

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
--	---	---	---

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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00197230. IN00197434, IN00198137, and IN00198212.</p> <p>Complaint IN00197230- Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Complaint IN00197434- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00198137- Substantiated. Federal/State deficiencies related to the allegation are cited at F323 and F514.</p> <p>Complaint IN00198212- Substantiated. Federal/State deficiency related to the allegation is cited at F514.</p> <p>Survey dates: April 25 & 26, 2016</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type: SNF: 6 SNF/NF: 95 Total: 101</p>	F 0000		

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 04/26/2016
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F 0323 SS=D Bldg. 00	<p>Census payor type: Medicare: 12 Medicaid: 81 Other: 8 Total: 101</p> <p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 4/27/16.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided related to residents left unattended on the secured dementia unit for 1 of 13 residents who resided on the unit. The facility also failed to ensure the proper</p>	F 0323	<p>F323 FREE OF ACCIDENTS/HAZARDS/SUPERVISION/DEVICES</p> <p>The facility requests paper</p>	05/09/2016
----------------------------	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2016
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>footwear was in place for 1 of 3 residents reviewed for falls in a sample of 11. (Residents #N and #F)</p> <p>Findings include:</p> <p>1. On 4/25/16 at 8:31 p.m., Resident #N was observed ambulating down the hall near the Dining Room on the secured Special Care unit. The resident was pulling a wooden Dining Room chair as she was ambulating down the hall towards the opposite end of the hall. No staff members or visitors were in the hallway or on the unit. CNA #1 entered thru the door of the Unit at 8:34 p.m. There were a total of 13 residents located on the unit.</p> <p>When interviewed on 4/25/16 at 8:34 p.m., CNA #1 indicated she had left the Unit to take a "quick break." The CNA indicated no other staff members were on the Unit when she left. The CNA indicated a staff member was to be on the unit at all times.</p> <p>When interviewed on 4/25/16 at 8:37 p.m., the Director of Nursing indicated staffing on the secured unit is usually 1 or 2 CNA's. The Director of Nursing indicated CNA #1 should not have left the unit with no other staff member being present.</p>		<p>compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · C.N.A. #1 was re-educated on secure unit supervision immediately. · Resident #F was provided non-skid footwear. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
--	---	---	---

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>2. On 4/26/16 at 8:10 a.m., Resident #F was observed seated in a chair in the Activity Dining Room. The resident had on light blue and white striped fuzzy socks. The resident did not have any slippers, shoes, or other footwear on. Staff were assisting the resident with his meal. There was a walker next the resident.</p> <p>On 4/26/16 at 8:44 a.m., the resident was observed ambulating from the Dining Room into the hall. Restorative Aide #1 was ambulating next to the resident. The resident had the same socks on and no footwear in place while ambulating down the hall toward the secured unit with the Restorative Aide.</p> <p>On 4/26/16 at 10:37 a.m., Resident #F was seated in a chair in the unit Dining Room. The resident had the same blue and white socks on with no shoes or other footwear in place. CNA #2 and Restorative Aide #2 assisted the resident up from the chair and the resident began to walk out of the room into the hallway with his walker. The staff did not change the resident's socks or place any other non-skid footwear on the resident's feet. The resident continued to walk in the hall with the Restorative Aide with no</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who reside in the secure unit have the potential to be affected the alleged deficient practice. Resident's at risk for falls have been reviewed to ensure fall interventions are in place. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> Nursing staff were re-educated regarding the use of interventions for residents at risk for falls and supervision in the secure unit by the DON/designee by 5/9/16. The Charge Nurse assigned to the secure unit will ensure that there is a staff member present at all times. 	

