STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING COMPLET. B. WING 08/29/20			ETED	
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000							
Bldg		paredness Survey was ndiana Department of Health in 2 CFR 483.73.	E 00	000			
	Survey Date: 08/29	9/2022					
	Care Tolleston Parl	155580 1064830 Preparedness survey, Aperion k, was found in substantial					
	Requirements for N	mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR					
	dually certified for	O certified beds. 152 beds are Medicare and Medicaid; 28 or Medicare only. At the time ensus was 133.					
	Quality Review con	mpleted on 09/06/22					
E 0004 SS=C Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §410 §441.184(a), §460 §483.73(a), §483. §485.68(a), §485.	5(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 620(a), 486.360(a),					
LABORATOR	I RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	I IGNATURI	I	TITLE		(X6) DATE

(X6) DATE

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		ľ	JILDING	NSTRUCTION	COMPL 08/29/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION DATE	
	Federal, State and preparedness required must develop estate comprehensive errorgram that mees section. The emer program must include the following elem (a) Emergency Pladevelop and main preparedness plar and updated at least must do all of the "For hospitals at §485.625(a):] Emergency Plane (CAH] must comprehensive errorgram that mees section, utilizing a "For LTC Facilities Emergency Plane develop and main preparedness plar and updated at least "For ESRD Facilities Emergency Plane develop and main preparedness plar and updated at least "For ESRD Facilities Emergency Plane develop and main develop and develop	uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, ents: an. The [facility] must tain an emergency that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency that must be [evaluated], that must be [evaluated],						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MUL A. BUIL B. WINC	DING	NSTRUCTION	(X3) DATE COMPL 08/29/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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	
	Based on record reversal failed to develop and preparedness plant at least annually in 483.73(a). This defended occupants. Findings include: During record reviet the Maintenance Did the facility was unathat the emergency reviewed in the more based on interviewed the Administrator at locate or provide the time of the surversal forms.	view and interview, the facility and maintain an emergency that was reviewed and updated accordance with 42 CFR accient practice could affect all even with the Administrator and rector on 08/29/22 at 2:47 p.m. ble to provide documentation preparedness plan was set recent twelve months. at the time of record review, greed that she was unable to e requested documentation at	E 000		I. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice. No residents were affected be alleged deficient practice. II. How other reside having the potential to be affected by the same deficient practice be identified and what correct action(s) will be taken. All residents have the potential be affected by this alleged deficient practice. The IDT reviewed and updated the complete emergency program. III. What measures will be put into place and what systemic changes will be made ensure that the deficient practices not recur. The IDT was in serviced on the emergency management requirements. A complete residence of the emergency plan was a to the QAPI calendar every months. IV. How the corrections.	ed for ree ant opy this ents rected be will betive tial to the wiew added 12	09/21/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLE				
		155580	B. W	NG		08/29/	2022
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
E 0013 SS=C Bldg	403.748(b), 416.5441.184(b), 482.1484.102(b), 485.6485.727(b), 485.9491.12(b), 494.62 Development of E §403.748(b), §416.9441.184(b), §46.9483.73(b), §483.9485.68(b), §485.68(b), §485.	4(b), 418.113(b), 5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),			action(s) will be monitored to ensure the deficient practice wonot recur i.e., what quality assurance program will be put place. The admin or designee will revite QAPI calendar monthly an also check the date of the last update of the emergency preparedness plan to ensure it reviewed at least every 12 monormolection The results of these audits will reviewed in Quality Assurance Meeting monthly x12 months of until an average of 100% compliance is achieved x12 consecutive months. The QAC Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2020	t is onthe corrections of the co	

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(b) Policies and procedures. [Facilities] must

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155580	B. WING	_	08/29/2022
	PROVIDER OR SUPPLIER		2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	T	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	on the emergency (a) of this section, paragraph (a)(1) of communication pla section. The polic be reviewed and of years.	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2			
	and procedures. I develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication pla section. The polic be reviewed and u	s at §483.73(b):] Policies The LTC facility must ement emergency icies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually.			
	*[For PACE at §46 procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The polic address managen nonmedical emerglimited to: Fire; eq failure; care-related disasters likely to	60.84(b):] Policies and PACE organization must ement emergency icies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not juipment, power, or water and emergencies; and natural threaten the health or			

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The policies and procedures must be

