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	04/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00373538, IN00373546, IN00373976, IN00374752 and IN00376174. Complaint IN00373538 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00373546 - Substantiated. Federal/State deficiencies related to the allegations are cited at F641, F656, F677, F684 and F760. Complaint IN00373976 - Unsubstantiated due to lack of evidence. Complaint IN00374752 - Unsubstantiated due to lack of evidence. Complaint IN00376174 - Substantiated. Federal/State deficiencies related to the allegations are cited at F585 and F758. Unrelated deficiency is cited. Survey dates: April 4, 5 and 6, 2022. Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 128 Total: 128 Census Payer Type: Medicare: 12 Medicaid: 111	F 0000		

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

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

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	Other: 5 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/8/22.			
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by			

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	Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. Based on record review and interview, the facility failed to provide funds for a resident as requested for 1 of 5 residents reviewed for resident rights. (Resident L) Finding includes: During an interview on 4/5/22 at 2:50 p.m., Resident L indicated she was not getting her money on time or as requested. It was due on the first of the month, but she had not received any of it yet. The resident's accounting record indicated she had received $25.00 on 3/4/22 and $22.00 on 3/28/22. She had not received any money from her account in April 2022. Interview with the Business Office Manager (BOM) on 4/6/22 at 8:55 a.m., indicated residents were allowed to take out up to $52.00 a day. The BOM kept cash on hand for the residents' requests. Sometimes the funds became depleted, but there was also petty cash available if that happened. She indicated the resident had requested money on 4/5/22. The cash on hand was depleted, and she had not given her money from the petty cash available.	F 0567	**Aperion- Tolleston Park** **POC Complaint Survey 2022** **Compliance 4/22/2022** **F 567 Protection/Management of Personal Funds** **The facility requests paper compliance for this citation.** *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.*	04/22/2022

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	A policy titled, "Resident Funds", dated 1/31/18, indicated, "...The residents may choose to have the facility hold, safeguard, and manage his/her personal funds..." The Administrator indicated during an interview on 4/6/22 at 11:34 a.m., there were no additional policies related to resident dispersal of funds. 3.1-6(c)		**1) Immediate actions taken for those residents identified:** Resident L was given personal funds on 4/6/22. **2) How the facility identified other residents:** The BOM completed an audit to identify a list of residents that have funds available in the facility. The facility will ensure there are sufficient resident funds upon request. **3) Measures put into place/ System changes:** The resident's trust fund amount was increased to ensure adequate funds are available. BOM has been in-serviced on Management of Personal Funds, including but not limited to providing funds to residents as requested. Cash box replenished weekly. **4) How the corrective actions will be monitored:** **The Administrator/Designee** will audit provision of funds for the residents requesting them weekly for 4 weeks to ensure sufficient funds are maintained for facility residents. Thereafter, these audits will be conducted on a monthly basis. Any identified concerns will be promptly addressed with the responsible individual(s).	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 04/22/2022**	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make			

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	information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal			

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	agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on record review and interview, the	F 0585	**Aperion- Tolleston Park**	04/22/2022

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	facility failed to investigate and complete grievances that were reported to staff for 1 of 3 residents reviewed for abuse. (Resident F) Finding includes: The record for Resident F was reviewed on 4/5/22 at 1:29 p.m. Diagnoses included, but were not limited to, hypertension, bipolar disorder, type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 1/21/22, indicated the resident was cognitively intact. A Concern/Compliment Form, dated 3/24/22, indicated the resident had reported he was missing various clothing items, a Bluetooth speaker, and $27 in cash. He had spoken with the previous Administrator about the missing items, and she was going to reimburse him $300 but he had not received the money prior to her leaving the facility. The corrective action taken indicated the grievance had already been resolved with the previous administrator and the resident was reminded. The grievance was considered resolved as of 3/30/22 per the grievance log. A Concern/Compliment Form, dated 10/28/21, indicated the resident had reported he was missing various clothing items and a Bluetooth speaker. There was no documentation of missing money. The corrective action taken indicated the facility would reimburse the resident for the missing items if the resident provided receipts. Interview with the Director of Nursing (DON) and the Administrator on 4/5/22 at 3:28 p.m., indicated the resident had never submitted any receipts for the missing items related to the		**POC Complaint Survey** **Compliance 04/22/2022** **F585 Grievances** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident F's missing money was replaced. **2) How the facility identified other residents:** Residents who have filed a grievance have the potential to be affected. An audit was completed	