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 04/26/2016
--	---	--	---

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>non-skid footwear in place.</p> <p>The record for Resident #F was reviewed on 4/26/16 at 11:09 a.m. The resident's diagnoses included, but were not limited to, dementia, heart failure, atrial fibrillation (an irregular heart rhythm), and anxiety disorder.</p> <p>Review of the 3/15/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance of one staff member for dressing. The assessment further indicated the resident had two or more falls since admission/entry or reentry, or prior assessment.</p> <p>A Fall Risk Assessment was completed on 3/14/16. The assessment indicated the resident's score was (11). A score of (11) indicated the resident was at risk for falls.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 10/16/2015 indicated the resident was at risk for falls related to an unfamiliar environment. Care plan interventions included, but were not limited to,</p>		<p>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</p> <ul style="list-style-type: none"> · Observation audits of fall interventions will be conducted by the DON/designee on at least 10 residents per week on varied shifts x 14 days, then 5 residents per week on varied shifts thereafter. · Director of Nursing will be responsible for oversight of these audits. · The results of these audits will be reviewed in monthly QAPI meeting until 100% compliance is achieved x 3 consecutive months. 	

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 04/26/2016
--	---	--	---

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
F 0514 SS=E Bldg. 00	<p>non-skid footwear when up. This intervention was initiated on 11/16/2015.</p> <p>When interviewed on 4/26/16 at 10:55 a.m., MDS Nurse #1 indicated the resident's current Care Plan indicated the resident should wear non-skid footwear.</p> <p>This Federal tag relates to Complaints IN00197230 and IN00198137.</p> <p>3.1-45(a)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review, and</p>	F 0514	F514	05/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2016	
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>interview, the facility failed to ensure clinical records were complete related to medical treatment not signed out as completed for 5 of 5 residents reviewed for clinical record documentation in a sample of 11. (Residents #E, #G, #H, #J, and #K)</p> <p>Findings include:</p> <p>1. On 4/25/16 at 7:08 p.m., Resident #J was observed in bed. The head of the bed was elevated. The resident had a tracheostomy tube in place and was receiving oxygen via the tracheostomy tube. A suction machine and tracheostomy kits were observed on the bedside dresser.</p> <p>The record for Resident #J was reviewed on 4/26/16 at 1:00 p.m. The resident's diagnoses included, but were not limited to, tracheostomy, heart failure, and chronic obstructive pulmonary disease.</p> <p>The 4/2016 Treatment Administration Records were reviewed. The following current Physician orders were noted on the 4/2016 Treatment Administration Records: - Change trach (tracheostomy) collar and ties daily and as needed every day shift. This treatment was not signed out as completed on 4/4/16, 4/8/16, 4/12/16,</p>		<p>RECORDS-COMPLETE/ACCURATE/ACCESSILE The facility requests paper compliance for this citation. <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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</i></p> <ul style="list-style-type: none"> · Resident #J is receiving trach care and wound care per physician's orders. · Resident #H is receiving treatments per physician's orders. · Resident #E is receiving treatments per physician's orders. · Resident #G is no longer residing at the facility. · Resident #K is receiving treatments per physician's orders. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · Residents who receive treatments have the potential to be affected by the alleged deficient practice. · The April MARs and TARs have 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2016
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>4/14/16, and 4/19/16.</p> <p>- Change trach inner cannula every day shift and as needed. This treatment was not signed out as completed on 4/4/16, 4/8/16, 4/12/16, 4/14/16, and 4/19/16.</p> <p>- Cleanse right heel with wound cleanser, apply Bactroban (an antibiotic ointment) 2%(mixed with Santyl) to the right heel topically every day shift. This treatment was not signed out as completed on 4/4/16, 4/8/16, 4/12/16, 4/14/16, and 4/19/16.</p> <p>When interviewed on 4/26/16 at 4:00 p.m., the Director of Nursing indicated all treatments should have been signed out.</p> <p>2. On 4/25/16 at 7:20 p.m., Resident #H was observed in bed. The resident was awake. A wound vac was in place.</p> <p>The record for Resident #H was reviewed on 4/26/16 at 10:00 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, heart failure, high blood pressure, and chronic kidney disease.</p> <p>The 4/2016 Treatment Administration Records were reviewed. The following current Physician orders were noted on the 4/2016 Treatment Administration Records:</p>		<p>been reviewed for all residents to identify other residents that may have been affected. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Nurses will be re-educated regarding completion and documentation of medications and treatments by the DON/designee by 5/9/16. · The DON/designee will audit the Medication and Treatment records 5 times week until 100% compliance is achieved. 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 · MAR/TAR audits will be conducted by the DON/designee 5 times a week ongoing. · Director of Nursing will be responsible for oversight of these audits. · The results of these audits will be reviewed in monthly QAPI meeting until 100% compliance is achieved x 3 consecutive months.</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 04/26/2016
--	---	--	---

