

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00156149 and IN00157215.</p> <p>Complaint IN00156149-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00157215-Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F425.</p> <p>Survey dates: October 1 and 2, 2014</p> <p>Facility number: 0008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Yolanda Love, RN-TC</p> <p>Census bed type: SNF: 7 SNF/NF: 108 Total: 115</p> <p>Census payor type: Medicare: 14 Medicaid: 96 Other: 5 Total: 115</p> <p>Sample: 8</p>	F000000		
---------	---	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2014	
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000282 SS=D	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 6, 2014, by Janelyn Kulik, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to ensuring pharmaceuticals were available for 1 of 3 residents reviewed for pharmacy related services. (Resident #F)</p> <p>Findings include:</p> <p>The record for Resident #F was reviewed on 10/1/2014 at 1:30 p.m. The resident's diagnoses included, but were not limited to, malignant neoplasm of the brain and spinal cord, anxiety, depression, and palliative care.</p> <p>The plan of care dated 4/16/14, indicated</p>	F000282	<p>F282</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for</p>	10/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2014	
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the resident had pain related to brain metastases. The interventions included, but were not limited to, administer medications as ordered.</p> <p>Review of the Physician's orders dated 7/10/14, indicated Percocet (a pain medication) 7.5-325 milligrams (mg), give one tablet by mouth every 6 hours. Continued review also indicated an order dated 6/19/14 for ABHR gel (an anti-nausea medication), apply 1 cc (cubic centimeters) topically in the morning.</p> <p>Review of the Medication Administration Record (MAR) dated September 2014, indicated the Percocet medication was not available for administration on 9/26/14 at 1800 (6:00 p.m.), 9/27/14 at 0000 (12:00 a.m.), and 9/27/14 at 0600 (6:00 a.m.), resulting in missed doses. Continued review also indicated the ABHR gel was not available for administration on 9/6/14 at 0800 (8:00 a.m.), 9/7/14 at 0800, 9/20/14 at 0800, 9/21/14 at 0800, and 9/22/14 at 0800, resulting in missed doses.</p> <p>Interview with the Unit Manager on 10/1/14 at 3:07 p.m., indicated it was her expectation for the nursing staff to reorder medications two to three days prior to the medication running out.</p>		<p>those residents identified:</p> <p>Resident #F medication audit complete and all medications ordered available.</p> <p>2) How the facility identified other residents:</p> <p>All residents' medications as ordered were audited for availability.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses will be in-serviced regarding re-ordering of medications per doctor orders.</p> <p>Audit will be conducted on 5 resident's a week for medication availability.</p> <p>The Director of Nursing or designee is responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 10/18/14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2014
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000425 SS=D	<p>Interview with the DON on 10/2/14 at 11:10 a.m., indicated nursing staff should reorder medications in accordance to the facility's policy.</p> <p>Review of the Refill Orders policy dated 5/2013, received by the DON on 10/2/14 at 10:30 a.m., indicated "Reorder all medications two days in advance of need."</p> <p>This Federal tag relates to Complaint IN00157215.</p> <p>3.1-25(a)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2014	
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure pharmaceuticals were available and administered as ordered for 1 of 3 residents reviewed for pharmacy related services. (Resident #F)</p> <p>Findings include:</p> <p>The record for Resident #F was reviewed on 10/1/2014 at 1:30 p.m. The resident's diagnoses included, but were not limited to, malignant neoplasm of the brain and spinal cord, anxiety, depression, and palliative care.</p> <p>Review of the Physician's orders dated 7/10/14, indicated Percocet (a pain medication) 7.5-325 milligrams (mg), give one tablet by mouth every 6 hours. Continued review also indicated an order dated 6/19/14 for ABHR gel (an anti-nausea medication), apply 1 cc (cubic centimeters) topically in the morning.</p> <p>Review of the Medication Administration Record (MAR) dated September 2014, indicated the Percocet medication was</p>	F000425	<p>F425</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #F medication audit complete and all medications ordered available.</p> <p>2) How the facility identified other residents:</p> <p>All residents' medications as ordered were audited for availability by pharmacy.</p> <p>3) Measures put into place/</p>	10/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2014	
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>not available for administration on 9/26/14 at 1800 (6:00 p.m.), 9/27/14 at 0000 (12:00 a.m.), and 9/27/14 at 0600 (6:00 a.m.), resulting in missed doses. Continued review also indicated the ABHR gel was not available for administration on 9/6/14 at 0800 (8:00 a.m.), 9/7/14 at 0800, 9/20/14 at 0800, 9/21/14 at 0800, and 9/22/14 at 0800, resulting in missed doses.</p> <p>Interview with the Unit Manager on 10/1/14 at 3:07 p.m., indicated it was her expectation for the nursing staff to reorder medications two to three days prior to the medication running out.</p> <p>Interview with the DON on 10/2/14 at 11:10 a.m., indicated nursing staff should reorder medications in accordance to the facility's policy.</p> <p>Review of the Refill Orders policy dated 5/2013, received by the DON on 10/2/14 at 10:30 a.m., indicated "Reorder all medications two days in advance of need."</p> <p>This Federal tag relates to Complaint IN00157215.</p> <p>3.1-25(a)</p>		<p>System changes:</p> <p>Licensed nurses will bein-serviced regarding re-ordering of medications per doctor orders.</p> <p>Audit will be conducted on 5resident's a week for medication availability.</p> <p>The Director of Nursing ordesignee is responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meetingmonthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date ofcompliance: 10/18/14</p>				

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2014
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	