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	grievance on 10/28/21. He then was discharged home. He was later readmitted to the facility and remembered the same missing items from the past. He was reminded that if he provided receipts, the facility would reimburse him. The missing money had only been mentioned in the grievance from 3/24/22. That part of the grievance had not been followed up on until today, 4/5/22, when they went to speak with the resident. A current facility policy titled, "Grievances", indicated, "...Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days..." This Federal tag relates to Complaint IN00376174. 3.1-7(a)(2)		on all grievances within the last 30 days to ensure adequate resolution. **3) Measures put into place/ System changes:** The IDT received in-service education relative to grievances, including but not limited to, ensuring adequate, timely resolution of grievances. Social Service Director/Designee will review grievances weekly to ensure adequate, timely resolution. Any identified concerns will promptly be addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** Administrator/designee will audit all grievances weekly for a period of 6 months to ensure that all grievances are adequately resolved. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% 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.**	

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F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to antibiotic medication use for 1 of 10 MDS assessments reviewed. (Resident G) Finding includes: Resident G's record was reviewed on 4/4/22 at 9:22 a.m. The resident was admitted to the facility on 1/25/22. Diagnoses included, but were not limited to, COVID-19 and Multiple Sclerosis. The Admission MDS assessment, dated 2/1/22, indicated the resident received no injections or antibiotics in the previous 7 days or since admission. The hospital Emergency Department (ED) Note, dated 1/25/22, indicated the resident had been discharged from the hospital the previous day diagnosed with COVID-19 and a urinary tract infection. Her port-a-cath (small device implanted beneath the skin for IV medication administration) was accessed for antibiotic use. A Physician's Order, dated 1/24/22, indicated to	F 0641	**5) Date of compliance: 04/22/2022** N/A	04/22/2022

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	administer ertapenem (antibiotic) 1 gram solution IV once every 24 hours for 7 days. A Physician's Order, dated 1/25/22, indicated to administer Daptomycin (antibiotic) 350 milligrams solution IV every 24 hours for 5 days. Interview with the MDS nurse on 4/4/22 at 3:10 p.m., indicated medications and diagnoses were gathered from the resident's clinical packet and Physician orders. The antibiotics had not been assessed on admission. This Federal tag relates to Complaint IN00373546. 3.1-31(i)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40			

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	but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to implement care plans related to new onset of behaviors and for antibiotic use for a urinary tract infection for 2 of 10 residents whose care plans were reviewed. (Residents B and G) Findings include: 1. Resident B's record was reviewed on 4/4/22 at 10:52 a.m. The resident was admitted to the facility on 12/2/21. Diagnoses included, but were not limited to, cerebral infarction and heart failure.	F 0656	**Aperion- Tolleston Park** **POC Complaint Survey** **Compliance 04/22/22** **F656 Develop/Implement Comprehensive Care Plan** The facility requests paper compliance for this citation. *This Plan of Correction is the*	04/22/2022

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	The Admission Minimum Data Set {MDS) assessment, dated 1/3/22, indicated the resident was cognitively intact. A Reportable event, dated 2/17/22, indicated the resident had been involved in an altercation with another resident. He accused the other resident of taking money from him and had threatened him with a butter knife. The police arrived at the facility and removed the butter knife. The resident was sent to the emergency room for evaluation, and was placed on 15 minutes checks upon return to the facility. The Reportable event indicated care plans would be reviewed and updated as needed. There was no updated care plan related to the incident or the behaviors. Interview with the Director of Nursing on 4/5/22 at 1:43 p.m., indicated a care plan should have been initiated for the resident's behaviors following the event, but was not. 2. Resident G's record was reviewed on 4/4/22 at 9:22 a.m. The resident was admitted to the facility on 1/25/22 from the hospital. Diagnoses included, but were not limited to, COVID-19 and Multiple Sclerosis. The hospital Emergency Department (ED) Note, dated 1/25/22, indicated the resident had been discharged from the hospital the previous day, diagnosed with COVID-19 and a urinary tract infection (UTI). Her port-a-cath (small device implanted beneath the skin for IV medication administration) was accessed for antibiotic use. A Physician's Order, dated 2/1/22, indicated to give Daptomycin (antibiotic), 500 milligrams IV		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. 2. Resident's B and G's care plans were updated. **2) How the facility identified other residents:** Residents with new onset of behaviors, or receiving an antibiotic have the potential to be affected, thus, this plan of correction applies to those residents. An audit was completed on all residents with behaviors and receiving antibiotic within the last 30 days. The care plans of identified residents were reviewed and revised, as necessary. **3) Measures put into place/ System changes:**	