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2022			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE			
	*[For ESRD Facilia and procedures. develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication placetion. The policible reviewed and uyears. These emenot limited to, fire, failures, care-relatively interruption likely to occur in the area. Based on record review and Preparedness Plan's at least annually in 483.73(a). This defoccupants. Findings include: Based on records reand Maintenance Dono documentation of Emergency Prepared Procedures were relast year. Based on review, the Adminited documentation to sl Procedures have bethe last year was no survey.	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are equipment or power ted emergencies, water in, and natural disasters in facility's geographic view and interview, the facility is update the Emergency is (EPP) Policies and Procedures accordance with 42 CFR icient practice could affect all eview with the Administrator irrector on 08/29/22 at 2:47 p.m., sould be found to show the edness Plan's (EPP) Policies and viewed and updated within the an interview during records	E 0013	E0013 DEVELOPMENT OF EPPOLICIES AND PROCEDURE I. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice. No residents were affected by alleged deficient practice. II. How other resident having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken. All residents have the potential be affected by this alleged deficient practice. The emergence preparedness policies and procedures were reviewed and	for this tts tted will //e tto ncy			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155580	B. WI	B. WING		08/29/2022		
		12000				00,20,		
NAME OF D	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
TWIND OF I	ADDA OR BUILDIN			2350 TA	AFT ST			
APERION	N CARE TOLLESTO	ON PARK		GARY,	IN 46404			
(VA) ID	CIBBARN	CTATEMENT OF DEPLOYENCE	1	ID.	Ī	(75)		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		irector during the exit			updated.			
	conference.							
					III. What measures wi	II		
					be put into place and what			
					systemic changes will be mad	e to		
					ensure that the deficient practi			
					does not recur.			
					4555 1151 15541.			
					The IDT was in serviced on the	_		
						C		
					emergency management	data		
					requirements. A review and up			
					of the emergency preparednes	SS		
					policies and procedures was			
					added to the QAPI calendar e	very		
					12 months.			
					I. How the correcti	ve		
					action(s) will be monitored to			
					ensure the deficient practice w	/ill		
					not recur i.e., what quality			
					assurance program will be put	into		
					place.			
					piaoe. 			
					The admin or designed will re-	riov.		
					The admin or designee will rev			
					the QAPI calendar monthly an			
					also check the date of the last			
					update of the emergency			
					preparedness plan to ensure i			
					reviewed at least every 12 mo	nths.		
					The results of these audits will	be		
					reviewed in Quality Assurance)		
					Meeting monthly x12 months			
					until an average of 100%			
					compliance is achieved x12			
					consecutive months. The QA			
					Committee will identify any tre	nus		
					or patterns and make			
					recommendations to revise the			
					plan of correction as indicated			

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

i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUP						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					COMPLETED 08/29/2022	
		155580	B. WIN	G		08/29/	2022	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Date of compliance: 09/21/202		(X5) COMPLETION DATE	
E 0029 SS=C Bldg	484.102(c), 485.62 485.727(c), 485.92 491.12(c), 494.62(Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §485.6 §485.68(c), §485.6 §494.62(c). (c) The [facility] mu an emergency pre plan that complies local laws and mus at least every 2 ye facilities]. Based on record rev failed to review and Preparedness Plan's least annually in acc 483.73(a). This defi occupants. Findings include: Based on records re and Maintenance Di no documentation of Emergency Prepare Communication Pla within the last year. records review, the documentation to she	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 485.68(c), 20(c), 486.360(c), (c) communication Plan 5.54(c), §418.113(c), 2.84(c), §482.15(c), 475(c), §484.102(c), 525(c), §485.727(c), 2.360(c), §491.12(c), 2.360(c), 2.	E 002	29	E0029 DEVELOPMENT OF COMMUNICATION PLAN I. What corrective action(will be accomplished for those residents found to have been affected by the deficient practic No residents were affected by this alleged deficie practice II. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The	(s) ce. nt	09/21/2022	

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404						
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF year was not availa This finding was re	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ble at the time of the survey. viewed with the Administrator irector during the exit	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) entire emergency plan was reviewed and updated by the into place and what systemic changes will be made to ensut that the deficient practice doe recur. The IDT was in service on the emergency prepared in requirements. A complete reviewed at the QAPI calendar every 1 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice on the recur i.e., what quality assurance program will be puplace. The admin or designee will refuse the QAPI calendar monthly at check the date of the last upon the emergency prepared in plan to ensure it is reviewed at least every 12 months. The refuse of these audits will be reviewed Quality Assurance Meeting monthly x12 months or until a average of 100% compliance achieved x12 consecutive months. The QA Committee identify any trends or patterns make recommendations to refuse the plan of correction as indictived to compliance: 09/21/20	DATE IDT. In put Iure In put Iure In put Iure In put Iure Iure				

