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	02/08/2024

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427929 and IN00427936. Complaint IN00427929 - Federal/state deficiencies related to the allegations are cited at F609. Complaint IN00427936 - Federal/state deficiencies related to the allegations are cited at F609. Survey date: February 8, 2024 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 135 Total: 135 Census Payor Type: Medicare: 9 Medicaid: 121 Other: 5 Total: 135 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/13/24.	F 0000		
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Frank Bensema	Administrator	02/24/2024

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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	violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported to the Indiana Department of Health (IDOH) immediately or within the 2 hour time period for 1 of 6 residents reviewed for abuse. (Resident B) The facility also failed to ensure the allegation submitted was not misleading with the facts reported, related to the dates of the allegation, names of residents possibly involved, description of the area at the time of the allegation, and the description of the allegation. (Residents B & C) Finding includes:	F 0609	**Tag number: F609** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident B assessed by charge nurse, physician notified, family notified. Resident B also placed on psychosocial follow up for 72 hours after event occurred**	02/21/2024

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	During a family interview on 2/8/24 at 8:20 a.m., they indicated they came to visit on 2/6/24, and they thought Resident B was being abused by his roommate. They had been told by another resident at the facility, the roommate was burning him with a cigarette or a lighter. They also indicated the resident had bruises on both arms. During an interview on 2/8/24 at 10:46 a.m., Employee 3 indicated on 2/6/24 at approximately 4 p.m., she was in another room and saw the family member talking to another resident, and overheard her say, "thank you for telling me". The family member informed Employee 3 she had been told Resident B had been burned by his roommate. Employee 3 indicated she reported this statement to the Administrator on 2/6/24. During the same interview, Employee 2 indicated the family member had voiced concerns to her about the resident not dressed in long sleeves, and not being shaven. They also had concerns about the area on his face. She indicated the family member made the allegation they had been told by two staff members the resident had been burned by his roommate. She indicated she had reported the allegation to the Administrator immediately. Resident B's record was reviewed on 2/8/24 at 11:33 a.m. The diagnoses included, but were not limited to, cerebral palsy. A Quarterly Minimum Data Set assessment, dated 12/22/23, indicated short and long term memory problems, no behaviors, and was dependent for toileting, bathing, dressing hygiene and wheelchair mobility. He required maximum assistance for bed mobility and transfers.		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; **All residents have the potential to be affected by the alleged deficient practice**. · III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator conducted whole facility In-service regarding abuse/neglect reporting and the importance of the prompt calling of the administrator for any alleged, suspected or confirmed abuse.** 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; **Social Services or designee will interview 10 residents weekly for 4 weeks and then 5 residents weekly ongoing.. Admin or designee will review grievances 5 days a week x 4**	

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	A Nurse's Progress Note, dated 1/23/24 at 12:17 p.m., indicated an area to the left cheek and left lower ear lobe was found by the Aide. The area on the cheek was identified as a possible ruptured blister. The Physician and the Responsible Party were notified. Orders were received for treatment to the areas for seven days. A Physician's Progress Note, dated 1/26/24, indicated the areas to the left side of the face presented as a hypopigmented macular rash. The treatment for bacitracin (antibiotic ointment) was to be continued. A Concern/Compliment Form, dated 2/6/24, and completed by Employee 2, indicated a family member informed her they had been told Resident B's roommate had burned the resident's face. During an observation on 2/8/24 at 9:35 a.m., Resident B was in his room in his wheelchair. He was shaven and had on a long sleeve shirt. Employee 1 indicated the left cheek was the area where the ruptured blister and rash was found. The area was now healed. She indicated the area had not looked like a burn and at the time, the resident had facial hair, and the facial hair had not been singed. There was a small area on the left ear also, which was healed. During an interview, on 2/8/24 at 10:34 a.m., the Administrator indicated he had just been informed of the allegation once he received the Emergency Room papers from the Hospital. He indicated the allegation was reported late. He had not reported the incident earlier, due to no one had heard the other resident tell the family member about the roommate burning the resident. He was unaware he had to report all allegations if abuse had not		**weeks and then 3x a week for 4weeks and then weekly ongoing.** **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.** **Compliance date 2/21/2024**	

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	been determined. The allegation had been investigate,d and the investigation was still in progress, but it was not reported. An undated and typed statement by the Administrator, received as part of the investigation in progress, indicated the incident was still under investigation. The Administrator heard about the family's concerns, saw the resident, and there were no burn marks on the resident's face, so the accusation was deemed false. An IDOH incident report, received on 2/8/24 after the Administrator was questioned about the incident, indicated the incident date was on 2/7/24 at 1:01 p.m. The residents involved section indicated Resident B. There was no mention of the resident's roommate, Resident C in the report. The incident was reported on 2/8/24, and indicated Resident B's family had made an allegation that the resident had a cigarette burn on his face. The type of injury section indicated there were no areas on the skin on 2/8/24. There was no description of the areas at the time of the allegation or when the areas were found. The immediate action taken section indicated, on 2/8/24, the family and Physician were notified and the investigation was initiated on 2/8/24. The facility's abuse policy, dated 10/28/22, indicated, when an allegation of abuse was received, the Resident's Representative and the Department of Public Health were to be informed, the occurrence of potential abuse was reported, and was being investigated. Any allegation of abuse was to be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse.			

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	This citation relates to Complaints IN00427929 and IN00427936. 3.1-28(c)			