PRINTED: 09/29/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES						FC	FORM APPROVED	
CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				O!	MB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMP	PLETED	
		155580	B. W	ING _		08/25	5/2023	
NAME OF I	PROVIDER OR SUPPLIE	R			T ADDRESS, CITY, STATE, ZIP COD TAFT ST			
APERIO	N CARE TOLLEST	ON PARK			Y, IN 46404			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DATE	
F 0000								
Bldg. 00								
· ·	This visit was for a	Recertification and State	F 0	000	The facility respectfully			
	Licensure Survey.	This visit included the			requests paper complian	ce for		
	Investigation of Co	omplaint IN00415961.			this survey.			
					This Plan of Correction is	the		
	Complaint IN0041:	5961 - Federal/State deficiencies			center's credible allegation	ı of		
	related to the allega	ations are cited at F921.			compliance.			
	Survey dates: Augu	ust 21, 22, 23, 24, and 25, 2023			Preparation and/or execut this plan of correction doe.			
	Facility number: 0	08505			constitute admission or ag			
	Provider number:				by the provider of the truth			
	AIM number: 200	064830			facts alleged or conclusion			
	Census Bed Type:				forth in the statement of deficiencies. The plan of			
	SNF/NF: 127				correction is prepared and	l/or		
	Total: 127				executed solely because in			
					required by the provisions			
	Census Payor Type	2:			federal and state law.	•		
	Medicare: 6							
	Medicaid: 117							
	Other: 4							
	Total: 127							
	These deficiencies	reflect State Findings cited in						
	accordance with 41							
	accordance with 41	10 11 to 10.2-3.1.						
	Quality review con	npleted on 9/1/23.						
F 0550	483.10(a)(1)(2)(b)	)(1)(2)						
SS=D	Resident Rights/E							
Bldg. 00	§483.10(a) Resid	ent Rights.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The resident has a right to a dignified existence, self-determination, and

communication with and access to persons and services inside and outside the facility, including those specified in this section.

(X6) DATE

TITLE

Deana Jordan Collins Regional Nurse Consultant 09/25/2023

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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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155580	A. BU B. W		00	08/25	
	PROVIDER OR SUPPLIER			2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident with resp each resident in a environment that enhancement of h recognizing each	acility must treat each ect and dignity and care for manner and in an promotes maintenance or his or her quality of life, resident's individuality. The ct and promote the rights of					
	access to quality of diagnosis, severity source. A facility remaintain identical regarding transfer provision of service	e facility must provide equal care regardless of y of condition, or payment must establish and policies and practices discharge, and the tes under the State plan for redless of payment source.					
	her rights as a res a citizen or reside	the right to exercise his or sident of the facility and as nt of the United States.					
	the resident can e	e facility must ensure that exercise his or her rights ce, coercion, discrimination, e facility.					
	free of interference and reprisal from or her rights and t	e resident has the right to be e, coercion, discrimination, the facility in exercising his o be supported by the cise of his or her rights as s subpart.					
	Based on observation interview, the facilities resident's dignity wearing a hospital s	on, record review, and ty failed to ensure each as maintained related to gown during the day for 1 of 2 for dignity. (Resident 63)	F 0:	550	I. What corrective action(s) wi accomplished for those reside found to have been affected b deficient practice; Resident # care plan was updated to refle resident's choice to wear a go	ents by the 63's ect	09/22/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155580	B. WING		08/25/2023
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	t		AFT ST	
ΔPERI∩N	N CARE TOLLESTO	ON PARK		IN 46404	
AI ENIOI	V OAKL TOLLEST	ZIVI MINI	GART,	IIV 70404	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	ĭ	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Finding includes:			while in bed.	
				II. How other residents having	the
		p.m., Resident 63 was observed		potential to be affected by the	
		The resident was awake and		same deficient practice will be	!
	wearing a hospital g	gown.		identified and what corrective	
				action(s) will be taken; All	
		a.m. and 2:10 p.m., the resident		residents have the potential to	
		room in bed wearing a		affected by the alleged deficie	nt
	hospital gown.			practice.	
				III. What measures will be put	into
		a.m., 10:07 a.m., 1:35 p.m., and		place and what systemic char	iges
	_	ent was observed in his room in		will be made to ensure that the	e
	bed. He was wearing	ng a hospital gown at those		deficient practice does not rec	eur;
	times.			Social Services/designee wil	I
				review residents clothing	
	The record for Resi	dent 63 was reviewed on		preferences at initial care pla	an
	8/24/23 at 1:44 p.m	. Diagnoses included, but were		and with the quarterly MDS.	
		e and hemiplegia (muscle		IV. How the corrective action(	s)
	weakness on one sid	de of the body).		will be monitored to ensure the	е
				deficient practice will not recu	r
	The Annual Minim	um Data Set (MDS)		i.e., what quality assurance	
	assessment, dated 6	/23/23, indicated the resident		program will be put into place;	
		paired for daily decision making		Social Services/designee wil	I
		ensive assistance with		review residents clothing	
	dressing.			preferences upon admission	
				and with each quarterly MDS	
		t have a care plan or		Care plans will be amended	as
		ted to any preference of		needed.	
	wearing a gown du	ring the day while in bed.		The results of these audits wil	
				reviewed in Quality Assurance	•
		Director of Nursing on 8/24/23		Meeting monthly for 6 months	or
	· -	ted the resident preferred a		until an average of 90%	
	gown while in bed	and his care plan needed to be		compliance or greater is achie	
	updated.			x4 consecutive weeks. The C	A
				Committee will identify any tre	nds
	3.1-3(t)			or patterns and make	
				recommendations to revise th	e
				plan of correction as indicated	

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SS=A Bldg. 00  Notice Requirements Before Transfer/Discharge \$483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  \$483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1) (i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1) (i)(D) of this section;	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
APERION CARE TOLLESTON PARK  APERION CARE TOLLESTON PARK  SUMMARY STATEMENT OF DEFICIENCE (RACH DIFFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR I.SC IDENTIFYING INFORMATION TOURS. AS 1.5(c)(3)-(6)(8)  SS=A  Bidg. 0  Notice Requirements Before Transfer/Discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section and (iii) Include in the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-(A) The safety of individuals in the facility would be endangered under paragraph (c)(1) (i)(C) of this section; (B) The health of individuals in the facility would be endangered; under paragraph (c)(1) (i)(D) of this section;			IDENTIFICATION NUMBER	A. BUILDING	JILDING <u>00</u>		COMPLETED	
XA) ID   SIMMARY STATEMENT OF DEFICIENCIE   PREFIX   GACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   PROVIDERS RLAY OF CORRECTION   COMMETTION	NAME OF	PROVIDER OR SUPPLIEF	₹			COD		
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG SASS-REFERENCE TO THE APPROPRIATE DATE OF THE A	APERIO	N CARE TOLLEST	ON PARK	GARY	7, IN 46404			
F 0623 SS=A Bldg. 00 Notice Requirements Before Transfer/Discharge \$483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  \$483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1) (i)(C) of this section; (B) The health of individuals in the facility would be endangered under paragraph (c)(1) (i)(O) of this section;					(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE		
(C) The resident's health improves sufficiently	F 0623 SS=A	REGULATORY OF  483.15(c)(3)-(6)(8)  Notice Requirement Transfer/Discharge \$483.15(c)(3) Notice Before a facility through the resident, the facility for the resident, the facility for the resident of the reasons of a language and magnetic facility must send representative of the Long-Term Care of the readischarge in the readischarge of the readischarge of the discharged of the discharged.  (ii) Notice must be practicable before (A) The safety of it would be endanged (i)(C) of this section (B) The health of would be endanged (i)(D) of this section of the section of t	ents Before le lice before transfer. ansfers or discharges a ty must- ent and the resident's of the transfer or discharge or the move in writing and in transfer they understand. The la copy of the notice to a the Office of the State Ombudsman. Issons for the transfer or desident's medical record in transfer or discharge when transfer or dis				DATE	

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to allow a more immediate transfer or

discharge, under paragraph (c)(1)(i)(B) of this

(D) An immediate transfer or discharge is

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DEPARTMENT OF HEALTH AND HUM	IAN SERVICES
CENTERS FOR MEDICARE & MEDICA	AID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	COMP	E SURVEY PLETED 5/2023	
	PROVIDER OR SUPPLIEI		2350	T ADDRESS, CITY, STATE, ZIP TAFT ST Y, IN 46404	COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	FULL PREFIX FULL PREFIX FULL PREFIX FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION
	required by the reneeds, under parasection; or (E) A resident has for 30 days.  §483.15(c)(5) Conwritten notice spethis section must (i) The reason for (ii) The effective of (iii) The location to transferred or disc (iv) A statement or rights, including the and email), and tentity which receinformation on howand assistance in submitting the application of the control of the control of the control of individuals with established under Developmental Discontinuity for nursing faintellectual and developmental Discontinuity of Rights Act of codified at 42 U.S. (vii) For nursing faintellectual and developmental Discontinuity of the codified at 42 U.S. (vii) For nursing faintellectual and developmental Discontinuity of the codified at 42 U.S. (vii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S. (viii) For nursing faintellectual and the codified at 42 U.S.	ident's urgent medical agraph (c)(1)(i)(A) of this is not resided in the facility intents of the notice. The cified in paragraph (c)(3) of include the following: transfer or discharge; is the resident is charged; if the resident's appeal in name, address (mailing elephone number of the ves such requests; and we to obtain an appeal form completing the form and one al hearing request; dress (mailing and email) in the care Ombudsman; cility residents with evelopmental disabilities or is, the mailing and email whone number of the agency developmental disabilities		(EACH CORRECTIVE ACTION :	SHOULD BE	
	number of the age protection and ad mental disorder e	address and telephone ency responsible for the vocacy of individuals with a stablished under the lvocacy for Mentally III				