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AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIER			2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	403.748(d), 416.5 441.184(d), 482.1 484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §483. §485.68(d), §485. §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625 485.727, CMHCs §486.360, and RH Training and testir develop and main preparedness train that is based on the in paragraph (a) of assessment at passection, policies at (b) of this section, plan at paragraph	ELSC IDENTIFYING INFORMATION 4(d), 418.113(d), 5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d) Festing 5.54(d), §418.113(d), 0.84(d), §482.15(d), 475(d), §484.102(d), 625(d), §485.727(d), 6.360(d), §491.12(d), 6.360(d), §491.12(d), 6.360(f), §491.12(f), 6.360(f),			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TTE .		
	*[For LTC facilities and testing. The land maintain an etraining and testin the emergency plate of this section, risl (a)(1) of this section	ated at least every 2 years. s at §483.73(d):] (d) Training LTC facility must develop mergency preparedness g program that is based on an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		A. BUILDING B. WING			COMPLETED 08/29/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
	section. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing prograemergency plans this section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i). *[For ESRD Facility Training, testing, a dialysis facility mule emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the communic of this section. The	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based replan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) the training, testing and m must be evaluated and						
	Based on record rev failed to review and Preparedness Plan's Plan at least annual	view and interview, the facility update the Emergency (EPP) Training and Testing ly in accordance with 42 CFR cient practice could affect all	E 003	6	E036 EP TRAINING AND TESTING/* The facility requests paper compliance for this citation. I. What corrective action(will be accomplished for those	. ,	09/21/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
		155580	B. WING		08/29/2022	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
AI LINOI		JIN I AIRIK	GAIXT,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	residents found to have been	DATE	
	and Maintenance D no documentation v show the Emergenc Training and Testin	eview with the Administrator pirector on 08/29/22 at 2:46 p.m., was available for review to by Preparedness Plan's (EPP) ag Plan was reviewed and		affected by the deficient practi No residents were affected by this alleged deficie practice II. How other residents ha	ent	
		last year. Based on an		the potential to be affected by		
	_	cords review, the Administrator		same deficient practice will be		
	_	ntation to show the EPP ng Plan has been reviewed or		identified and what corrective		
	_	last year was not available at		action(s) will be taken. All residents have the		
	the time of the surv			potential to be affected by this		
	the time of the surv	cy.		alleged deficient practice. The		
	This finding was re	viewed with the Administrator		entire emergency plan was		
	_	virector during the exit		reviewed and updated by the	TOI	
	conference.	nector during the exit		Teviewed and updated by the	ID1.	
	Controller			III. What measures will be into place and what systemic changes will be made to ensu that the deficient practice does recur. The IDT was in service on the emergency preparednes requirements. A complete revi of the emergency plan was act to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice who trecur i.e., what quality assurance program will be put place. The admin or designee will revi	re s not ed ess iew Ided 2	
				the QAPI calendar monthly an		

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update of the emergency

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED			ETED	
		155580	B. W	NG		08/29/	2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			2350 TA			
APERION	N CARE TOLLESTO	ON PARK			IN 46404		
WA ID	CLD O () DV	THE TENT OF DEFICIENCIE	1				(77.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
IAG	REGULATORT OR	LESC IDENTIF TING INFORMATION		IAG	preparedness plan to ensure i	· ie	DAIL
					reviewed at least every 12 mo		
					The results of these audits will		
					reviewed in Quality Assurance		
					Meeting monthly x12 months of		
					until an average of 100%		
					compliance is achieved x12		
					consecutive months. The QA		
					Committee will identify any tre	nds	
					or patterns and make		
					recommendations to revise the		
					plan of correction as indicated		
					Date of Compliance: 09/21/20	22	
14 0000							
K 0000							
Bldg. 01							
Diag. 01	A Life Safety Code	Recertification and State	K ₀	000			
	-	as conducted by the Indiana	110	000			
		th in accordance with 42 CFR					
	483.90(a).						
	Survey Date: 08/29	0/2022					
	Facility Number: 0	08505					
	Provider Number:	155580					
	AIM Number: 2000	064830					
	-	Code survey, Aperion Care					
		found not in compliance with					
	Requirements for Pa	•					
		, 42 CFR Subpart 483.90(a), re and the 2012 edition of the					
	•	etion Association (NFPA) 101,					
		SC), Chapter 19, Existing					
	•	ancies and 410 IAC 16.2.					
	This one-story facil	ity with a partial basement was					
	determined to be of	Type V (111) construction and					
I			1				i

