STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	02/16/2022

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00372293, IN00372315, IN00372357, and IN00372689. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00372293 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00372315 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00372357 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Complaint IN00372689- Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Unrelated deficiencies are cited. Survey dates: February 14, 15, and 16, 2022 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 135 Total: 135 Census Payor Type: Medicare: 22 Medicaid: 105 Other: 8	F 0000		

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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	Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/17/22.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
	Based on record review and interview, the facility failed to ensure a resident was free from abuse, related to a staff member forcing the resident to sit in the wheelchair and forcing her to go to her room against her will, for 1 of 3 residents reviewed for abuse. (Resident C and LPN 2) Finding includes: A reportable incident to the Indiana Department of Health (IDOH), dated 2/3/22, indicated the Resident C informed a hospital nurse that a nurse at the facility was rough with her, while putting her to bed.	F 0600	**Aperion- Tolleston Park** **Complaint Survey 02/16/2022** **Compliance 02/28/22** **F-600 Free from Abuse** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	02/28/2022

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APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	A Follow-up incident to the IDOH, dated 2/10/22, indicated the resident had attempted to smoke a cigarette in the dining area. Staff encouraged the resident to return to the unit and the resident continued to return to the dining room. LPN 2 had indicated the resident became combative when they attempt to take her back to her room occurred. The resident struck the nurse in the head and face. LPN attempted to hold the resident in the chair as she was taken to her room. Two other residents were interviewed (Residents F and G) and they provided the same recollection of events. Media was observed and it indicated the resident was attempting to hit LPN 2. LPN 2 was also observed holding the resident against the chair while pushing her to her room. The statement from LPN 2, dated 2/3/22, indicated between the time of 9 p.m.-10 p.m., the resident was propelling her wheelchair towards the dining room. LPN 2 had asked the resident to return to her room or stay near the Nurses' Station. The resident continued towards the dining room. CNA 1 and CNA 2 were asked to bring the resident to her room. The resident returned to the Nurses' Station from her room and claimed other residents were going to the dining room. No other residents were seen in the hallway. LPN 2 attempted to assist her back to her room and she became combative and grabbed the shirt collar. She attempted to stand from the wheelchair and LPN 2 placed his hand on her neck and shoulders so she would not fall out of the chair. The resident grabbed her wheels, which made the transportation to the room difficult. She was assisted to her room with the help of CNA 1 and CNA 1 transferred the resident to bed.		*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:** Contracted Staff LPN 1 was immediately re-in serviced on facility and Company policy for Abuse and Restraint. LPN 1 no longer works for the facility. **2) How the facility identified other residents:** All residents have the potential to be affected by this alleged deficient practice. All residents were observed for signs and symptoms of abuse and no resident was observed to have any sign or symptoms of Abuse. **3) Measures put into place/ System changes:** Staff will be re-educated on Facility abuse Policy. Staff were re-educated on Abuse on 2/16/22 and ongoing. **4) How the corrective actions**	

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	A Written statement from CNA 1, dated 2/14/22, indicated she had been interviewed by the Administrator 2/3/22 and was told to write a statement. She had forgotten to write the statement until the Administrator called her this morning. She indicated when she came back from break, she heard the resident hollering, "leave me alone, I don't have to go in my room". CNA 1 walked down the hallway and saw LPN 2 behind the resident's wheelchair trying to push her into her room. When LPN 2 was asked what was wrong, he indicated he wanted her in her room, so he kept pushing her from behind in the wheelchair to get her in the room. He finally was able to get her in her room. The resident was standing from the wheelchair, and wanted her telephone. CNA 1 encouraged the resident to sit down to avoid a fall and her cell phone was given to her. The resident indicated she was alright and the CNA left the room. There were no statements written from Residents F and G in the investigation. Resident F was interviewed on 2/14/22 at 2:01 p.m. He indicated the nurse had his hand and arm around the resident's neck. She was in the wheelchair and both of his hands were on her. She had been yelling. He was trying to get her to go into her room. Resident G was interviewed on 2/14/22 at 2:04 p.m. He indicated the resident stood up and LPN 2 was holding her back and told her to go to her room. She told the nurse she did not have to go. She stood up twice and he "aggressively" pushed her down by her shoulders. LPN 2's left arm was around her upper chest/lower neck area he pressed on her shoulder with his right elbow.		**will be monitored:** The Administrator /designee will conduct random Abuse audits with 5 residents per week for 6 weeks. 3 resident for 6 weeks and 2 residents 12 weeks to ensure staff compliance with Abuse Policy. Any reported issues will be handled per the Abuse Policy. Audits will continue until 6 months of compliance is achieved. **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 02/28/2022**	