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				SURVEY ETED
ANDILAN	OF CORRECTION	155580	B. WING	<u>00                                   </u>	08/25/	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	•	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	Individuals Act.					
	If the information is to effecting the trafacility must update notice as soon as updated information. §483.15(c)(8) Not closure In the case of facing who is the administ provide written not impending closure. Agency, the Office Care Ombudsmar and the resident ruthe plan for the trafaction of the reducation of the reducation. (Reducation in the reducation of the reducati	dent 52 was reviewed on n. Diagnoses included, but were lepressive disorder, high blood ions, bipolar disorder,	F 0623	I. What corrective action(s) wi accomplished for those reside found to have been affected by the deficient practice: Resident 52 Poa was mailed a transfer notification.  II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Hospit transfers from the last 14 days were audited to ensure the residents responsible party received transfer notifications when appropriate.  III. What measures will be put place and what systemic char	ents by the c's the al s	09/22/2023

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A Nurses' Note, dated 7/24/23 at 5:13 p.m.,

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will be made to ensure the

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r '	CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED				
		155580	B. WING		08/25/2023				
	PROVIDER OR SUPPLIER		2350	T ADDRESS, CITY, STATE, ZIP COD TAFT ST Y, IN 46404					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	In I					
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION				
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG						
	indicated the reside	nt was not looking well during		deficient practice does not red	cur;				
		rying, yelling, and placing		Social Services will be educate					
	herself on the floor.	The Nurse Practitioner (NP)		on sending a transfer notice to	оа				
	_	ve orders to send the resident		residents responsible party w	hen				
	to the hospital.			a resident is sent to the					
				hospital. ="" b="">					
		lmitted to the hospital with		IV. How the corrective action(	s)				
	altered mental statu	S.		will be monitored to ensure th					
				deficient practice will not recu	r				
		ation the State transfer form		i.e., what quality assurance					
	was mailed to the re	esident's responsible party.		program will be put into place					
	The state of the s	7 110 1 P		Administrator/designee will au					
		Social Service Director on		hospital transfers to ensure th	ie				
		n., indicated the State transfer		responsible party was sent a					
		d to the resident's Responsible		transfer notification. Audits wi					
	Party.			completed on 3 hospital trans					
	2.1.12(-)(()(:)			a week x 8 weeks, then month 4 months.="" b="">	niy x				
	3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)			The results of these audits wi	ll bo				
	3.1-12(a)(b)(III)								
				reviewed in Quality Assurance Meeting monthly for 6 months					
				until an average of 90%	O				
				compliance or greater is achie	aved				
				x4 consecutive weeks. The C					
				Committee will identify any tre					
				or patterns and make	, indo				
				recommendations to revise th	e				
				plan of correction as indicated					
F 0641	483.20(g)								
SS=D	Accuracy of Asses	ssments							
Bldg. 00	(0)	acy of Assessments.							
		must accurately reflect the							
	resident's status.								
		on, record review, and	F 0641		09/22/2023				
		ty failed to ensure the		I. What corrective action(s) wi					
	-	nimum Data Set (MDS)		accomplished for those reside					
		ccurately completed related to		found to have been affected by	- I				
	hospice care, antico	_		deficient practice; R24, R37 a	nd				
	uracheostomy care i	for 3 of 30 MDS assessments	I	R60 will have MDS	l				

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W	NG		08/25/	2023
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
				2350 TA			
APERIO	N CARE TOLLEST	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'E	DATE
	reviewed. (Resider	nts 24, 37, and 60)			modification made and		
	·				transmitted		
	Findings include:				II. How other residents having	the	
					potential to be affected by the		
	1. The record for R	Resident 24 was reviewed on			same deficient practice will be		
	8/22/23 at 1:50 p.m	. Diagnoses included, but were			identified and what corrective		
		rosclerotic heart disease,			action(s) will be taken; All		
		llure, and hypertension.			residents with special care		
					needs including		
	The Quarterly Mini	mum Data Set (MDS)			Anticoagulants, tracheostom	ıv İ	
	assessment, dated 6	5/6/23, indicated the resident			and hospice care will have	·	
		paired and he had received an			MDS reviewed for accuracy a	all	
	anticoagulant (blood thinner) for 7 days during				inaccuracies will be modified		
	the assessment reference period.				as indicated.		
		-			III. What measures will be put	into	
	A Physician's Order	r, dated 10/27/21 and listed as			place and what systemic chan		
	-	ıst 2023 Physician's Order			will be made to ensure that the	•	
	Summary (POS), in	ndicated the resident was to			deficient practice does not rec	ur;	
	receive Plavix (an a	antiplatelet) 75 milligrams (mg)			IDT team will be re-educated		
	daily.				on the MDS process and		
					accuracy of MDS		
	The resident had no	orders for an anticoagulant			_		
	during the assessme	ent reference period.			IV. How the corrective action(s	s)	
					will be monitored to ensure the	e	
	Interview with the l	Director of Nursing on 8/24/23			deficient practice will not recu	-	
	at 3:00 p.m., indica	ted the resident's MDS had			i.e., what quality assurance		
	been coded incorrec	ctly related to anticoagulant			program will be put into place;		
	use.				DON or Designee will review	5	
					MDS/week for accuracy and		
	2. The record for R	Resident 37 was reviewed on			modifications will be made a	s	
	8/24/23 at 9:34 a.m	. Diagnoses included, but were			indicated.		
	not limited to, demo	entia without behavioral					
	disturbance and Alz	zheimer's disease.			The results of these audits will	lbe	
					reviewed in Quality Assurance	,	
	The Significant Cha	ange Minimum Data Set (MDS)			Meeting monthly for 6 months	or	
	assessment, dated 7	7/19/23, indicated the resident			until an average of 90%		
		paired for daily decision making			compliance or greater is achie	ved	
	and he was not rece	eiving hospice services while a			x4 consecutive weeks. The Q	Α	
	resident of the facil	ity.			Committee will identify any tre	nds	
					or patterns and make		

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE ( A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 25/2023
NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  A Physician's Order, dated 7/6/23, indicated the resident was admitted to hospice.  Interview with the Director of Nursing on 8/25/23 at 11:00 a.m., indicated hospice should have been coded on the Significant Change MDS assessment.  3. The record for Resident 60 was reviewed on 8/22/23 at 1:57 p.m. Diagnoses included, but were not limited to, anoxic brain damage and chronic obstructive pulmonary disease (COPD).  The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was receiving tracheostomy (trach - a surgical		2350	r address, city, state, zip TAFT ST ', IN 46404	COD		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	1			recommendations to plan of correction as		
	at 11:00 a.m., indic coded on the Signif	ated hospice should have been				
	8/22/23 at 1:57 p.m not limited to, anox	. Diagnoses included, but were ic brain damage and chronic				
	assessment, dated 5 was receiving trach	/17/23, indicated the resident eostomy (trach - a surgical trachea to allow breathing) care				
	current on the Augu Summary (POS), in tracheostomy stoma	r, dated 9/1/22 and listed as ast 2023 Physician's Order dicated the resident's a was to be cleansed with overed with a dry dressing (PRN).				
	9:29 a.m., indicated removed and she ju	MDS Coordinator on 8/25/23 at the resident's trach had been st had a stoma. The MDS had ately related to tracheostomy				
	3.1-31(i)					
F 0644 SS=D Bldg. 00	§483.20(e) Coord A facility must coo the pre-admission	ASARR and Assessments ination.  ordinate assessments with screening and resident program under Medicaid in				

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If continuation sheet

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155580	B. WING	08/25/2023		
		.00000			30/20/2020	
NAME OF D	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	NO VIDER OR SUPPLIER		2350 T	AFT ST		
APERION	N CARE TOLLESTO	ON PARK	GARY.	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	subpart C of this p	part to the maximum extent				
	practicable to avoi	id duplicative testing and				
	effort. Coordinatio					
	onort. Coordinatio	Tritolados.				
	§483.20(e)(1)Inco	rnorating the				
	- ', ', ',	-				
		from the PASARR level II				
		the PASARR evaluation				
	-	ent's assessment, care				
	planning, and tran	sitions of care.				
	§483.20(e)(2) Ref	erring all level II residents				
	- ' ' ' '	vith newly evident or				
		nental disorder, intellectual				
		ited condition for level II				
	-					
		oon a significant change in				
	status assessmen					
		view and interview, the facility	F 0644	I. What corrective action(s) wi		
	failed to ensure a re	sident with diagnoses of		accomplished for those reside	ents	
	mental illness receiv	ved a new Level 1 PASARR		found to have been affected b	y the	
	(Preadmission Scree	ening and Resident Review) for		deficient practice; Resident #2	22	
	1 of 1 residents revi	ewed for PASARR. (Resident		had a new Level I completed		
	22)			the Social Services Director b	-	
				date of compliance.	,	
	Finding includes:			date of compilatioe.		
	r maing metades:			II How other residents beside	the	
	Th 10 P '	1		II. How other residents having		
		dent 22 was reviewed on		potential to be affected by the		
		n. The resident was admitted to		same deficient practice will be		
	-	21. Diagnoses included, but		identified and what corrective		
	·	bipolar disorder and		action(s) will be taken; All		
	schizoaffective diso	order.		residents with a mental health		
				diagnosis have the potential to		
	The 8/14/23 Ouarte	rly Minimum Data Set (MDS)		affected by the alleged deficie		
		d the resident was cognitively		practice; The SSD will perfor		
	intact.	cognitively		100% audit of all residents to	~	
	mact.				data	
	AT 11 DAG ( D.D.	1 . 1 . 10/20/2017		determine accurate and up-to-	-uaie	
		R, completed on 10/20/2016		Level Is are completed and		
	-	t's admission to the facility),		therefore also determine the r		
	indicated a PASAR	R Level 2 was not required.		for any Level IIs to be comple	ted	
				based on any current and nev	<i>l</i>	