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>- Apply Lotrisone cream to the peri area topically every day shift. This treatment was not signed out as completed on 4/2/16 and 4/15/16.</p> <p>- Apply Jublia to the right great toes every day shift. This treatment was not signed out as completed on 4/2/16 and 4/15/16.</p> <p>When interviewed on 4/26/16 at 4:00 p.m., the Director of Nursing indicated all treatments should have been signed out.</p> <p>3. The closed record for Resident #E was reviewed on 4/25/16 at 7:40 p.m. The resident's diagnoses included, but were not limited to, gastrostomy, convulsions, tracheostomy, and anemia.</p> <p>The 11/2015 Medication and Treatment Administration records were reviewed. The following Physician orders were noted on the 11/2015 Treatment Administration Records:</p> <p>- Cleanse the non disposable inner cannula and the trach (tracheostomy) ties daily and as needed every shift. This treatment was not signed out as completed on the Evening shift on 11/4/15 and the Night shift on 11/5/15.</p> <p>- May suction trach every shift and as needed. This treatment was not signed out as completed on the Evening shift on</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 04/26/2016	
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>11/4/15 and the Night shift on 11/5/15. - Check residual before medications and tube feeding, if greater then 100 hold feeding and/or medications and notify the Physician. This treatment was not signed out as completed on the Evening Shift on 11/4/15 and the Night shift on 11/5/15.</p> <p>When interviewed on 4/26/16 at 4:00 p.m., the Director of Nursing indicated all treatments should have been signed out.</p> <p>4. The closed record for Resident #G was reviewed on 4/26/16 at 12:33 p.m. The resident's diagnoses included, but were not limited to, tracheostomy, anoxic brain injury, gastrostomy tube, and high blood pressure.</p> <p>The 3/2016 Treatment Administration Records were reviewed. The following Physician order were noted on the 3/2016 Treatment Administration Records: - Trach (tracheostomy) care very shift. This treatment was not signed out as completed on the Day shifts on 3/4/16, 3/14/16, 3/20/16, 3/20/16 and 3/21/16. This treatment was not signed out as completed on the Evening shifts on 3/3/16, 3/6/16, and 3/11/16. This treatment was not signed out as completed on the Day shifts on 3/4/16, 3/14/16, 3/20/16, and 3/21/16. This</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 04/26/2016
--	---	--	---

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>treatment was not signed out as completed on the Night shifts on 3/10/16, 3/18/16, and 3/21/16.</p> <p>When interviewed on 4/26/16 at 4:00 p.m., the Director of Nursing indicated all treatments should have been signed out.</p> <p>5. The record for Resident #K was reviewed on 4/26/16 at 2:45 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, peripheral vascular disease, and legally blind.</p> <p>The 4/2016 Treatment Administration Records were reviewed. The following current Physician orders were noted on the 4/2016 Treatment Administration Records:</p> <ul style="list-style-type: none"> - Apply Skin Prep wipes to the right plantar foot every shift. This treatment was not signed out as completed on the 4/1/16, 4/2/16, 4/3/16 and 4/6/16 Evening shifts. The treatment was not signed out as completed on the Night shifts on 4/6/16 and 4/9/16. - Monitor the areas to the right plantar foot and left heel every shift for drainage of blister. This treatment was not signed out as completed on the Day shifts on 4/2/16 and 4/22/16. This treatment was not signed out as completed on the 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
--	---	---	---

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>Evening shifts on 4/1/16, 4/2/16, 4/3/16, 4/6/16 and 4/22/16. This treatment was not signed out as completed on the Night shifts on 4/6/16, 4/8/2016, and 4/21/16.</p> <p>When interviewed on 4/26/16 at 4:00 p.m., the Director of Nursing indicated all treatments should have been signed out.</p> <p>This Federal tag relates to Complaints IN00198137 and IN00198212.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			