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	CNA 1 came and assisted the nurse. During an interview with the Administrator, on 2/14/22 at 2:44 p.m., she indicated she didn't write down what Residents F and G told her when she interviewed them. She had only documented what she saw on the video camera. She could only see the back of the resident and LPN 2. She had not witnessed the other residents in the hallway nor the nurse forcefully push the resident back down in the wheelchair. Resident G had indicated he thought the nurse was rough with her. The Administrator provided typed statements later in the day on 2/14/22, which indicated on 2/3/22, the video of the security cameras were observed and Resident C attempted to strike LPN 2 with her right arm. LPN 2 reached around the resident and held her arm down and her body against the chair as he pushed the wheelchair to the room. She had interviewed Resident G on 2/4/21 and he indicated he was able to see the resident and the nurse from his doorway and the nurse was "rough" with the resident. Resident F was also interviewed and he indicated he could not see too much since he was on the other side of the curtain. He had heard her yelling and cussing at the nurse to leave her alone and let her go. LPN 2 was terminated due to a violation of the abuse policy. During an interview on 2/15/22 at 8 a.m., the Administrator indicated she had attempted to talk to the resident about the incident and she would not speak to her. The facility abuse policy, dated 12/17/21 and received from the Administrator as current, indicated the resident had a right to be free from			

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	abuse, which included, but was not limited to, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This Federal tag relates to Complaints IN00372357 and IN00372689. 3.1-(a)(1) 3.1-(a)(4)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure residents who required extensive to dependent assistance with ADL's (activity of daily living) received bathing at least twice a week for 2 of 3 residents reviewed for ADL's. (Residents B & E) Findings include: 1) Resident B's closed record was reviewed on 2/14/22 at 11 a.m. The diagnoses included, but were not limited to, COVID-19 and dementia. The admission date was 1/19/22. An Admission/5-day Medicare Minimum Data Set (MDS) assessment, dated 1/19/22, indicated a severely impaired cognitive status and dependent on one staff for bathing. The Care Plan, dated 1/19/22, indicated assistance was required for ADL's. The intervention included to assist with ADL's.	F 0677	**Aperion- Tolleston Park** **POC Complaint Survey** **Exit 02/16/2022** **Compliance 02/28/2022** **F 677 ADL Dependent Residents** *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*	02/28/2022

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	The Bathing Task Form, dated 1/2022, indicated from 1/19/22 through 1/30/22, the resident received bathing one time on 1/24/22. 2) During an interview on 2/14/22 at 11:58 a.m., Resident E indicated she had not had a shower nor her hair washed. Resident E's record was reviewed on 2/14/22 at 3 p.m. The diagnoses included, but were not limited to glaucoma and diabetes mellitus. The admission date was 1/22/22. The Admission/5-day Medicare MDS assessment, indicated a moderately impaired cognitive status, required extensive assistance of for hygiene and no shower had been given. A Care Plan, dated 1/23/22, indicated assistance was required with ADL's. The interventions included to assist with ADL's. The Bathing Task Forms, dated 1/2022 and 2/2022, indicated bathing was scheduled for Mondays and Thursdays. Bathing had not been completed on 1/27/22, 1/31/22, and 2/10/22. During an interview on 2/14/22 at 12:25, the Director of Nursing indicated the bathing had not been completed twice a week. This Federal tag relates to Complaint IN00372293. 3.1-38(b)(2)		*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:** Resident B no longer resides in the facility. Resident E was given a shower. **2) How the facility identified other residents:** The facility completed an audit to identify any dependent residents who need assistance with grooming and personal hygiene. The facility staff provided grooming and personal care including showers as needed. **3) Measures put into place/ System changes:** The facility staff was in-serviced on providing ADL care for residents unable to carry out activities of daily living and to ensure that residents receive good nutrition, grooming and hygiene. **4) How the corrective actions will be monitored:** **The DON/Designee** will complete Dignity Rounds at least 5 times	