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	every shift for 7 days. A Physician's Order, dated 2/1/22, indicated to give Ivanz (antibiotic, 1 gram intramuscularly every shift for 7 days. There was not a care plan initiated for a UTI or antibiotic use related to the UTI. Interview with the MDS Nurse on 4/4/22 at 3:10 p.m., indicated there should be a care plan for anyone with a UTI receiving antibiotics. This Federal tag relates to Complaint IN00373546. 3.1-35(a)		Education was provided to MDS, Social Services, and Infection Preventionist relative to Comprehensive Care Plans, including but not limited to, ensuring care plans are reviewed with revisions made, as needed, to meet the needs of patient centered care. **4) How the corrective actions will be monitored:** SSD/MDS/IP/Designee will review the care plans of 10 random residents per week for 1 month to ensure any newly identified behaviors, or newly ordered antibiotics, have been addressed. Thereafter, SSD/MDS/IP/Designee will review the care plans of 10 random residents per month for 2 months to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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	155580	A. BUILDING 00 B. WING	04/06/2022

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to a dependant resident related to assisting the resident out of bed for 1 of 3 residents reviewed for ADL care. (Resident K) Finding includes: On 4/5/22 at 2:50 p.m., Resident K was observed in bed on her right side facing the wall with her eyes open. At 3:30 p.m., the resident was on her right side and calling out "help me". Nursing staff was notified and replied "she always does that." On 4/6/22, the resident was observed in bed on her right side at 8:46 a.m., 9:16 a.m., 10:42 a.m., 11:48 a.m., 12:30 p.m. and 1:07 p.m. The resident nodded her head when asked if she wanted to get out of bed. The resident's record was reviewed on 4/5/22 at 3:02 p.m. Resident diagnoses included, but were not limited to, CVA with hemiplegia (paralysis on one side of body). The Quarterly Minimum Data Set (MDS) assessment, dated 1/19/22, indicated the resident	F 0677	**plan of correction as indicated.** **5) Date of compliance: 04/22/22** **Aperion- Tolleston Park** **POC Complaint Survey** **Compliance 04/22/22** **F 677 ADL Care Provided for Dependent Residents** **The facility requests paper compliance for this citation.** *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*	04/22/2022

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	had severe cognitive impairment and required extensive assistance of two staff for transfers, and extensive assistance of one for bed mobility. An ADL Care Plan, updated 2/1/22, indicated the resident needed assistance of staff for bed mobility and transfers. Approaches included using a mechanical lift for transfers. There were no care plans related to behaviors or resisting care. Interview with CNA 1 on 1:18 p.m., indicated she frequently cared for the resident. She got her up occasionally, two times a week, because she could be resistant to care. She had not offered to get her up today because she was giving other residents showers, but she would get her up now as requested. This Federal tag relates to Complaint IN00373546. 3.1-38(a)(3)		*federal and state law.* **1) Immediate actions taken for those residents identified:** Resident K was offered to get out of bed at the time of survey. Resident declined and behavior care planned. **2) How the facility identified other residents:** An audit was conducted to identify dependent residents needing assistance with bed mobility and transfers. This plan of correction applies to those residents identified. **3) Measures put into place/ System changes:** Nursing staff was in-serviced on ADL Care Provided for Dependent Residents, including but not limited to, ensuring assistance is provided to residents for bed mobility and transfers, as well as all other ADLs. **4) How the corrective actions will be monitored:** **The DON/Designee** will complete Dignity Rounds at least 5 times weekly at varied times for 4 weeks to ensure residents are provided with assistance in bed mobility and transfers. Any identified	