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		l ′	LDING	INSTRUCTION 01	(X3) DATE COMPL 08/29/	ETED	
	PROVIDER OR SUPPLIES			2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	system with smoke spaces open to the smoke detectors are South wing residen	The facility has a fire alarm detection in the corridors, corridors. Battery powered a located in the North and at rooms; the PCU resident the with hard wired smoke					
	detectors.	ected by a 30-kW natural gas					
	generator and a 45-	kW diesel generator.					
	dually certified for	O certified beds. 152 beds are Medicare and Medicaid; 28 or Medicare only. At the time of sus was 133.					
	access were sprink	e residents have customary lered. A detached wood shed was unsprinklered.					
	Quality Review con	mpleted on 09/06/22					
K 0161 SS=E Bldg. 01	Building Construct 2012 EXISTING Building construct						
		ction Type (332), II (222) Any number non-sprinklered and					
	2 II (111) non-sprinklered	One story					
		Maximum 3 stories					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLETED		
		155580	B. W	NG		08/29/	/2022	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
			2350 T	AFT ST				
APERION CARE TOLLESTON PARK			GARY,	IN 46404				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	sprinklered							
	3 II (000)	Not allowed						
	3 II (000) non-sprinklered	Not allowed						
	4 III (211)	Maximum 2 stories						
	sprinklered	Maximam 2 didnes						
	5 IV (2HH)							
	6 V (111)							
	7 III (200)	Not allowed						
	non-sprinklered							
	8 V (000)	Maximum 1 story						
	sprinklered							
	1 '	s must be sprinklered						
		approved, supervised						
	9.7. (See 19.3.5)	in accordance with section						
		iption, in REMARKS, of the						
		number of stories, including						
		on which patients are						
		of smoke or fire barriers and						
	dates of approval	. Complete sketch or attach						
		the building as appropriate.						
		on and interview, the facility	K 0	161	K161 BUILDING		09/21/2022	
		he building construction type			CONSTRUCTION TYPE AND			
		deficient practice could affect			HEIGHT			
		s, staff and visitors within the			The facility requests paper			
	facility.				compliance for this citation.			
	Findings include:							
	I mumgs meruue.							
	Based on observation	ons on 08/29/22 during a tour			I. Immediate			
		52 p.m. with the Maintenance			actions taken for those reside	nts		
	Director, there was	an approximate six foot long			identified:			
		ection of drywall missing on						
		e exterior wall in the electrical			The Maintenance Director wil	I		
		rridor from Medical Records.			replace the six foot long by			
	This missing drywa	all exposed the wood ceiling			one-foot-wide section of drywa	all		

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joists and roof decking above. Based on interview at the time of observation, the Maintenance

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No resident or staff was found to

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	01	DATE SURVEY COMPLETED 08/29/2022
	PROVIDER OR SUPPLIES		2350	CADDRESS, CITY, STATE, ZIP COD TAFT ST C, IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION that the building construction	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) be affected by this alleged	(X5) COMPLETION DATE
	missing drywall on This finding was re	I due to the aforementioned the ceiling. Eviewed with the Administrator Director at the exit conference.		II. 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. III. Measures put into place/ System changes:	
				The Maintenance Director will make rounds weekly to ensure building structure is intact and document findings on the preventative maintenance log	
				actions will be monitored: The administer or designee will review the preventative maintenance log 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	I

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/29/2022	
	ROVIDER OR SUPPLIER		2350	TADDRESS, CITY, STATE, ZIP COD TAFT ST T, IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
				identify any trends or patterns make recommendations to rev the plan of correction as indica	rise
K 0211 SS=E Bldg. 01	in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.1 Based on observation facility failed to main from obstructions in facility. LSC 19.2.3 required width shall equipment, provided conditions are met: (a) The wheeled equipment conditions are met: (b) The wheeled equipment conditions are met: (c) The wheeled equipment conditions are met: (a) The wheeled equipment conditions are met:	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.	K 0211	K211 MEANS OF EGRESS The facility requests paper compliance for this citation. I. What corrective action will be accomplished for those residents found to have been affected by the deficient praction No residents were affected by this alleged deficient practicular compliance.	09/21/2022 (s) ce.
	training program ad wheeled equipment emergency. (c) The wheeled equ following: i. Equipment in use	dress the relocation of the during a fire or similar aipment is limited to the and carts in use cy equipment not in use		practice. II. How other residents hat the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 15 residents, staff and	ving the

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CENTERS FOR MEDICARE & MEDICAID SERVI	CES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		 JILDING	onstruction 01	(X3) DATE S COMPLI 08/29/2	ETED	
	PROVIDER OR SUPPLIER		2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
PREFIX	REGULATORY OF This deficient pract 15 residents, staff a Findings include: Based on observation Maintenance Direct the facility between following was noted a) there was a bed be corridor by resident observed in the corr location during an i to 10:35 a.m. b) a roll on type flo near resident room the floor scale was a storage, reducing the half feet. Based on an intervi- Director at the time that there was storag the above mentione This finding was re	consumate with the tor on 08/29/22 during a tour of a 12:45 p.m. and 2:45 p.m. the desired by room 327. The bed was also ridor by room 327 at this initial walk thru from 10:20 a.m. or scale was sitting the floor 231. Across the corridor from a multi shelf cart for linen the corridor width to four and a lew with the Maintenance of the observations, he agreed ge in the egress corridors in	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ent te of put re s not lete t to	COMPLETION
				audits will be reviewed in Qua Assurance Meeting monthly x months or until an average of compliance or greater is achie x3 consecutive months. The 0 Committee will identify any tre	lity 6 90% eved QA	

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	OF CORRECTION	IDENTIFICATION NUMBER 155580	A. BUILDING B. WING	01	COMPLETED 08/29/2022
	ROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record revinterview, the facilit alarm systems was a LSC 9.6.1.3. LSC 9 system to be installed accordance with NF Code and NFPA 72, NFPA 72, Section 1 defects and malfunce deficient practice con Findings include:	n - Testing and n is tested and maintained n an approved program requirements of NFPA 70, code, and NFPA 72, n and Signaling Code. n acceptance, maintenance adily available.	K 0345	or patterns and make recommendations to revise the plan of correction as indicated. Compliance: 09/21/2022 K345 FIRE ALARM SYSTEM The facility requests paper compliance for this citation. I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice.	(s) ce.