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			weekly at varied times to ensure proper hygiene is maintained for facility residents. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 02/28/22**	
F 0689 SS=K Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a risk for hazards to residents did not occur related to a resident who was deemed unable to maintain her own smoking materials due to safety, repeatedly keeping her smoking materials on her person	F 0689	**Aperion- Tolleston Park** **POC Complaint Survey**	02/18/2022

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without facility intervention, the resident continued to light cigarettes inside the facility, and placed a lit cigarette in the trash can, causing a fire which activated the fire alarm and had to be extinguished. All residents in the facility not residing on the 2 locked, inaccessible units were at risk for fire hazards related to unsafe smoking. (Resident C)

The Immediate Jeopardy began on 1/20/22, when the resident placed a lit cigarette in the trash can, causing a fire which activated the fire alarm and had to be extinguished. The facility failed to follow their smoking policy and the resident continued to keep her smoking material and have occurrences of lighting a cigarette inside the building in non-approved smoking areas. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 2/15/22 at 10:39 a.m. The immediate jeopardy was removed on 2/16/22, but noncompliance remained at the lower scope and severity level of no actual harm, with potential for more than minimal harm that is not immediate jeopardy.

Finding includes:

Resident C was observed on 2/14/22 at 12:15 a.m., in the front lobby, sitting in a wheelchair. She was wearing her winter coat, gloves and hat. She indicated she had just been outside to smoke and she does not turn her cigarettes and lighter in to the staff. She then pointed to her pocket of her coat and indicated her cigarettes and lighter were in her pocket

Resident C's record was reviewed on 2/14/22 at 12:35 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary

Exit 02/16/2022

Compliance 02/28/2022

F 689 Smoking

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:
Resident C smoking assessment completed. The assessment determined that resident c in unsafe with smoking materials. Resident C’s smoking materials remain in nursing cart until resident smoking times.

2) How the facility identified other residents:
The facility completed a smoking assessment on all resident smokers to determine if the resident is safe to have smoking

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	disease and schizophrenia. A Quarterly Minimum Data Set, dated 1/25/22, indicated an intact cognitive status, no behaviors, required limited assistance for bed mobility and transfers, and extensive assistance with ambulation and locomotion, and received an anti-anxiety and antidepressant medication the past 7 days. A Care Plan, dated 9/24/21, indicated she was a smoker. The intervention indicated she would be instructed about the smoking risks and hazards and educated on the smoking cessation aids that were available. A Care Plan, dated 12/6/21, indicated she was a smoker and had been assessed as being unsafe to smoke independently, had smoked inside her room and refused to turn in the lighter and cigarettes to the nurse. The interventions included, a smoking schedule would be created as needed and reviewed with the resident, family, and staff. The family would be educated to not provide cigarettes, lighter or matches to the resident. The Nursing Staff would keep the Cigarettes and lighter/matches in a safe area. A Smoking Assessment, dated 12/13/21, indicated she was not able to store smoking materials. The Nursing Progress Notes indicated the following: On 12/5/22 at 11:17 a.m., she was observed sitting in a wheelchair in her room. A cigarette was lit and she was smoking. She was instructed to put the cigarette out and was easily redirected. She was asked by the nurse for the smoking		materials. If resident's assessment determined that the resident cannot have smoking materials. The nurse will hold the materials on the nursing cart and provide the materials to the resident during smoking times. The assessment will be completed on new admissions, quarterly and with a significant change to ensure resident are safe with smoking materials. **3) Measures put into place/ System changes:** The facility staff was in-serviced the smoking policy **4) How the corrective actions will be monitored:** **The DON/Designee** will complete smoking rounds 5 times weekly for 3 month and 3 times weekly for 3 months at varied times to ensure that residents are following smoking policy and are allowed to have their smoking materials deem by smoking assessment. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6**	