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			concerns will be promptly addressed with the responsible individual(s). Thereafter, DON/Designee will complete Dignity Rounds at least 5 times per month at varied times for 2 months. Any identified concerns will be promptly addressed with the responsible individual(s). **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 04/22/2022**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to initiate antibiotic treatment as	F 0684	**Aperion- Tolleston Park**	04/22/2022

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	ordered and did not monitor a resident's intravenous (IV) access site for 1 of 3 residents reviewed for IV medications. (Resident G) Findings include: Resident G's record was reviewed on 4/4/22 at 9:22 a.m. The resident was admitted to the facility on 1/25/22 from the hospital. Diagnoses included, but were not limited to, COVID-19 and Multiple Sclerosis. The hospital Emergency Department (ED) Note, dated 1/25/22, indicated the resident had been discharged from the hospital the previous day diagnosed with COVID-19 and a urinary tract infection. Her port-a-cath (small device implanted beneath the skin for IV medication administration) was accessed for antibiotic use. A Physician's Order, dated 1/24/22, indicated to administer ertapenem (antibiotic), 1 gram solution IV once every 24 hours for 7 days. A Physician's Order, dated 1/25/22, indicated to administer Daptomycin (antibiotic), 350 milligrams solution IV every 24 hours for 5 days. The Physician's orders from the hospital for the antibiotics had not been transferred to the resident's record when admitted to the facility. The initial Nursing Note, dated 1/25/22 at 11:45 p.m., indicated the resident had arrived at the facility, she had a catheter, a treatment on her coccyx, and was placed in isolation related to COVID-19. There was no assessment of the port-a-cath access site. The January and February 2022 Medication		**POC Complaint Survey** **Compliance 04/22/22** **F 684 Quality of Care** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident G has been discharged from the facility. Therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** An audit was conducted to identify any resident with antibiotic orders for the last 30 days. These residents have the potential to be	

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	Administration Records did not contain monitoring of IV access site. Nursing notes did not contain IV access site assessments. Interview with the Director of Nursing (DON) on 4/4/22 at 3:00 p.m., indicated there was a clarification of the orders that needed to be completed. It should have been clarified on admission, but was not. The order was not clarified with the Physician and antibiotics were not initiated until 2/2/22. There was no monitoring of the IV access site located. This Federal tag relates to Complaint IN00373546. 3.1-37(a)		affected. No concerns were identified. **3) Measures put into place/ System changes:** Licensed nurses were in-serviced on Quality of Care, including but not limited to, provision of treatment and care in accordance with professional standards of practice. Included in the education was timely initiation of ordered antibiotics, and other medications, and monitoring of IV access sites. The DON/Pharmacy/designee will review and audit all current medication orders, including availability of medications, to ensure timely administration without any omissions. Any identified concerns will be promptly addressed. DON/designee will audit new admission orders daily, on scheduled days of work, for 4 weeks, then weekly thereafter, to ensure medication orders are initiated timely, to ensure medication availability, and to ensure medications are administered as ordered. Any identified concerns will be addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** The results of the audit will be reviewed in the Quality Meeting monthly for 6 months or until	

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			100% compliance is achieved. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction, as indicated. **5) Date of compliance: 04/22/2022**	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive			

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	psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to administration of an anti-anxiety medication as ordered for 1 of 3 residents reviewed for unnecessary medications. (Resident F) Finding includes: The record for Resident F was reviewed on 4/5/22 at 1:29 p.m. Diagnoses included, but were not limited to, hypertension, bipolar disorder, type 2 diabetes mellitus. A Physician's Order, dated 2/22/22, indicated clonazepam (Klonopin, an anti-anxiety medication) 0.5 milligrams (mg) three times a day for anxiety.	F 0758	**Aperion- Tolleston Park** **POC Complaint Survey** **Compliance 04/22/22** **F 758 Free from Unnecessary Medication** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	04/22/2022

