generator Record - North" and "Weekly Emergency Generator Record - PCU" (the facility has two generators) had missing monthly testing documentation for July of 2021. Based on an interview at the time of record review, the Maintenance Director confirmed monthly generator testing for the month of July, 2021 was not documented or available for review at the time of this survey. 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) 3) Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.4.4.1.1.3 states for Type 1 EES (Essential Electrical System)		**4) How the corrective actions will be monitored:** **·An Environmental QAPI tool will be utilized monthly to monitor compliance.** **·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 trends or patterns and make recommendations to revise the plan of correction as indicated** **5) Date of compliance: 08/19/2021**	

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	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 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container 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			

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	enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 6 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet)	K 0923	**Aperion Care Tolleston Park** **K -923 Gas Equipment** **Compliance 08/19/2021** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the***	08/19/2021

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	but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect as many as 25 residents, 3 staff, and 1 visitor. Findings include: Based on observations made with the Maintenance Director on 08/02/21 during a tour the facility at 12:14 p.m., two of six green 'E' type oxygen cylinders was standing upright on the floor of the oxygen storage and transfilling room and were not supported or in an approved carrier. Five liquid oxygen containers were also observed stored in the room. Based on interview at the time of observation, the Maintenance Director advised that he has told staff numerous times that the portable oxygen containers need to be placed in the holder, but that they do not listen to him. 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)		***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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **·The facility placed the "E" type oxygen cylinders 9in approved carriers** **·The five-oxygen containers were removed and stored in proper area with in the approved carriers** **2.) How the facility identified other residents:** **·Residents, staff and visitors have the potential to be affected by the alleged deficient 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**	

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			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 for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated** **5) Date of compliance: 08/19/2021**	