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CENTERS FOR MEDICARE & MEDICAID SERVICES 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 08/29/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Director on 08/29/22 from 10:35 a.m. to 12:45 p.m., the fire alarm report dated 02/21/2022 by the How other residents having facility's fire alarm vendor indicated the the potential to be affected by the annunciator located at the South Unit Nurse's same deficient practice will be station failed inspection and was 'falling off the identified and what corrective wall'. The fire alarm report dated 08/15/2022 stated action(s) will be taken. the annunciator panel failed injection and was All residents had the 'falling off the wall'. During a tour of the facility potential to be affected by this with the Maintenance Director on 08/29/22 from alleged deficient practice. The the 12:45 p.m. to 2:45 p.m., the fire alarm annunciator annunciator panel will be installed at the South Unit Nurse's station had black properly to the wall. electrical tape wrapped around the device. Based on interview at the time of record review, the What measures will be put Maintenance Director stated he had been on the into place and what systemic job for one week and was unable to show changes will be made to ensure documentation that repairs had been made. that the deficient practice does not recur. The maintenance director This finding was reviewed with the Administrator and Maintenance Director at the exit conference. will be inserviced on properly reviewing the fire inspection 3.1-19(b) reports and requesting repairs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The administrator or designee will review the fire inspection records quarterly or when available to ensure suggested repairs are completed timely and document the results on the fire system repair audit tool. The results of

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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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>			ETED	
		155580	B. W	B. WING		08/29/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C		2350 T	AFT ST		
APERIO	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ļ	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
					months. The QA Committee videntify any trends or patterns		
					make recommendations to rev		
					the plan of correction as indica		
					and plan of correction as indica	mou.	
					Date of compliance: 09/21/202	22	
K 0353	NFPA 101						
SS=F	Sprinkler System	- Maintenance and Testing					
Bldg. 01	Sprinkler System	- Maintenance and Testing					
	Automatic sprinkle	er and standpipe systems					
	are inspected, tes	ted, and maintained in					
	accordance with N	NFPA 25, Standard for the					
	1	g, and Maintaining of					
		Protection Systems.					
	1	n design, maintenance,					
		sting are maintained in a					
		nd readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMAF	RKS information on					
		non-required or partial					
	automatic sprinkle	er system.					
	9.7.5, 9.7.7, 9.7.8,						
		ation and interview, the facility	K 0	353	K353 SPRINKLER SYSTEM-		09/21/2022
		f 1 sprinkler systems was			MAINTENANCE AND TESTIN	G	
	_	are sprinklers, a spare sprinkler			The facility requests paper		
		kler wrench on the premises.			compliance for this citation.		
		for the Inspection, Testing,					
		f Water-Based Fire Protection					
	1 -	ion, Section 5.4.1.4 states a nklers (never fewer than six)			\\/\bot corrective setime	(a)	
		on the premises so that any			I. What corrective action will be accomplished for those	. ,	
		Premiero de mar any	1		I so accomplication to those		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155580	B. W	ING		08/29/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		2350 T			
ΔPERIO!	N CARE TOLLESTO	ON PARK			IN 46404		
AI LINIO	ALLITON CARE TOLLEGION FARR			OAITI,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	been operated or damaged in			residents found to have been		
		mptly replaced. The sprinklers			affected by the deficient practi		
	_	the types and temperature			All residents and staf		
		clers on the property. The			had the potential to be affecte	-	
	_	kept in a cabinet located where			this alleged deficient practice.		
	-	which they are subjected will at			l		
		degrees Fahrenheit. A special			II. How other residents ha	-	
		all be provided and kept in the			the potential to be affected by		
		n the removal and installation			same deficient practice will be)	
	_	deficient practice could affect			identified and what corrective		
	all residents and sta	III in the facility.			action(s) will be taken.	J	
	F' 1' ' 1 1				All residents, staff, and		
	Findings include:				visitors have the potential to b		