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	materials and the resident refused to turn them in. The Physician, family, and Nursing Supervisor were informed of the incident. On 12/18/21 at 7:28 p.m., the resident was propelling herself in the wheelchair in the hallway with a lit cigarette, and began to smoke the cigarette by the North Nurses' Station. On 12/18/21 at 8:01 p.m., the nurse was unsuccessful in getting the resident's cigarettes and lighter from the resident. The family was notified and informed the nurse, "to do what is needed". A Behavior/Mood Note, dated 1/20/22 at 5:26 p.m., indicated a fire was observed in the trash can, located in the resident's room. The fire alarm had been activated and a full fire event took place due to the resident setting the fire. A Nurse's Progress Note, dated 1/20/22 at 6:21 p.m., indicated the nurse smelled smoke, and observed a flame in the garbage can in the resident's room. The Administrator was informed the resident had set a fire in the garbage can. The Physician was notified and the Resident's family was notified. The resident was sent to the hospital to be evaluated and treated. A Nurse's Progress Note, dated 1/21/22 at 9:20 a.m., indicated she returned to the facility with no new orders. A Nurse's Progress Note, dated 2/11/22 at 9:51 a.m., indicated the resident was smoking in her room. She allowed staff to extinguish the cigarette and she then proceeded to the smoking area.		**months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 02/28/22**	

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A Nurse's Progress Note, dated 2/15/22 at 3:40 a.m., indicated she attempted to smoke a cigarette in the hallway. She then voluntarily relinquished the lighter and cigarettes to the staff. She was educated on the dangers and safety of smoking in the facility. The Administrator was notified of the incident.

A reportable incident, dated 2/3/22 with the follow up on 2/10/22 by the Administrator, indicated the resident had been attempting to smoke in the dining area. There was no documentation in the progress notes of this behavior on 2/3/22.

The CNA Task form indicated safety checks every 15 minutes to monitor violations of the smoking agreement and resident safety were to be completed. Random dates were reviewed and the 15 minute checks were completed at the following times:

On 1/17/22 they were completed at 9:42 p.m., 9:43 p.m., 9:44 p.m., and 9:45 p.m.

On 1/19/22, safety checks were completed at 1:34 a.m., 1:46 a.m., then at 6:50 a.m., 6:51 a.m., then at 2:42 p.m., 2:47 p.m., then at 7:02 p.m. and 7:03 p.m., then at 8:15 p.m. through 10:45 p.m. they were completed every 15 minutes, and none were completed after 10:45 p.m.

On 1/20/22, at 7:18 p.m. it was documented the resident was not available and there was not any other documentation for the day.

On 1/21/22, the fifteen minute checks were started at 6:45 a.m. then completed at 6:46 a.m. and 6:47 a.m. The next check was at 1:59 p.m., 2 p.m. and 2:01 p.m. The next check was at 8:28

p.m. 8:45 p.m., and then 10:08 p.m.

On 2/10/22, the fifteen minute checks were started at 12:59 p.m. and 1:03 p.m. The next check was at 1:34 p.m. 1:36 p.m., and 2:29 p.m. There were no other checks after 2:29 p.m.

On 2/11/22, the fifteen minute checks were started at 12:04 p.m., 12:16 p.m., 1:30 p.m., 2 p.m., 2:15 p.m., 2:30 p.m., and 2:45 p.m. The next check was at 7:53 p.m. and 7:54 p.m. There were no more checks completed after 7:54 p.m.

During an interview on 2/14/22 at 1:42 p.m., the Administrator indicated the resident's family had been notified and they said they were not bringing the resident's cigarettes and lighters. The resident gave money to others and they would bring them to her. She refused to turn in her smoking material and would not allow staff to look for them. She was placed on 15 minute checks. There was not a fire, LPN 1 was right outside the room and she walked in as the resident was throwing the cigarette in the trash can. It was not reported, there was no fire, and the alarm had not been activated.

During an interview on 2/14/22 at 1:50 p.m., LPN 1 indicated there was a fire and it was in the trash can. The fire had activated the fire alarm. The resident was propelling herself in the hallway and she was coming toward LPN 1. There was a smell and the resident's room was entered. LPN 1 indicated she started to walk out of the room and saw "orange" out of the corner of her eye and saw it was a fire. There were flames coming from the trash can. The fire extinguisher was used to put the fire out.

During an interview on 2/15/22 at 1:12 p.m., the

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	155580	A. BUILDING 00 B. WING	02/16/2022

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

Director of Nursing indicated the 15 minute checks were not being completed.