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There was no other Level 1 PASARR completed

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mental health diagnoses. 100%

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155580	B. W	ING		08/25	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	2		2350 TA			
ΔΡΕΒΙ∩Ν	N CARE TOLLESTO	ON PARK			IN 46404		
, u LINOI	· O/ IIIL TOLLLOT	>11 / UMA		OAITI,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	after 10/20/16.				audit to be completed by the		
					facility SSD by date of		
		Social Service Director on			compliance.		
		n., indicated she was not aware			III. What measures will be put		
		nental illness diagnosis and			place and what systemic chan		
	she did not have a I	Level 2 completed.			will be made to ensure that the		
	2.1.16(1)(1)(4)				deficient practice does not rec	ur;	
	3.1-16(d)(1)(A)				Administrator/designee to		
					re-educate Social Services on		
					need to ensure up-to-date and		
					accurate Level Is and Level IIs	s are	
					completed based on each		
					resident's mental health		
					diagnoses. Education to be	200	
					completed by date of compliar  IV. How the corrective action(s		
					will be monitored to ensure the		
					deficient practice will not recui		
					i.e., what quality assurance		
					program will be put into place;		
					DON/MDS/designee will cond		
					an audit of all new admissions		
					weekly for 6 months to determ		
					accuracy of Level I's for all ne		
					admissions. In addition, the S		
					will perform an audit every 2		
					weeks for 6 months to cross		
					reference the facility's psychia	ıtric	
					MD/NP visits to ensure all new		
					diagnoses are monitored and	-	
					Level I's are completed timely		
					The results of these audits will	l be	
					reviewed in Quality Assurance	)	
					Meeting monthly for 6 months		
					until an average of 90%		
					compliance or greater is achie	ved	
					x4 consecutive weeks. The Q		
					Committee will identify any tre	•	
					or natterns and make		

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155580 B. WING			00	COMPL 08/25/	ETED	
NAME OF PROVIDER OR SUPPL APERION CARE TOLLES		2	350 TA	DDRESS, CITY, STATE, ZIP COD IFT ST N 46404		
PREFIX (EACH DEFICE	RY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
				recommendations to revise the plan of correction as indicated.		
Bldg. 00 §483.21(b) (Con §483.21(b)(1) T implement a co care plan for ear the resident right and §483.10(c)) objectives and the resident's medic psychosocial necomprehensive comprehensive comprehensive following -  (i) The services attain or maintal practicable physic psychosocial with §483.24, §483.2 (ii) Any services required under but are not provided are not provided as a resident's reprovided as a resident resident's representation of the findings of the tits rationale in the consultation resident's representation (B) The resident desired outcom (B) The resident	ns. If a facility disagrees with the PASARR, it must indicate the resident's medical record. For with the resident and the sentative(s)-t's goals for admission and					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155580	B. W	ING		08/25	/2023
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			AFT ST		
ΛDEDIΩ!	N CARE TOLLESTO				IN 46404		
AFERIUI	N CARE TULLEST			GARY,	IIN 40404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ent's desire to return to the					
		ssessed and any referrals					
	_	gencies and/or other					
		es, for this purpose.					
	. ,	ns in the comprehensive					
		ropriate, in accordance with					
	-	set forth in paragraph (c) of					
	this section.						
	- ' ' ' '	e services provided or					
		acility, as outlined by the					
	comprehensive ca						
	(iii) Be culturally-c	competent and					
	trauma-informed.	1	F 0	c = c			00/00/000
		on, record review, and	F 00	556	I. What corrective action(s) wi		09/22/2023
		ty failed to complete a Care			accomplished for those reside		
	_	pice care and oxygen use for 1			found to have been affected b	•	
	of 30 Care Plans re	viewed. (Resident 37)			deficient practice; Resident #3		
	Einding includes				care plan was updated to refle		
	Finding includes:				the use of oxygen and hospice	е	
	On 8/21/23 at 10:40	a.m., Resident 37 was			services	tho	
		m. He was wearing oxygen by			II. How other residents having		
	the way of a nasal of				potential to be affected by the		
	uic way of a flasaf C	vannura.			same deficient practice will be identified and what corrective	;	
	The record for Resi	dent 37 was reviewed on			action(s) will be taken; Any		
		. Diagnoses included, but were			resident receiving hospice ser	vices	
		entia without behavioral			or on oxygen has the potentia		
	disturbance and Alz				be affected by the alleged def		
	and an ounce and The	and the second of the second o			practice. ="" b="">	ioioi it	
	The Significant Cha	ange Minimum Data Set (MDS)			III. What measures will be put	into	
		7/19/23, indicated the resident			place and what systemic char		
		paired for daily decision making			will be made to ensure that the	-	
		eiving hospice services while a			deficient practice does not rec		
		ity. The resident was also			MDS coordinator/designee wil		
	identified as receiving				conduct a care plan audit to		
					ensure residents care plans a	re	
	A Physician's Order	r, dated 7/6/23, indicated the			accurate and up to date. Audit		
	resident was admitt				will be completed as follows: 8		
		•			residents care plans a week u		
	A Physician's Order	r, dated 7/7/23, indicated the			all residents care plans have b		

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CENTERS FOI	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  08/25/2023
	PROVIDER OR SUPPLIEN		2350 1	ADDRESS, CITY, STATE, ZIP COD FAFT ST , IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	The resident's Car He had no Care Pl oxygen use. Interview with the at 3:00 p.m., indic	reive oxygen at 2 liters per nasal asly.  Plan was revised on 7/14/23.  In related to hospice care and  Director of Nursing on 8/24/23 ated the resident should have ated to hospice and oxygen.		reviewed for accuracy and upon as needed. ="" span=""> IV. How the corrective action(swill be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place; DON/designee will audit the or listing report to ensure any resident placed on hospice services and/or new orders for oxygen usage also has a care plan reflecting the same. Audit will be completed 5x a week x 4 week, 2x a week x 4 weeks, weekly x 4 weeks then monthly 3 months  The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achie x4 consecutive weeks. The Quality Committee will identify any treating month or correction as indicated.	eder  s  y x  be  or  ved  A  nds
F 0677 SS=E Bldg. 00	§483.24(a)(2) A carry out activitie necessary servic nutrition, groomin hygiene;	ed for Dependent Residents resident who is unable to s of daily living receives the es to maintain good ng, and personal and oral ion, record review, and	F 0677	What corrective action(s) will	The 00/22/2023
	interview, the faci residents received	lity failed to ensure dependent assistance with ADL's living) related to nail care for 4	F 00//	accomplished for those resider found to have been affected by deficient practice; Residents #	nts y the

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of 7 residents reviewed for ADL's. (Residents 63,

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#27, #35, #68 received nail care