	Događ on obsamjetic	ons during a tour of the facility			affected by this alleged deficie	HIL	
		ce Director on 08/29/22 at 1:34			practice. An inspection of the sprinklers and the sprinkler		
		o spare sprinkler cabinets at the			cabinet was completed. An		
	_	echanical room across the			additional sprinkler cabinet wa	ne .	
		rirector of Nursing office. There			ordered to ensure compliance		
		prinklers either laying loose on			10 sprinkler were stored prope		
		or inside the cabinets not in			in the protective slots.	Sily	
	_	litionally, there were no spare			The Maintenance		
	_	in the cabinets. During a tour			Director completed a dry and	wet	
		ce Director, sidewall sprinklers			sprinkler system gauge inspec		
		alled in the facility. Based on			III. What measures will be		
	interview at the tim	e of the observations, the			into place and what systemic	•	
	Maintenance Direct	tor stated he had been on the			changes will be made to ensu	re	
	job one week, and v	was unaware that the spare			that the deficient practice does	s not	
	sprinklers were not	properly stored and there were			recur.		
	not any spare sidew	all sprinkler heads.			The sprinkler system		
					maintenance and testing sche	dule	
		review and interview, the			was added to the preventive		
	I	cument sprinkler system			maintenance log.		
		rdance with NFPA 25. NFPA					
		e Inspection, Testing, and			IV. How the corrective		
		ter-Based Fire Protection			action(s) will be monitored to		
	I -	ion, Section 5.2.4.1 states			ensure the deficient practice v	vill	
		sprinkler systems shall be			not recur i.e., what quality		
		to ensure that they are in good			assurance program will be put	t into	
	condition and that r	normal water supply pressure			place.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		A. BUI	A. BUILDING <u>01</u> B. WING		COMPLETED 08/29/2022			
	F PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	on dry pipe sprinkle weekly to ensure the pressures are being states valves and firshall be inspected, accordance with Characteria accordance with accordance and wisitors. Findings include: Based on review of inspection reports from the period with 108/29/2022 from 10 dry sprinkler system documentation for week period was now wet sprinkler system documentation for month period was a addition, monthly in all sprinkler system the most recent 12 for review. The sprinkler system the most record review the facilitatype sprinkler system of record reviews tated he had been could not locate any control accordance with the present the could not locate any states and the system of record reviews the had been could not locate any control accordance with the present the system of record reviews the had been could not locate any control accordance with the present the system of record reviews the had been could not locate any control accordance with the present the system of the pre	all be made available to the risdiction upon request. This build affect all residents, staff, The sprinkler system for the most recent twelve the Maintenance Director 0:35 a.m. to 12:45 p.m., weekly in gauge inspection 48 weeks of the most recent 52 but available for review. Monthly			The administrator or designee will audit the maintenance log monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The C Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated Date of compliance:09/21/2025	ved QA nds		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			COMPLETED	
		155580	B. WI	NG		08/29/	2022	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0355	weekly and monthly survey. These findings were Administrator and Mexit conference. 3.1-19(b)	extation for the aforementioned by periods at the time of the experience reviewed with the Maintenance Director at the						
K 0355 SS=D Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 of the electrical room was installed in acc Standard for Portab Edition. Section 6.1 extinguishers other shall be installed us means. (1) Securely extinguishers. (2) In extinguisher manufapproved for such precess. This deficient resident care area be electrical room. Findings include:	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers.	K 03	355	K355 PORTABLE FIRE EXTINGUISHERS The facility requests paper compliance for this citation. I. What corrective action will be accomplished for those residents found to have been affected by the deficient practi The discharged fire extinguisher was discarded appropriately. No residents were affected by this alleged deficie practice. II. How other residents ha	ice.	09/21/2022	
	p.m., a discharged A	ABC portable fire extinguisher rical room by the Social			the potential to be affected by same deficient practice will be	the		