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	The Medication Administration Record (MAR), dated 4/2022, indicated the clonazepam medication had not been signed out as administered on the following dates and times: - 8:00 a.m. on 4/1/22, 4/4/22, and 4/5/22. The Medication Administration Record (MAR), dated 3/2022, indicated the clonazepam medication had not been signed out as administered on the following dates and times: - 8:00 a.m. on 3/2/22, 3/3/22, 3/4/22, 3/8/22, 3/11/22, 3/13/22, 3/14/22, 3/17/22, 3/19/22, 3/21/22, 3/22/22, 3/27/22, 3/28/22, and 3/31/22. - 2:00 p.m. on 3/11/22 and 3/26/22. - 10:00 p.m. on 3/12/22 Interview with the Director of Nursing (DON) on 4/6/22 at 11:42 a.m., indicated the clonazepam had not been signed out as given on the MAR. She had counted the medications and they matched up to being administered but just hadn't been signed off. This Federal tag relates to Complaint IN00376174. 3.1-48(a)(6)		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident F's medication was administered. A missing entry audit was completed on all residents to ensure appropriate medication was provided. **2) How the facility identified other residents:** The facility completed an audit to identify that resident MARs are accurate, and medications are being signed out when administered. All residents have the potential to be affected, therefore, this plan of correction applies to all current residents. **3) Measures put into place/ System changes:** Licensed nurses have received in-service education relative to Free from Unnecessary Psychotropic Meds/PRN Use, including but not limited to, ensuring residents are free from unnecessary medications being	

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			administered. DON/designee will audit MARs daily, on scheduled days of work, for 4 weeks, then weekly thereafter, to ensure that medications are administered in accordance with physician orders. Any identified concerns will be promptly addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** The results of the audits will be reviewed in the Quality Meeting monthly for 6 months or until 90% compliance is achieved. The QA committee will identify any trends or patterns and will make recommendations to revise the plan of correction, as indicated. **5) Date of compliance: 04/22/2022**	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure all scheduled doses of a medication were administered to a resident receiving intravenous (IV) antibiotic therapy for 1 of 3 residents reviewed for IV medications. (Resident H) Finding includes: Resident H's record was reviewed on 4/4/22 at	F 0760	**Aperion- Tolleston Park** **POC Complaint Survey** **Compliance 04/22/22** **F 760 Residents are Free of Significant Med Error** **The facility requests paper**	04/22/2022

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	2:18 p.m. The resident was admitted on 3/25/22. Diagnoses included, but were not limited to, osteomyelitis (bone infection) and cellulitis (soft tissue infection). A Physician's Order, dated 3/25/22, indicated to give Zosyn (antibiotic), 3.375 gram IV every 6 hours. The March and April 2022 Medication Administration Records lacked documentation the antibiotic was given on 3/26 at 6:00 a.m., 3/27 at 6:00 a.m., 3/28 at 12:00 a.m. and 6:00 a.m., 3/31 at 6 a.m., 4/4 at 6:00 a.m., and 4/5 at 6:00 a.m. Interview with the Director of Nursing on 4/5/22 at 10:57 a.m., indicated the medications had not been signed out as given for the above dates. This Federal tag relates to Complaint IN00373546. 3.1-48(c)(2)		**compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident H's IV antibiotic was administered. **2) How the facility identified other residents:** An audit was conducted to identify any resident with antibiotic orders for the last 30 days. These residents have the potential to be affected. No concerns were identified. **3) Measures put into place/ System changes:** Licensed nurses were in-serviced on Residents are Free of	

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			Significant Med Errors, including but not limited to, all scheduled doses of a medication are administered to residents according to physician orders. The DON/designee will audit MARs daily, on scheduled days of work, for 4 weeks, then weekly thereafter, to ensure that medication orders are carried out appropriately including ensuring all scheduled doses of a medication are administered according to physician orders. **4) How the corrective actions will be monitored:** The results of the audits will be reviewed in the Quality Meeting monthly for 6 months or until 100% compliance is achieved. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction, as indicated. **5) Date of compliance: 04/22/2022**	