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  INSERT ADDRESS, CITY, STATE, ZIP COD  2350 TAFT ST  GARY, IN 46404  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX TAG  27, 35, and 68)  Findings include:  1. On 8/21/23 at 1:55 p.m., Resident 63 was observed in his room in bed. His fingermals on both hands were long and in need of trimming.  On 8/22/23 at 9:15 a.m. and 2:10 p.m., the resident's fingermals remained long.  On 8/24/23 at 9:15 a.m. and 1:104 a.m., the resident's fingermals remained long.  On 8/24/23 at 9:15 a.m. 1:35 p.m., and 2:45 p.m., the resident's fingermals remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1:44 p.m. Diagnoses included, but were not limited to, stroke and hemisplegia (muscle weakness on one side of the body).  The Annual Minimum Data Set (MDS) assessment, dated 6/23/23, indicated the resident was cognitively impaired for daily decision making and he required extensive assistance with personal hygiene.  Documentation in the "task" section of the resident's word on 8/17, 8/21, and 8/24/23 at 3:00 p.m., indicated the resident's fingermals should have been trimmed at least weekly, 2. During made on beservations on 8/21/23 at 2:45 p.m. the resident's fingermals should have been trimmed at least weekly, 2. During made on beservations on 8/21/23 at 2:45 p.m. and 2-45 p.m. the resident's fingermals should have been trimmed at least weekly, 2. During made on beservations on 8/21/23 at 2:45 p.m. and 2-45 p.m. the resident's fingermals should have been trimmed at least weekly, 2. During made on beservations on 8/21/23 at 2:45 p.m. and 2-45 p.m. and 2-	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK  APERION CARE TOLLESTON PARK  TAG  PREFIX TAG  27, 35, and 68)  Findings include:  1. On 8/21/23 at 1.55 p.m., Resident 63 was observed in his room in bed. His fingermals on both hands were long and in need of trimming.  On 8/22/23 at 9.04 a.m. and 2.10 p.m., the resident's fingermalis remained long.  On 8/22/23 at 9.15 a.m., 10.07 a.m., 1.35 p.m., and 2.45 p.m., the resident's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 9.15 a.m., 10.07 a.m., 1.35 p.m., and 2.45 p.m., the resident's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. but president's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. but president's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. but president's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. but president's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. but president's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. but president's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. and 2.45 p.m. the resident's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. and 2.45 p.m. the resident's fingermalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. and 2.45 p.m. the resident's fingermalis remained long and were in med of trimming.  The record for Resident 63 was reviewed on 8/24/23 at 1.45 p.m. and 2.45 p.m. the resident's fingermalis remained long and were in med of trimming.  The record for Resident 63 was reviewed on 8/24/23 indicated the resident was cognitively impaired for daily decision making and he required extensive assistance with personal hygienc.  Documentation in the "task" section of the resident was cog								
APERION CARE TOLLESTON PARK  (X4) ID  PREPIX TAG  RIGHATORY FOR IS CIDENTEYING INFORMATION  27, 35, and 68)  Findings include:  1. On 8/21/23 at 1:55 p.m., Resident 63 was observed in his room in bed. His fingernalis on both hands were long and in need of trimming.  On 8/22/23 at 7:55 a.m. and 11:04 a.m., the resident's fingernalis remained long.  On 8/24/23 at 7:55 a.m. and 11:04 a.m., the resident's fingernalis remained long.  On 8/24/23 at 9:15 a.m., 10:07 a.m., 1:35 p.m., and 2:45 p.m., the resident's fingernalis remained long and were in need of trimming.  The record for Resident 63 was reviewed on 8/24/23 at 1:44 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (muscle weakness on one side of the body).  Documentation in the "task" section of the resident's ingernal bygiene.  Documentation in the "task" section of the resident's indicated the resident's fingernalis should have been trimmed at least weekly, 2.  During random observations on 8/21/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly, 2.  During random observations on 8/21/23 at 2:45	AND PLAN	OF CORRECTION				<u> </u>		
APERION CARE TOLLESTON PARK  (X4) ID  REGULATORY OR LIST DEPITIENT OF DEFICIENCE (LEACH DEPICIENCY MUST BE PRICEDED BY PULL TAO  7, 35, and 68)  Findings include:  1. On 8/21/23 at 1:55 p.m., Resident 63 was observed in his room in bed. His fingernalis on both hands were long and in need of trimming.  On 8/22/23 at 9:04 a.m. and 2:10 p.m., the resident's fingernalis remained long.  On 8/23/23 at 7:55 a.m. and 11:04 a.m., the resident's fingernalis remained long.  On 8/24/23 at 9:15 a.m., 10:07 a.m., 1:35 p.m., and 2:45 p.m., the resident's fingernalis remained long and were in need of trimming.  The record for Resident 63 was reviewed on 8/24/23 at 1:45 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (muscle weakness on one side of the body).  Documentation in the "task" section of the resident's exident's record, indicated the had received a shower on 8/17, 8/21, and 8/24/23, at 1:40 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly 2.  During random observations on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should ha			155580	B. W	ING		08/25/	/2023
APERION CARE TOLLESTON PARK  (X4) ID  PREFIX  TAG  REGULATORY DELSC IDENTIFYING INFORMATION  27, 35, and 68)  Findings include:  1. On 8/21/23 at 1:55 p.m., Resident 63 was observed in his room in bed. His fingernalis on both hands were long and in need of trimming.  On 8/22/23 at 9:04 a.m. and 2:10 p.m., the resident's fingernalis remained long.  On 8/24/23 at 9:04 a.m. and 1:04 a.m., the resident's fingernalis remained long.  On 8/24/23 at 9:15 a.m., 10:07 a.m., 1:35 p.m., and 2:45 p.m., the resident's fingernalis remained long.  The record for Resident 63 was reviewed on 8/24/23 at 1:44 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (muscle weakness on one side of the body).  The Annual Minimum Data Set (MDS) assessment, dated 6/23/23, indicated the resident was cognitively impaired for daily decision making and he required extensive assistance with personal hygiene.  Documentation in the "task" section of the resident's record, indicated he had received a showr on 8/17, 8/21, and 8/24/23.  Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated the resident's fingernalis should have been trimmed at least weekly. 2.  During random observations on 8/21/23 at 2:45  During random observations on 8/21/23 at 2:45  Dour mental to be affected by the same deficient practice will be identified and what corrective action(s) will be tasken; Any resident what or received and with a corrective action(s) will be tasken; Completed for 2 residents practice.  III. How other residents having the potential to be affected by the same deficient practice will be dientified and what corrective action(s) will be tasken; Any resident what or requires assistance with particular to require a sassistance with action of the resident's fingernalis remained long.  III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; IV. How the corrective action(s) will be monitored to ensure had before the resident of the resident'	NAME OF P	ROVIDER OR SUPPLIEF	······································					
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During random observations on 8/21/23 at 2:45  Committee will identify any trends								
pinn, or an an and and an and an		_				or patterns and make		
8:30 a.m., and 8/24/23 at 8:40 a.m. and 10:05 a.m., recommendations to revise the		_				1 -	е	
Resident 27 was observed with long dirty plan of correction as indicated.								

5Z4Q11

	IT OF DEFICIENCIES OF CORRECTION	CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		COMP	(X3) DATE SURVEY COMPLETED 08/25/2023	
	ROVIDER OR SUPPLIER		2350	ET ADDRESS, CITY, STATE, ZIP CO I TAFT ST Y, IN 46404	D	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	TOTAL	DATE
	fingernails on both	hands.				
	8/22/23 at 2:38 p.m not limited to, mult and contracture of t  The 7/27/23 Quarte assessment indicate cognitively intact. Tassist with a 2 persohygiene and was tot bathing.	dent 27 was reviewed on  Diagnoses included, but were iple sclerosis, stroke, dementia, he right hand.  Ty Minimum Data Set (MDS) and the resident was not The resident needed extensive on physical assist for personal tally dependent on staff for d on 4/22/22, indicated the				
		ff assistance for all activities				
		mentation the resident refused are and that her nails were ad.				
		Director of Nursing on 8/24/23 ted the resident's nails were to med.				
	a.m. and 3:02 p.m., p.m., 8/23/23 at 8:3 at 8:40 a.m. and 10:	bservations on 8/21/23 at 10:55 8/22/23 at 9:25 a.m. and 2:20 0 a.m. and 1:43 p.m., and 8/24/23 0:05 a.m., Resident 35 was and dirty fingernails on both				
	8/22/23 at 1:52 p.m the facility on 8/1/2 were not limited to, pressure.	dent 35 was reviewed on  The resident was admitted to  Diagnoses included, but stroke and high blood				
	The Admission Mir	nimum Data Set (MDS)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5Z4Q11

Facility ID: 008505

If continuation sheet

Page 16 of 52

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00		SURVEY LETED 5/2023	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION  /8/23, indicated the resident	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	was not cognitively	intact. The resident needed h 1 person physical assist for				
		8/2/23, indicated the resident daily living self care deficit				
	personal hygiene ca trimmed and cleane					
	at 2:00 p.m., indicate have been cleaned a					
	a.m. and 3:03 p.m., at 8:40 a.m. and 10:	bservations on 8/21/23 at 10:52 8/23/23 at 8:30 a.m., and 8/24/23 05 a.m., Resident 68 was and dirty fingernails on both				
	8/22/23 at 2:10 p.m not limited to, demo	dent 68 was reviewed on . Diagnoses included, but were entia with mild behavioral tiety, bipolar disorder, stroke, rder.				
	Set (MDS) assessm the resident was not	f the Quarterly Minimum Data ent, dated 5/22/23, indicated cognitively intact and he was ith 1 person physical assist e.				
	· · · · · · · · · · · · · · · · · · ·	d on 2/3/22, indicated the vities of daily living self care troke.				
	There was no docur	mentation the resident refused				

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DEPARTMEN CENTERS FOI	OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (	(X3) DATE SURVEY COMPLETED 08/25/2023	
	PROVIDER OR SUPPLIE		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST		_
APERIO	N CARE TOLLEST	ON PARK	GARY	, IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
	trimmed and cleand Interview with the	Director of Nursing on 8/24/23 ted the resident's nails were to				
F 0679 SS=D Bldg. 00	§483.24(c) Activities §483.24(c)(1) The on the comprehener plan and the preference ongoing program choice of activities group and individing independent activities and psychosocial encouraging both interaction in the Based on observation interview, the faciliactivity program with woriented, cognitive residents for 2 of 5 activities. (Residents for 2 of 5 activities.)	e facility must provide, based nsive assessment and care erences of each resident, and to support residents in their s, both facility-sponsored ual activities and vities, designed to meet the support the physical, mental, well-being of each resident, independence and community.  In the series of	F 0679	I. What corrective action(s) will accomplished for those resider found to have been affected by deficient practice; Residents #6 and #10 had a new Comprehensive Activity Assessment completed with the collaboration of family as need. The focus to be on 1:1 activities. The Activity Director to complete by date of compliance II. How other residents having the potential to be affected by the	e ed. s. te	

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On 8/22/23 at 9:04 a.m. and 2:10 p.m., the resident

was observed in his room in bed. The resident

was awake and his television was turned off.