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
	SUMMARY (EACH DEFICIEN REGULATORY OF Services Office was interview at the tim Maintenance Direct sitting on the floor This finding was re	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION S sitting on the floor. Based on the of observation, the tor agreed the extinguisher was	2350 T	AFT ST IN 46404 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) identified and what corrective action(s) will be taken. Staff had the potential be affected by this alleged deficient practice. The dischar fire extinguisher was discarde appropriately. The ABC portal fire extinguishers were all inspected. III. What measures will be into place and what systemic changes will be made to ensu that the deficient practice does recur. The maintenance direct will audit the portable fire extinguishers weekly to ensure they are inspected at least monthly and record the results audit on the preventive maintenance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality	to rged d ble put re s not ctor e	(X5) COMPLETION DATE
				assurance program will be put place. The administrator or designee will review the maintenance log monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie	e e r	

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x3 consecutive months. The QA Committee will identify any trends

or patterns and make

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/29/2022					
	ROVIDER OR SUPPLIER		2350 T	STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE				
				recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/202					
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke baselid bonded wood construction that r Nonrated protectivare permitted. Doof fixed fire window as are self-closing or require latching, as in the direction of provides a minimular for swinging or ho 19.3.7.6, 19.3.7.8, Based on observation failed to ensure 1 of would restrict the management of the movement of second the movement of second affect at least visitors. Findings include: Based on observation	re plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing egress travel. Door opening of clear width of 32 inches rizontal doors. 19.3.7.9 In and interview, the facility of 6 sets of smoke barrier doors averent of smoke for at least ection 19.3.7.8 requires that diers shall comply with LSC, a Section 8.5.4.1 requires doors close the opening leaving blearance necessary for proper defined as 1/8 inch to restrict moke. This deficient practice 10 residents, staff and	K 0374	K374 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER The facility requests paper compliance for this citation. I. What corrective action will be accomplished for those residents found to have been affected by the deficient practic No residents were affected by this deficient practic	(s) (s) ce. ce.				
		or on 08/29/22 during a tour		II How other residents ha	vina				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	·			PLETED	
		155580	B. W	ING		08/29/2	2022	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			AFT ST			
APFRIO	N CARE TOLLEST	ON PARK			IN 46404			
	ı		_					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		:45 p.m. to 2:45 p.m., the smoke			the potential to be affected by			
		Lobby area leading to the			same deficient practice will be	;		
		fully close and latch when			identified and what corrective			
	_	arate attempts leaving a			action(s) will be taken.			
		closed at the fullest. Based on			At least 10 residen			
		time of observation, the			staff and visitors had the pote	ntial		
		tor agreed that the doors failed			to be affected by this alleged			
		g that the astragal was			deficient practice. All barrier			
		ong side of the door which			doors were inspected to ensur			
	stopped the doors f	rom latening.			proper closure. The barrier do			
	Th: - C. 1:				listed on the 2567 was the onl	- 1		
	This finding was reviewed with the Administrator and Maintenance Director at the exit conference.				doors not to close properly an			
	and Maintenance D	orrector at the exit conference.			were adjusted. The astragal w	as		
	2 1 10(b)				installed properly.			
	3.1-19(b)				III. What measures will be	nut		
					III. What measures will be into place and what systemic	put		
					changes will be made to ensu	ro		
					that the deficient practice does			
					recur.	5 1101		
					All barrier doors will be	<u> </u>		
					inspected monthly to ensure	^		
					proper closure. The results of	the		
					inspection will be documented			
					the preventative maintenance			
						. J. J.		
					IV. How the corrective			
					action(s) will be monitored to			
					ensure the deficient practice v	vill		
					not recur i.e., what quality			
					assurance program will be put	t into		
					place.			
					The administrator will			
					audit the maintenance log mo	nthly		
					to ensure doors are inspected	-		
					functioning properly.			
					The results of these audits wil	l be		
					reviewed in Quality Assurance	•		
					Meeting monthly x6 months of	r		
					until an average of 90%			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/29/2022				
NAME OF	PROVIDER OR SUPPLIEF	.		ADDRESS, CITY, STATE, ZIP COD				
APERIO	N CARE TOLLEST	ON PARK	2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				compliance or greater is achie x3 consecutive months. The committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated	QA ends			
				Date of compliance: 09/21/20	22			
K 0531 SS=D Bldg. 01	Elevators are insp specified in ASME Elevators and Esc Service is operate record. Existing elevators A17.3, Safety Cod and Escalators. A a travel distance obelow the level the emergency perso purposes, conform Requirements of a (Includes firefighter recall and smoke firefighter's service key operation, madetectors, and eledetectors.) 19.5.3, 9.4.2, 9.4. Based on record rev	view and interview, the facility	K 0531	K531 ELEVATORS	09/21/2022			
	failed to maintain to firefighter recall in	esting of 1 of 1 staff elevator accordance with 9.4.6, Elevator	K 0331		09/21/2022			
	_	5.2 states that all elevators with ency operations in accordance		The facility requests paper compliance for this citation.				

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039				
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 08/29/2022		
	PROVIDER OR SUPPLIEF		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST , IN 46404			
(X4) ID PREFIX TAG	with 9.4.3 shall be a with a written record kept on the premise A17.1/CSA B44, S Escalators. This destaff that use the electric based on record revious based on the elevation of the elevation based on the elevation based on interview at the Maintenance Direction on the elevation based	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Subject to a monthly operation and of the findings made and as as required by ASME afety Code for Elevators and ficient practice would affect evator. View with the Maintenance 12 at 12:30 p.m., the monthly attor firefighter recall for the missing 11 of the last 12 attion dated 06/09/2022 of recall testing was performed ervice of the elevator. Based time of record review, the tor stated he had been on the and could not located the sets at the time of the survey. Viewed with the Administrator are Director at the exit	ID PREFIX TAG	I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. II. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. All residents and state had the potential to be affected this alleged deficient practice. II. All residents and state had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. All residents and state had the potential to be affected this alleged deficient practice. Firefighter Recall Testing is completed monthly and documented on the OTIS Log Monthly Elevator testing. The Maintenance Director was in-serviced on how to perform recall testing on 9/13/22 by Other testing on 9/13/22 by Other testing. I. What measures will be made ensure that the deficient practices on the made on the original practices and what systemic changes will be made ensure that the deficient practices not recur.	n(s) e cice. by aving the e aff ed by . The I of e the the the the the the the the the t		
				in-serviced on how to perform recall testing on 9/13/22 by O The Maintenance Director will complete recall testing month	TIS. I		

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and document on the log. How the corrective

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		A. BU	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/29/2022			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE	
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the n is capability for the life branches. Maintenance generator and transfer ormed in accordance with e inspected weekly, nad 30 minutes 12 times a intervals, and exercised onths for 4 continuous hours.			action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality assurance program will be purplace. The administrator or designed audit the monthly elevator test log monthly to ensure complia. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months ountil an average of 90% compliance or greater is achiex 3 consecutive months. The Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/203	t into e will ting ance. Il be e r eved QA ends		

