| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155580 | A. BUILDING -- B. WING | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE TOLLESTON PARK | 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 PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 10/03/2024<br><br>Facility Number: 008505<br>Provider Number: 155580<br>AIM Number: 200064830<br><br>At this Emergency Preparedness survey, Aperion Care Tolleston Park, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 180 certified beds. 152 beds are dually certified for Medicare and Medicaid; 28 beds are certified for Medicare only. At the time of the survey, the census was 131.<br><br>Quality Review completed on 10/07/24 | E 0000 | | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 10/03/2024<br><br>Facility Number: 008505<br>Provider Number: 155580<br>AIM Number: 200064830 | K 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Frank Bensema | Administrator | 10/21/2024 |

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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| | At this Life Safety Code survey, Aperion Care Tolleston Park was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one-story facility with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors. Battery powered smoke detectors are located in the North and South wing resident rooms; the PCU resident rooms are equipped with hard wired smoke detectors.<br><br>The facility is protected by a 30-kW natural gas generator and a 50 kW diesel generator.<br><br>The facility has 180 certified beds. 152 beds are dually certified for Medicare and Medicaid; 28 beds are certified for Medicare only. At the time of the survey, the census was 131.<br><br>All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered.<br><br>Quality Review completed on 10/07/24 | | | |
| K 0222<br>SS=E<br>Bldg. 01 | NFPA 101<br>Egress Doors<br><br>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 exit gates on the lockdown unit were readily accessible for residents without a clinical | K 0222 | I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; | 10/18/2024 |

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| | diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. LSC 7.2.1.5.3 requires if provided, locks shall not require of a key, a tool, or special knowledge or effort for operation from the egress side This deficient practice could affect over 15 residents on hall-3.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director and Maintenance Assistant #1 on 10/03/24 between 1:30 p.m. and 3:29 p.m., the marked emergency exit, leading from the lockdown unit's activity room, had a gate which was locked with a padlock. The Maintenance Director was asked which employees had keys to the padlock. The Maintenance Director then stated that the only employees to have a key are the Maintenance Director and Assistant Maintenance Director. When asked about key availability overnight when maintenance staff was not in the facility, he clarified that staff would not have a key. The staff within the unit was also asked for a key which could not be produced at the time of the survey. Based on interview at the time of observation, the Maintenance Director acknowledged that evacuation through the gate would be impeded due to the key for the padlock not being readily available.<br><br>The finding was reviewed with Maintenance Director, Maintenance Assistant #1 and Administrator during the exit conference.<br><br>3.1-19(b) | | The key for the indicated lock was provided to the nurses required key set. This is located at the nurse's station. This was also completed for the other exit gate.<br>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br>All staff and residents and staff in that area have the potential to be affected but none were.<br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>The maintenance director or designee will audit to ensure that the key is located on the required key ring and is clearly marked.<br>IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | |

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| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 7 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 30 residents and staff.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director and the Maintenance Assistant #1 on 10/03/24 between 1:30 p.m. and 3:24 p.m., in the north wing corridor, across from resident room 124, had one sprinkler head that contained a gap between the ceiling and escutcheon plate that measured approximately 1/4 inches. Based on interview at the time of observation, the Maintenance Assistant #1 acknowledged the gap near the sprinkler head and would try and fix the issue.<br><br>The finding was discussed with the Administrator, Maintenance Director and Maintenance Assistant #1 at exit conference.<br><br>3.1-19(b) | K 0353 | I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>No residents were identified. The one sprinkler head had a gap between the ceiling and the escutcheon plate.<br>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br>The gap between the ceiling and the escutcheon on the identified sprinkler head was corrected.<br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Maintenance will audit and report all deficiencies to the administrator and correct the deficiency immediately.<br>IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | 10/18/2024 |

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| K 0741<br>SS=E<br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br><br>Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas and 1 of 1 kitchen areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 15 residents and staff.<br><br>Findings include:<br><br>Based on observation during a tour of the facility with the Maintenance Director and Maintenance Assistant #1 on 10/03/24 between 1:30 p.m. and 3:29 p.m., in the courtyard resident smoking area there were over 50 cigarette butts disposed around the courtyard in the grass, on the cement and in the nearby mulch. Furthermore, containers for cigarette butts were located around the smoking area, however the containers were made of noncombustible material, but did not have self-closing covers. Also, the emergency exit area, outside of the kichen, had approximately 10 cigarette butts in the grass and sidewalk. Based on interview at the time of observation, the Maintenance Director acknowledged the improperly disposed cigarette butts and further stated that housekeeping does clean up the area usually every day.<br><br>This finding was reviewed with the Maintenance Director, Administrator and Maintenance Assistant #1 during the exit conference.<br><br>3.1-19(b) | K 0741 | I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>The identified cigarette buts were picked up and the required cigarette containers were put in place.<br>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:<br>All residents have the potential to be affected by this alleged deficient practice.<br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>The Facility will check daily the both identified areas to make sure that it is free of cigarette butts and that the cigarette containers are in place.<br>IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 months.<br>The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | 10/18/2024 |

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| K 0920 SS=D Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 4 staff.<br><br>Findings include:<br><br>Based on observation during a tour of the facility with the Maintenance Director and Maintenance Assistant #1 on 10/03/24 between 1:30 p.m. and 3:29 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by an extension cord. The extension cord was then plugged into a power bank. Based on interview at the time of observation, the Maintenance Director confirmed the extension cord and further stated that they would remove the extension cord.<br><br>The finding was discussed with the Maintenance Director, Maintenance Assistant #1 and Administrator at exit conference.<br><br>3.1-19(b) | K 0920 | I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>The identified extension cord was immediately removed.<br>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br>The facility was checked for any other occurrences. None found.<br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>Maintenance Director or designee will audit the facility for the deficient practice. Any finding will be corrected immediately.<br>IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 months.<br>The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | 10/18/2024 |
| K 0923 SS=E Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag | | | |

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| | 1. Based on observation and interview, the facility failed to ensure approximately 10 of 10 cylinders were segregated from full and empty cylinders and were marked to avoid confusion. NFPA 99, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect approximately 40 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director and Maintenance Assistant #1 on 10/03/24 between 1:30 p.m. and 3:29 p.m., the two oxygen storage areas within the facility contained approximately 10 oxygen cylinders and 6 liquid oxygen reservoirs that were not marked or separated as full and empty cylinders. Based on interview at the time of observation, the Maintenance Director acknowledge that the two oxygen storage/transfilling rooms did not have the aforementioned signage.<br><br>This finding was reviewed with the Administrator, Maintenance Director and Maintenance Assistant #1 at exit conference.<br><br>3.1-19(b)<br>2. Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 2 of 2 oxygen trans-filling rooms. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum | K 0923 | I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>The shelves identified in the deficient practice were removed from both 02 storage rooms.<br>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br>All resident have the potential to be affected this practice.<br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>No shelves will be put in these two 02 storage areas. Maintenance will audit weekly.<br>IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of | 10/18/2024 |

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| | distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect 40 residents and staff.<br><br>Findings include:<br><br>Based on observation during the tour of the facility with the Maintenance Director and Maintenance Assistant #1 on 10/03/24 between 1:30 p.m. and 3:29 p.m., the two oxygen storage/transfilling rooms contained wooden shelves that were all approximately less than four feet from the transfilling area. Based on interview at the time of observation, the Maintenance Director confirmed that the shelves were not over five feet away and would most likely take them down due to the aforementioned issue.<br><br>The finding was discussed with the Maintenance Director, Administrator and Maintenance Assistant #1 at exit conference.<br><br>3.1-19(b) | | | |