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same deficient practice will be

identified and what corrective

action(s) will be taken; All residents have the potential to be

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155580	B. W	ING		08/25/	2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			AFT ST		
APERION	N CARE TOLLESTO	ON PARK			IN 46404		
	Г				<u> </u>	1	OV.E.
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	ì ·	CY MUST BE PRECEDED BY FULL  PLICE IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		a.m., the resident was observed	-	TAG		nt	DATE
					affected by the alleged deficie		
	in his room in bed. The resident was awake and his television was turned off.				practice. The Activity Director	WIII	
	his television was turned off.				perform a 100% audit of all residents to determine accura	to	
	On 8/24/23 at 0.15	a.m., 10:07 a.m., 1:35 p.m., and				ı <del>c</del>	
	2:45 p.m., the resident was observed in his room in				and up-to-date Activity Assessments – particularly		
	_	was awake and his television			related to 1:1 activities. 100%		
	was turned off.	vas aware and ms television			audit to be completed by the	'	
	was turned on.				facility Activity Director by date	a of	
	The record for Resi	dent 63 was reviewed on			compliance.	. Ji	
		. Diagnoses included, but were			III. What measures will be put	into	
	_	te and hemiplegia (muscle			place and what systemic chan		
	weakness on one side of the body).				will be made to ensure that the	~	
weakness on one side of the body).				deficient practice does not rec			
	The Annual Minimum Data Set (MDS)				Administrator/designee to	, ui,	
		/23/23, indicated the resident			re-educate Activity Director ar	nd	
		paired for daily decision making			Staff on the need to ensure		
		ensive assistance with			up-to-date Activity Assessmer	nts	
	transfers.				and participation records of		
					residents in group and 1:1		
	It was somewhat in	portant for the resident to			activities are according to eac	h	
		listen to music, and keep up			resident preference. Education		
	with the news.				be completed by date of		
					compliance.		
	A Care Plan, dated	6/26/23, indicated the resident			IV. How the corrective action(s	s)	
	_	decreased activity/recreational			will be monitored to ensure the	е	
		receiving one to one room			deficient practice will not recui	r	
	visits. His interests	were watching television in			i.e., what quality assurance		
	his room. Intervent	ions included, but were not			program will be put into place;		
	limited to, provide	in room activities as requested			Administrator/designee will		
	and needed.				conduct an audit of group acti	vity	
					participation and 1:1 activity		
	1	sment, dated 6/26/23,			participation 3 X weekly for 4		
		nt's current interests were			weeks, 1 X week for 4 week,		
	television, movies,	music, and current events.			monthly x 4 months to ensure		
					participation of residents in		
		receive one-to-one visits			activities per resident preferer	ice.	
		on Monday, Wednesday, and					
	Friday.				The results of these audits wil		
					reviewed in Quality Assurance	)	

	IT OF DEFICIENCIES OF CORRECTION			ULTIPLE CO JILDING ING	onstruction 00	(X3) DATE ( COMPL 08/25/	ETED
	PROVIDER OR SUPPLIEIN CARE TOLLEST			2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
TAG	One to one docume indicated the reside one-to-one visit on sensory stimulation.  Interview with the 12:35 p.m., indicate received one-to-one his television shoul.  2. An interview wit 12:55 p.m., indicate activities, but no or would like to go to.  On 8/22/23 from 9: resident remained i participate in any g.  The record for Resi 8/22/23 at 2:25 p.m. not limited to, strok behaviors, major de delusional disorder.  The 1/13/23 Annua assessment, indicate cognitively intact at to read or to have a books, listen to mu do her favorite activithe resident was convex extensive assist wit locomotion on and.  A Care Plan, revise	entation for August 2023, and had only received one, 8/16/23, which consisted of a conversation, and music.  Activity Director on 8/25/23 at end the resident should have be visits three times a week and do have been turned on.  The Resident 10 on 8/21/23 at end she would love to go the ever comes to get her. She church.  On a.m. until 2:20 p.m., the in her room and did not roup activities.  In Diagnoses included, but were the end and the pressive disorder, and the pressive disorder, and the pressive disorder was and it was somewhat important vailable newspapers and sic, keep up with the news, and wities.  In MDS assessment, indicated gnitively intact and needed the preson physical assist for		TAG	Meeting monthly for 6 months until an average of 90% compliance or greater is achie x4 consecutive weeks. The Q Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	ved A nds	DATE
	approaches were fo	r 1 to 1 staff visits as needed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE B. WING 08/25/202			LETED		
		100000	<i>D.</i> W	_	ADDDECC CITY CTATE 718 COD	30/23	, 2020
NAME OF F	PROVIDER OR SUPPLIE	R		2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST		
APERIO	N CARE TOLLEST	ON PARK			IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	<del></del>	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
TAG		ocialization and participation in		IAU			DATE
	activities of her che						
	A Care Plan, revised on 9/16/19, indicated the						
	_	dent on staff for sensory					
	-	pproaches were to provide drop					
		resident verbal reminders of an					
	-	nmencement of the activity, and nedule in the resident's room.					
	post an activity sen	reduie in the resident's 100m.					
	The last documents	ed Annual Activity					
	Assessment was da	ated 3/22/22, which indicated					
	the resident's curre	nt interests were spiritual					
		events, television/music and					
		information was provided by					
	the resident.						
	The 8/7/23 Ouarter	ly/Annual Participation Review					
		ent enjoyed watching television					
	in her own room ar	nd her activity participation was					
	stop by visits.						
	The Activity partic	ipation in the last 30 days					
		ent did not attend worship or					
	church.						
	The 1 to 1 activity	log for 8/2023, indicated the					
	-	eive multi-stimulation three					
		only documented visit was on					
	8/16/23 for the enti	ire month.					
	Interview with Act	ivity Aide 1 on 8/24/23 at 3:30					
		resident had not attended					
	church services. Sh	ne was unaware if the resident					
		ts as another activity aide did					
		en without an Activity					
	Director "for a min	ute."					
	Interview with Act	ivity Aide 2 on 8/24/23 at 3:30					
		did the 1 to 1 visits, however,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155580		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/25/2023	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD FAFT ST , IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	Interview with the A 10:45 a.m., indicate challenges and just to do 1 to 1 visits. The participated in churum of the challenges and just to do 1 to 1 visits. The participated in churum of the challenges and just to do 1 to 1 visits. The participated in churum of the challenges and the care is a capplies to all treat facility residents. It comprehensive as facility must ensure treatment and care professional stand comprehensive per and the residents. Based on observation of the facility discoloration and some monitored for 2 of 2 conditions non-present and 45.  Findings include:  1. On 8/21/23 at 10 observed with numed discoloration to both hand. He was wear time. No geri sleeved that is worn on the standard in the challenges and the participation of the conditions of the challenges and the participation of the participation	of care a fundamental principle that ment and care provided to Based on the assessment of a resident, the re that residents receive e in accordance with dards of practice, the erson-centered care plan,	F 0684	I. What corrective action(s) waccomplished for those reside found to have been affected deficient practice; Residents and #45 had no adverse out related to the alleged deficient practice.  II. How other residents havin 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 affected by the alleged deficient practice. A full house skin sw	tents by the #97 comes int g the e e to be ent
	were in use.			with be completed by date of compliance to ensure all area	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155580	B. WING		08/25/2023	
		1	CTDE	ET ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		TAFT ST		
∧DEDI∩I	N CARE TOLLESTO	ON DARK		Y, IN 46404		
AI LINO	· · · · · · · · · · · · · · · · · · ·	JIV I AIKK	GAIN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		E COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		a.m., the discoloration remained		have been identified.		
	to his right arm and his right hand. The resident			III. What measures will be p	ut into	
	had a geri sleeve in place to his left arm but not			place and what systemic cha	-	
	his right. He was wearing a short sleeve shirt.			will be made to ensure that		
				deficient practice does not re		
		resident at that time, indicated		DON/designee to educate n	ursing	
		w he got the areas but they		staff on "Skin Condition		
	wanted him to wear	r the sleeves on his arms.		Assessment and		
				Monitoring-Pressure and		
		a.m., the resident was in his		Non-Pressure" to include are	eas of	
	_	eri sleeves were in use and he		discoloration and scabbing.		
	was wearing a short sleeve shirt. The			IV. How the corrective action	` '	
	reddish/purple discoloration remained to both of			will be monitored to ensure		
	his arms and his right hand.			deficient practice will not rec	ur	
				i.e., what quality assurance		
		ident 97 was reviewed on		program will be put into place		
	_	. Diagnoses included, but were		DON/designee to conductra		
	_	gestive heart failure, chronic		visual observation rounds th		
	_	ary disease (COPD), and renal		times weekly times 4 weeks	, then	
	dialysis.			weekly times 4 weeks, then		
	TI C' 'C' . CI	Mili D. (G. (MDG)		monthly x 4 months to ensur	-	
	_	ange Minimum Data Set (MDS)		areas of discoloration or sca	bbing	
		5/22/23, indicated the resident		have been identified.		
		paired for daily decision making		The results of these audits v		
	-	ensive assistance with bed d assistance with transfers.		reviewed in Quality Assuran		
	inobility and minite	d assistance with transfers.		Meeting monthly for 6 month	is of	
	The resident did no	t have a care plan related to		until an average of 90%	iovod	
	the bruising.	it have a care plan related to		compliance or greater is act x4 consecutive weeks. The		
	the oransing.			Committee will identify any t		
	Δ Physician's Orde	r, dated 8/21/23, indicated the		or patterns and make	rends	
		e geri sleeves to his bilateral		recommendations to revise	·he	
		r preventative care. The		plan of correction as indicate		
		moved for hygiene purposes.		plan of conscion as indicate	,u.	
	Siccios conta de lei	ine rea for hygiene purposes.				
	A Weekly Skin ass	essment, dated 8/15/23,				
		ent's skin was intact. No areas				
	of bruising were do					
	li simbing were do					
	There was no order	to monitor the discoloration to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/25/2023 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY, IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the resident's bilateral arms and hands. Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated LPN 3 was instructed on 8/21/23 to get an order for geri-sleeves and to complete a skin assessment related to the areas of discoloration.2. On 8/21/23 at 10:33 a.m., Resident 45 was observed with a left swollen foot, scabs were present on the second toe, fourth toe, and inner left ankle. The resident indicated he told the staff he wanted to go to the emergency room. Resident 45 was sent to the emergency room on 8/21/23. The record for Resident 45 was reviewed on 8/23/23 at 11:00 a.m. Diagnoses included, but were not limited to, hyperlipidemia, chronic obstructive pulmonary disease, cellulitis of unspecified part of the limb, amputation of left great toe, hypertension, and peripheral vascular disease. The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/23, indicated the resident required limited assistance with bed mobility, transfers, dressing, eating, toileting, and bathing. A Care Plan, dated 8/1/23, indicated the resident was on antibiotic therapy related to cellulitis. A Physician's Order, dated 8/22/23, indicated to monitor the scab to the left ankle every shift, to monitor the scab to the left foot inner, every shift, to monitor the scab to the left foot 4th toe every shift for changes. Skin Observations, from 8/11/23 through 8/21/23,