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Scheduled test under load conditions include

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01 COMPI			ETED
		155580	B. W	ING		08/29/	/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED ON AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	a complete simulated cold start and						
	automatic or man	ual transfer of all EES					
	loads, and are cor	nducted by competent					
	personnel. Mainte	nance and testing of stored					
		rces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		e inspected annually, and a					
		dically exercising the					
	· ·	tablished according to					
	•	uirements. 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.						
		ssibility of damage of the					
		source is a design					
	consideration for r	<u> </u>					
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	,					
		review and interview, the	K 0	918	K918 ELECTRICAL		09/21/2022
		ercise the generator for 12 of 12	110	<i>)</i> 10	SYSTEMS-ESSENTIAL		09/21/2022
	1	requirements of NFPA 110,			ELECTRIC SYSTEM		
		tandard for Emergency and					
	Standby Powers Sy	stems, Chapter 8.4.2. Section					
	8.4.2 states diesel g	enerator sets in service shall			The facility requests paper		
	be exercised at leas	t once monthly, for a minimum			compliance for this citation.		
	· ·	g one of the following					
	methods:						
		intains the minimum exhaust			I. What corrective action	. ,	
		recommended by the			will be accomplished for those)	
	manufacturer				residents found to have been		
		temperature conditions and at			affected by the deficient practi	ice.	
	1	cent of the EPS (Emergency			No residents were	4	
	Power Supply) nam	-			affected by this alleged deficie	ent	
	Section 8.4.2.3 states diesel-powered EPS				practice		
		not meet the requirements of			II How other residents be	wing	
		ised monthly with the available Power Supply System) load and			II. How other residents ha	-	
	, ,	nnually with supplemental			the potential to be affected by		
		n 50 percent of the EPS			same deficient practice will be identified and what corrective	;	
	l rouge at not ross tha	ii so percent or the Li b	1		I morning and what confective		I

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EPARTMENT OF HEALTH AND HUN	FORM APPROVED					
ENTERS FOR MEDICARE & MEDICA	NTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING <u>01</u>	COMPLETED		
	155580	B. WING		08/29/2022		
			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER			2350 TAFT ST			
APERION CARE TOLLESTO	ON PARK		GARY, IN 46404			

			GARY, IN 46404			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
	nameplate kW rating for 30 continuous minutes		action(s) will be taken.			
	and at not less than 75 percent of the EPS		All residents have the			
	nameplate kW rating for 1 continuous hour for a		potential to be affected by this			
	total test duration of not less than 1.5 continuous		alleged deficient practice.			
	hours. This deficient practice could affect all		Generators were inspected and			
	occupants.		passed inspection.			
	Findings include:		III. What measures will be put			
			into place and what systemic			
	Based on review of generator load testing		changes will be made to ensure			
	documentation with the Maintenance Director		that the deficient practice does not			
	from 10:35 a.m. to 12:45 p.m. on 08/29/22, the load		recur.			
	information to show the actual load percentage for		The maintenance director			
	the diesel powered generator was documented as		was in serviced on inspecting			
	"ok". Based on interview at the time of record		generators weekly. The			
	review, the Maintenance Director stated he had		maintenance director will			
	been on the job for one week and agreed the		document the required generator			
	monthly generator load documentation did not		inspections on the generator log			
	show the actual load percentage.					
			IV. How the corrective			
	2. Based on record review and interview, the		action(s) will be monitored to			
	facility failed to ensure a written record of weekly		ensure the deficient practice will			
	inspections for the generator was maintained for 4		not recur i.e., what quality			
	of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite		assurance program will be put into			
	generators shall be maintained in accordance with		place.			
	NFPA 110, Standard for Emergency and Standby		The administrator or designee will			
	Power Systems. NFPA 110, 8.4.1 requires an		audit the generator log weekly to			
	Emergency Power Supply System (EPSS)		ensure compliance			
	including all appurtenant components, shall be		The results of these audits will be			
	inspected weekly and exercised monthly. NFPA		reviewed in Quality Assurance			
	99, 6.4.4.2 requires a written record of inspection,		Meeting monthly x6 months or			
	performance, exercising period, and repairs for the		until an average of 90%			
	generator to be regularly maintained and available		compliance or greater is achieved			
	for inspection by the authority having		x3 consecutive months. The QA			
	jurisdiction. This deficient practice could affect all		Committee will identify any trends			
	residents, staff and visitors.		or patterns and make			
			recommendations to revise the			
	Findings include:		plan of correction as indicated.			
	Based on record review with the Maintenance					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING			(X3) DATE SURVEY COMPLETED 08/29/2022		
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK			STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	the last documented was dated 08/02/20 generator and the N on an interview at the Maintenance Direct job for one week an inspection document review at the time of these findings were	•			Date of compliance: 09/21/20	22	

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