A facility smoking policy, dated 11/28/12 and revised on 1/22/19, was provided by the Administrator as current. The policy indicated the facility had the right to enforce a policy prohibiting residents from keeping any smoking materials in their possession for health, safety and security reasons. Smoking privileges would be revoked if there was a pattern of persistent, hazardous behavior. All persons interested in retaining smoking privileges must follow the guidelines set forth in this policy.

The immediate jeopardy that began on 1/20/22 was removed on 2/16/22 when the facility had inserviced 77 of the 130 facility staff on the facility smoking safety policy. Staff were interviewed and indicated if the resident was assessed to be unsafe to keep their own smoking materials then the materials would be locked in the Medication Cart or in the Medication Room. Residents who smoked in an unauthorized area would have their materials stored in the Medication Cart or in the Medication Room. The Administrator, Director of Nursing, and Charge Nurse would be notified of the behavior. The Administrator would be notified if the resident refused to turn in the smoking materials. All staff will be inserviced on the safe smoking policy either by phone or prior to working their next shift. All residents who smoke were reassessed for safety and a meeting was held to re-educate on the safe smoking policy of the facility. The non-compliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility still needs to inservice the rest of the

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	staff who work in the facility. The facility will monitor residents who smoke. Smoking safety risk assessment will be completed on admission. Those residents who are at risk for keeping smoking materials will be questioned randomly if they have smoking materials on their persons. Findings of the questioning of residents will be discussed monthly during QAPI meeting with necessary revisions implemented, for six months based on the committee's recommendations. 3.1-45(a)			
F 9999 Bldg. 00	3.1-13(g)(1) Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to inform the Indiana Department	F 9999	**Aperion- Tolleston Park** **POC Survey 02/02/2022** **Compliance 02/20/2022** **F9999 Reporting of unusual occurrence** **1) Immediate corrective action(s) for those residents affected by the deficient practice:** All residents and staff may be affected by the alleged deficient practice. **2) Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** The	02/28/2022

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of Health (IDOH) of a fire in the facility, which was caused by a resident throwing a lit cigarette in the trash can. (Resident C)

Finding includes:

Resident C's record was reviewed on 2/14/22 at 12:35 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and schizophrenia.

A Behavior/Mood Note, dated 1/20/22 at 5:26 p.m., indicated a fire was observed in the trash can, located in the resident's room. The fire alarm had been activated and a full fire event took place due to the resident setting the fire.

A Nurse's Progress Note, dated 1/20/22 at 6:21 p.m., indicated the nurse smelled smoke, and observed a flame in the garbage can in the resident's room. The Administrator was informed the resident had set a fire in the garbage can.

During an interview on 2/14/22 at 1:42 p.m., the Administrator indicated there was not a fire, LPN 1 was right outside the room and she walked in as the resident was throwing the cigarette in the trash can. It was not reported to the IDOH, there was no fire, and the alarm had not been activated.

During an interview on 2/14/22 at 1:50 p.m., LPN 1 indicated there was a fire and it was in the trash can. The fire had activated the fire alarm. The resident was propelling herself in the hallway and she was coming toward LPN 1. There was a smell and the resident's room was entered. LPN 1 indicated she started to walk out of the room and saw, "orange" out of the corner of her eye and saw it was a fire. There were flames coming from the trash can. The fire extinguisher

Administrator review State of Indiana reporting guidelines.

3) Facility measures and systemic changes to ensure the deficient practice does not recur:
The Administrator will review all occurrences with IDT and determine if the incident is considered an unusual occurrence.

4) Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:
The IP will call the red cap system monthly to ensure that there are no discrepancies. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.

5) Date of compliance: 02/28/2022

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	was used to put the fire out. During an interview on 2/14/22 at 2:44 p.m., the Administrator indicated the fire had not been reported as she did not feel it affected the health and safety of other residents. A facility policy for reporting incidents and unusual occurrences to the IDOH, dated 7/15/15, and received from the Administrator as current indicated the IDOH was to be notified within 24 hours of an unusual occurrence that directly threaten the welfare, safety, or health of the resident or residents. Examples included fires within the facility due to any cause.			