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indicated "not applicable, none of the above observed, or resident not available". There was no

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/25/2023 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK GARY, IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE documentation of swelling to the left foot, scrapes to the second left toe, fourth toe, or inner ankle. A Discharge Summary, dated 8/21/23, indicated Resident 45 had an amputation of the left great toe, excoriations (raw or irritated skin), on the medial aspect of the left foot, and erythema (redness) of the left foot, the left lower leg, the right lower leg, and the right foot. Interview with the Director of Nursing (DON) on 8/24/23 at 2:50 p.m., indicated she wanted to go see the foot scabs on the resident's foot for herself, and she would get the assessment from the ER visit the day before. During a follow up Interview with the DON on 8/25/23 at 8:54 a.m., she provided the hospital assessment of Resident 45's foot and indicated the resident cellulitis is probably why the foot looked scabbed. Skin assessments by staff should have indicated what was seen on the skin. A facility policy titled, "Skin Condition Assessment & Monitoring - Pressure and Non-Pressure", provided as current by the DON on 8/25/23 at 11:10 a.m., indicated... " Nonpressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc,) will be assessed for healing progress and signs of complications or infection weekly". The "Skin Condition Assessment & Monitoring" policy also indicated, ... "A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse".

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /	(X2) MULTIPLE CONSTRUCTION (X3) DAT					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		155580	B. WING 08/25/2023					
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0689	483.25(d)(1)(2)							
SS=D	Free of Accident							
Bldg. 00	Hazards/Supervisi							
	§483.25(d) Accide							
	The facility must e							
	- ',','	e resident environment f accident hazards as is						
	possible; and	accident nazards as is						
	possible, and							
	8483 25(d)(2)Fact	h resident receives						
	- ',','	sion and assistance devices						
	to prevent acciden							
	•	on, record review, and	F 0689		I. What corrective action(s) will be		09/22/2023	
		ty failed to ensure fall		accomplished for the			05/22/2023	
	precautions were in	place for a resident with a			found to have been affected b			
		of 2 residents reviewed for			deficient practice; Resident #52			
	accidents. (Resident	t 52)			had no adverse outcomes rela	ited		
					to the alleged deficient practic	e.		
	Finding includes:				II. How other residents having	the		
					potential to be affected by the			
		5 a.m., Resident 52 was			same deficient practice will be			
	_	n her room reaching towards			identified and what corrective			
		She was dressed in only a			action(s) will be taken; All			
		wearing plain gray socks. The			residents have the potential to			
		a non-skid surface. Her gown			affected by the alleged deficie	nt		
	_	er shoulder and she was			practice; DON/designee to			
		t. She was attempting to walk			complete a 100% fall intervent	tion		
		s redirected by the surveyor to			audit by 9/29/23. span="">			
		e bed. The resident's breakfast			III. What measures will be put			
	over bed table.	already finished, was on the			place and what systemic chan	-		
	over bed table.				will be made to ensure that the deficient practice does not	<del>5</del>		
	On 8/24/23 at 8.40 a	a.m., the resident was observed			recur;DON/designee to re-edu	ıcate		
		s closed and dressed in a			nursing staff on ensuring fall	ioaio		
		0:05 a.m., she was still in bed			interventions are in place as			
		losed. The head of the bed			preventative measures.			
	· ·	er head was leaning to one			IV. How the corrective action(s	s)		
		tray was placed in front of her			will be monitored to ensure the	•		
	on the over bed tabl				deficient practice will not recur			
on the over bed table.				i e what quality assurance				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/25/2023 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The record for Resident 52 was reviewed on program will be put into 8/24/23 at 11:30 a.m. Diagnoses included, but were place;DON/designee will conduct not limited, major depressive disorder, high blood a fall intervention audit as follows: pressure, hallucinations, bipolar disorder, Audits will be completed on 10 dementia, and catatonic disorder. residents at risk for falls weekly for 8 weeks, then 10 residents The 7/7/23 Significant Change Minimum Data Set monthly x 4 months (MDS) assessment indicated the resident was not The results of these audits will be cognitively intact. The resident was a limited reviewed in Quality Assurance assist with a 2 person physical assist for transfers Meeting monthly for 6 months or and for walking in the room. There were no history until an average of 90% of falls since the last assessment. compliance or greater is achieved x4 consecutive weeks. The QA A Care Plan, revised on 8/25/23, indicated the Committee will identify any trends resident was at risk for falls. The approaches were or patterns and make to follow the facility's fall protocol and to educate recommendations to revise the the staff to assist the resident to get up by plan of correction as indicated. breakfast. The 6/5/23 Fall Risk Assessment, indicated the resident was a high risk for falls. A Fall-Initial Occurrence Note, dated 6/5/23 at 10:50 a.m., indicated the resident had an unwitnessed fall in her room by the bed. The sheets were off of the bed and under the resident. A Fall IDT Note, dated 6/6/23 at 8:52 a.m., indicated the root cause of the fall was the resident attempted to self transfer herself and she required assistance with transfers. An intervention was included on the Care Plan which was to educate the staff on having the resident up and dressed and in the wheelchair by breakfast. Interview with the Director of Nursing (DON) on 8/24/23 at 2:00 p.m., indicated the resident was

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supposed to be up and dressed by breakfast and for her safety, to have non-skid socks on her feet.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
		155580	B. WING 08/25/2023				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	Ł		2350 T/	AFT ST		
APERION	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG		ised 11/21/17 "Fall Prevention		TAG	DEFICIENCY		DATE
		rovided by the DON on 8/25/23					
		ated fall/safety interventions					
		re not limited to: footwear					
	-	to ensure the resident had					
		and/or footwear was non					
	skid.						
	3.1-45(a)(2)						
F 0694	483.25(h)						
SS=D	Parenteral/IV Fluid	ds					
Bldg. 00	§ 483.25(h) Paren						
	- ' '	nust be administered					
	consistent with pro	ofessional standards of					
	practice and in ac	cordance with physician					
	orders, the compr	ehensive person-centered					
	-	resident's goals and					
	preferences.						
		on, record review, and	F 00	594	I. What corrective action(s) wil		09/22/2023
		ty failed to care for a PICC line			accomplished for those reside		
		ed central catheter, intravenous			found to have been affected b	-	
	_	the peripheral veins of the			deficient practice; Resident #3		
		dance with professional			orders were reviewed and rev	isea	
	_	e, related to flushing the PICC ents reviewed for intravenous			as appropriate.	tho	
	care. (Resident 379)				II. How other residents having potential to be affected by the		
	care. (Resident 377)	,			same deficient practice will be		
	Finding includes:				identified and what corrective		
	<i>6</i>				action(s) will be taken; Any		
	On 8/23/23 at 9:02	a.m., LPN 2 was observed			resident receiving IV medication	on	
		to Resident 379. He prepared			has the potential to be affected		
		tibiotic medication) 2 grams.			the alleged deficient practice.	•	
	He primed new intr	avenous (IV) tubing, cleaned			resident with a PICC line will h	-	
		PICC access lumen with an			their orders reviewed and revi		
	· · · · · · · · · · · · · · · · · · ·	ed the PICC with 5 milliliters			as needed by date of complian		
		ne, attached the IV tubing			III. What measures will be put		
		oime, and started the IV			place and what systemic chan		
	infusion.				will be made to ensure that the		
					deficient practice does not rec	ur;	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			ETED	
		155580	B. WING 08/25/2023			2023	
				CTD FET.	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
ADEDION	LOADE TOLLEGE			2350 TA			
APERIO	N CARE TOLLESTO	JN PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	At 9:44 a.m., LPN 2	2 was observed disconnecting			DON/designee will educate nu	ırses	
	the IV tubing after t	the medication had completed			on following physicians orders		
	_	ed the PICC with 5 ml of normal			regarding PICC line care.		
	-	PICC with 5 ml of heparin (an			IV. How the corrective action(s	3)	
		applied a new cap to the			will be monitored to ensure the	,	
	lumen.				deficient practice will not recur		
					i.e., what quality assurance		
	Resident 379's reco	rd was reviewed on 8/23/23 at			program will be put into place;		
		es included, but were not limited			DON/designee will conduct au		
	_	rpe 2 diabetes mellitus, and			on residents with PICC lines to		
	hypertension.	1			ensure the nurse is following	-	
	пуретиныны				physicians orders related to		
	A Physician's Order	r, dated 8/19/23, indicated			flushes. Audits will be conduct	-ed	
	•	s) every 12 hours (9 a.m. and 9			on 5 residents a week x 8 wee		
	p.m.) intravenously				then 5 residents a month x 4	,no,	
	p.m.) maravenously	101 20 days.			months		
	A Physician's Order	r, dated 8/22/23, indicated			The results of these audits will	l ho	
	•	5 ml intravenously every 12			reviewed in Quality Assurance		
	hours (9 a.m. and 9				Meeting monthly for 6 months		
	nours (5 u.m. una 5	p.iii.).			until an average of 90%	Oi	
	A Physician's Order	r, dated 8/22/23, indicated			compliance or greater is achie	hav	
		travenously every 12 hours (9			x4 consecutive weeks. The Q		
		here were no Physician's			Committee will identify any tre		
		he PICC was to be flushed with			or patterns and make	iius	
		ter the administration of the			recommendations to revise the	•	
	antibiotic medication						
	antibione medicalic	<i>7</i> 11.			plan of correction as indicated	•	
	The Medication Ad	ministration Record (MAR),					
		ated the cefepime had been					
		ered starting on 8/19/23.					
		imented saline or heparin					
		•					
	flushes to the PICC	inic utiti 6/22/23.					
	Intomious with the	Director of Nursing (DON) on					
		<b>Q</b> \					
	-	., indicated LPN 2 had					
		edication and flushed the PICC					
	-	the orders for the flushes had					
		computer late and incorrectly.					
		ushed the PICC with saline					
	before and after eac	ch antibiotic administration,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER						X3) DATE SURVEY COMPLETED	
711.12.12.11	o. commenon	155580	B. WING 08/25/2023				
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
3333	and then flushed wi 3.1-47(a)(2)						
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such oprofessional stand comprehensive pethe residents' goal 483.65 of this sub Based on observation interview, the facility respiratory care and the correct flow rate for oxygen. (Resident Findings include:  1. On 8/21/23 at 10 observed with oxygicannula in use. The concentrator was seen on 8/22/23 at 9:19 was wearing his oxygen concentrator. On 8/23/23 at 7:55 room in bed. His or use and the concentration.	e and tracheal suctioning, eare, consistent with lards of practice, the erson-centered care plan, its and preferences, and part.  on, record review, and ty failed to provide proper its ervices related to oxygen at er for 2 of 2 residents reviewed ents 37 and 35)  on, Resident 37 was en by the way of a nasal eresident's oxygen that 3 1/2 liters.  a.m. and 2:10 p.m., the resident and his rewas set at 3 1/2 liters.  a.m., the resident was in his and the resident was in the main dining was in use and his portable	F 0695	5	I. What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; Resident #3 and #35 oxygen concentrators set at the correct liter flow rate. Neither resident has any adveoutcomes related to the allege deficient practice.  II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who receive oxygen the potential to be affected by alleged deficient practice. All residents with oxygen were audited to ensure the settings at the correct liter flow rate.  III. What measures will be put place and what systemic chan will be made to ensure that the	the have the into ges	09/22/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETE			ETED	
		155580	B. W	'ING	_	08/25	/2023
N	NOTHER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	Z.		2350 T/			
APERIO	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	0:- 9/24/22 -+ 0:16	4hi d i h i -			deficient practice does not rec		
		a.m., the resident was in his g. His oxygen was in use and			DON/designee to educate nur	sing	
	-	s set at 1 1/2 liters. At 10:27			staff on following physicians orders for the correct oxygen I	litor	
		as in the main dining room.			flow rate.	iilei	
		use and his portable oxygen			IV. How the corrective action(s	s)	
	tank was set at 4 lite				will be monitored to ensure the	•	
	Set at 1 IIt				deficient practice will not recui		
	The record for Resi	dent 37 was reviewed on			i.e., what quality assurance		
		. Diagnoses included, but were			program will be put into place;		
		entia without behavioral			DON/designee will conduct ar		
		mer's disease, congestive heart			oxygen audit to ensure correc		
	failure, and chronic	obstructive pulmonary			liter flow rate. Audits will be		
	disease (COPD).				conducted on 10 residents a v	veek	
					x 4 weeks then 10 residents a		
	-	ange Minimum Data Set (MDS)			month x 5 months		
		/19/23, indicated the resident			The results of these audits wil		
		paired for daily decision making			reviewed in Quality Assurance		
		g oxygen while a resident of			Meeting monthly for 6 months	or	
	the facility.				until an average of 90%		
	The medial 4 1: J	t horre a Come Dlan1-4-14-			compliance or greater is achie		
		t have a Care Plan related to			x4 consecutive weeks. The Q		
	oxygen use.				Committee will identify any tre	iius	
	A Physician's Order	r, dated 7/6/23, indicated the			or patterns and make recommendations to revise the	Δ.	
		oxygen at 2 liters per nasal			plan of correction as indicated		
		to 4 liters to maintain oxygen			plan of correction as indicated	1.	
		0% every 8 hours as needed					
	(PRN) for preventar						
	. , ,						
	A Physician's Order	r, dated 7/7/23, indicated the					
	resident was to rece	ive oxygen at 2 liters per nasal					
	cannula continuous	ly.					
	The state of	CN					
		Director of Nursing on 8/24/23					
	-	ted the resident's oxygen order					
		ed. 2. During random 1/23 at 10:55 a.m. and 3:02					
		5 a.m. and 2:20 p.m., and 8/23/23 ent 35 was observed wearing					
	a. 0.50 a.m., reside	and a straig observed wearing	1		i		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or condition	155580	B. WING		08/25/2023
NAME OF F	PROVIDER OR SUPPLIER	₹	STREET A 2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST	
APERIO	N CARE TOLLEST	ON PARK	GARY,	IN 46404	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG	oxygen per a nasal	cannula. The flow rate was set ute via the concentrator tank.	TAG		DATE
	a wheelchair in his wearing his oxygen connected to a port	p.m., the resident was seated in room. He was observed a per nasal cannula and it was able tank hanging on the back. The oxygen tank was set on 2			
	sitting on the side of breakfast. He was of cannula in his nose	a.m., the resident was observed of the bed, waiting for observed with the nasal and the tubing was connected tank, however, the oxygen			
	observed lying in b	5 a.m., the resident was ed and he was awake. The or was turned on and the flow iters per minute.			
	8/22/23 at 1:52 p.m the facility on 8/1/2 were not limited to,	dent 35 was reviewed on  The resident was admitted to  January and Diagnoses included, but stroke, chronic obstructive (COPD), and high blood			
	assessment, dated 8	nimum Data Set (MDS) 5/8/23, indicated the resident r intact. The resident received dent.			
	A Care Plan, dated had COPD.	8/2/23, indicated the resident			
	Physician's Orders, at 3 liters per nasal	dated 8/2/23, indicated oxygen cannula.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/25/2023			
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD FAFT ST , IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0698	Interview with the I	Director of Nursing on 8/24/23 ted the resident's oxygen was to			5.112
SS=D Bldg. 00	Dialysis §483.25(I) Dialysis The facility must e require dialysis re- consistent with pro practice, the comp care plan, and the preferences. Based on record rev failed to monitor a f receiving hemodialy reviewed for dialysis Finding includes:  The record for Resi 8/24/23 at 9:45 a.m not limited to, end s dependence on rena The 7/26/23 Quarte assessment indicate intact and received he The approaches wer (dialysis access por shift and record and	ensure that residents who believe such services, of pressional standards of prehensive person-centered a residents' goals and when and interview, the facility fluid restriction for a resident sysis for 1 of 1 residents is. (Resident 46)  I dent 46 was reviewed on a Diagnoses included, but were stage renal disease and	F 0698	I. What corrective action(s) wil accomplished for those reside found to have been affected by deficient practice; Resident II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident on a fluid restriction in the potential to be affected by cited practice. An audit was completed on any resident on fluid restriction to ensure their restriction is being monitored a per orders.  III. What measures will be put place and what systemic chan will be made to ensure that the deficient practice does not recur; DON/designee to educa nurses on documenting the amount of fluid the resident consumed as per physicians	ents y the the a fluid as into ages e
	-	rday. Provide a renal, no		orders.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPI 08/25		
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP CO AFT ST , IN 46404	OD .	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		
TAG	added salt regular to proteins every meal restriction with 600  The Treatment and Records (TAR) and indicated there was restriction was mon  Interview with the I at 2:00 p.m., indicate to indicate how the fluid restriction.  The current 2017 "F provided by the Dir 11:10 a.m., indicate typically ordered in which then must be dining services, and allowed at meals was individual's meal car recommended to incommended to incomm	exture diet. Serve double and follow a 1.8 liter fluid milliliters (ml) every shift.  Medication Administration (MAR) for 7/2023 and 8/2023, no documentation the fluid itored by nursing staff.  Director of Nursing on 8/24/23 and there was no documentation nurses were monitoring the  Fluid Restriction " policy, ector of Nursing on 8/25/23 at d fluid restrictions were total milliliters allowed per day divided among nursing, activities. The amount as usually indicated on the rd. Nursing services were clude the amount allocated in the MAR or an other flow	PREFIX TAG	IV. How the corrective a will be monitored to ensideficient practice will not i.e., what quality assurate program will be put into DON/designee to condition on any resident with a frestriction to ensure the allotted amount is being documented. Audits will conducted on 5 resident for 4 weeks, 2 residents for 4 weeks, then 5 resimonth x 4 months. The results of these autreviewed in Quality Ass Meeting monthly for 6 nuntil an average of 90% compliance or greater is x4 consecutive weeks. Committee will identify or patterns and make recommendations to replan of correction as incompliance or greater is x4 consecutive weeks.	action(s) sure the action(s) sure the of recur ance place; uct an audit fluid e residents I be ats a week dents a dits will be surance nonths or s achieved The QA any trends	COMPLETION DATE
SS=D Bldg. 00	Free from Unnec I Use §483.45(e) Psychology §483.45(c)(3) A psychology drug that affects b with mental proces	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any rain activities associated sses and behavior. These are not limited to, drugs in gories:				

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CENTERS FOR	MEDICARE & MEDIC				OMB	NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155580	B. WING		08/25/2023		
		10000	<u> </u>		00/20/2		
NAME OF P	ROVIDER OR SUPPLIER	8	STREET .	ADDRESS, CITY, STATE, ZIP COD			
TWINE OF T	NO VIDER OR SOLVEIEN	•	2350 T	AFT ST			
APERION	N CARE TOLLESTO	ON PARK	GARY,	IN 46404			
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	ID	I	<u> </u>	(X5)	
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			
PREFIX	•	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY (	+	DATE	
	(iv) Hypnotic						
	•	rehensive assessment of a					
	resident, the facilit	ty must ensure that					
	§483.45(e)(1) Res	sidents who have not used					
	psychotropic drug	s are not given these drugs					
	unless the medica	ation is necessary to treat a					
	specific condition	as diagnosed and					
	documented in the						
		,					
	§483.45(e)(2) Res	sidents who use					
	- ' ' ' '	s receive gradual dose					
		ehavioral interventions,					
	-	ontraindicated, in an effort					
	to discontinue the	se drugs;					
	- , , , ,	sidents do not receive					
	psychotropic drug	s pursuant to a PRN order					
	unless that medica	ation is necessary to treat					
	a diagnosed speci	ific condition that is					
		e clinical record; and					
	§483.45(e)(4) PRI	N orders for psychotropic					
	- ' ' ' '	to 14 days. Except as					
		45(e)(5), if the attending					
		. , . ,					
		cribing practitioner believes					
		te for the PRN order to be					
	-	14 days, he or she should					
	document their rat	tionale in the resident's					
	medical record an	d indicate the duration for					
	the PRN order.						
	§483.45(e)(5) PRI	N orders for anti-psychotic					
		to 14 days and cannot be					
	_	ne attending physician or					
		ioner evaluates the resident					
		eness of that medication.					
		view and interview, the facility	E 0750			00/22/2022	
		_	F 0758	I. What corrective action(s) will		09/22/2023	
	ianed to ensure thei	re was an adequate indication	1	accomplished for those reside	nts		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPL			ETED	
		155580	B. WING 08/25/2023			2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
ARERION CARE TOULECTON RARK			2350 T/				
APERIOR	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	for the use of a hyp	notic medication for 1 of 5			found to have been affected b	y the	
	residents reviewed	for unnecessary medications.			deficient practice; Resident #5	2	
	(Resident 52)				discharged from the facility on		
	, , ,				8/30/23.		
	Finding includes:				II. How other residents having	the	
	Č				potential to be affected by the		
	The record for Resi	dent 52 was reviewed on			same deficient practice will be		
		n. Diagnoses included, but were			identified and what corrective		
	not limited, major d	_			action(s) will be taken; All		
		lar disorder, dementia, and			residents who receive a hypno	otic	
	catatonic disorder.	,			medication has the potential to		
					affected by the alleged deficie		
	The 7/7/23 Signification	ant Change Minimum Data Set			practice. An audit will be		
		indicated the resident was not			completed on any resident wh	0	
	, ,	n the last 7 days, the resident			receives a hypnotic medication		
		i-anxiety medication 7 times.			ensure they have an indication		
					use.		
	There was no Care	Plan for a hypnotic medication.			III. What measures will be put	into	
		31			place and what systemic chan		
	Physician's Orders,	dated 7/26/23, indicated			will be made to ensure that the	-	
	-	notic medication) oral capsule			deficient practice does not rec		
		, give 1 capsule by mouth every			DON/designee to educate nur		
	day.				staff on ensuring any resident	-	
					receives an order for a hypnot		
	An After Care Sum	mary from the hospital, dated			drug has the indication for use		
		o continue the medication of			IV. How the corrective action(s		
	Temazepam 15 mg				will be monitored to ensure the	•	
					deficient practice will not recur		
	There was no indica	ation for the use of the			i.e., what quality assurance		
	hypnotic medication	n.			program will be put into place;		
					DON/designee will audit new		
	Interview with the I	Director of Nursing on 8/25/23			orders to ensure any hypnotic		
	at 11:10 a.m., indica	ated she had just spoken to the			drug has the indication for use		
	resident's Physician	and he discontinued the			present. Audits will be conduc		
	Temazepam.				5x a week for 4 weeks, 2x wee		
	_				for 4 weeks, weekly x 4 weeks		
	3.1-48(a)(4)				then monthly x 3 months		
					The results of these audits will	be	
					reviewed in Quality Assurance	;	
					Meeting monthly for 6 months		

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

PRINTED: 09/29/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155580		A. BUILDING B. WING	00	COMPLETED  08/25/2023	
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				until an average of 90% compliance or greater is achie x4 consecutive weeks. The C Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	nA ends e
F 0761 SS=D Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accinstructions, and the applicable.  §483.45(h) Storage §483.45(h)(1) In a Federal laws, the famous access to the keys separately locked, compartments for listed in Schedule Drug Abuse Preventage drug districted the quantity stored dose can be readilisted in Schedule compartments for listed in Schedule brug Abuse Preventage drug districted in Schedule compartments for listed in Schedule brug Abuse Preventage drug districted in Schedule brug Abuse Preventage drug drug drug drug drug drug drug drug	and Biologicals and of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include accessory and cautionary and expiration date when  e of Drugs and Biologicals accordance with State and facility must store all drugs locked compartments acreature controls, and aized personnel to have accordance with State and facility must provide accordance with State and facility must store all drugs locked compartments acreature controls, and aized personnel to have accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and facility must store all drugs locked compartments accordance with State and	F 0761	I. What corrective action(s) wi	Il be 09/22/2023
	Based on observation interview, the facility		F 0761	I. What corrective action(s) wi accomplished for those reside found to have been affected be	ents

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/25/2023 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medication rooms observed. (PCU) deficient practice; The medication in the PCU med room was Finding includes: secured as per policy. II. How other residents having the On 8/22/23 at 1:23 p.m., the PCU Medication Room potential to be affected by the was observed with LPN 1. Inside the unlocked same deficient practice will be refrigerator was a black tackle box. The box was identified and what corrective not locked. Inside the box was a medication card action(s) will be taken; All of dronabinol (Marinol) pills. Interview with LPN residents have the potential to be 1 at that time, indicated the black box was affected by the alleged deficient normally locked. She wasn't sure why it was not practice. All facility medication locked currently. She would notify the Director of rooms will be audited to ensure Nursing (DON). the proper storage of controlled substances. Interview with the DON on 8/22/23 at 1:46 p.m., III. What measures will be put into indicated earlier in the day the QMA had notified place and what systemic changes her the lock on the black box had broken. They will be made to ensure that the deficient practice does not recur; had requested a new lock from the pharmacy, and it was coming in tonight. She had asked the DON/designee will educate Maintenance staff to go to the store and get a nurses/QMA's on the policy lock until the new lock arrived from pharmacy, but "Medication Storage" to include they had not gotten to it yet. the proper storage of controlled substances. A facility policy, titled "Medication Storage," IV. How the corrective action(s) indicated, "...12. Controlled substances will be monitored to ensure the storage...12.2. After receiving controlled deficient practice will not recur substances and adding to inventory, facility i.e., what quality assurance should ensure that schedule II-V controlled program will be put into place; substances are immediately placed into a secured DON/designee will audit storage area (i.e., a safe, self-locked cabinet or medication rooms to ensure all locked room, in all cases in accordance with controlled substances are secured Applicable Law) and double locked (i.e. locked as per policy. Audits will be narcotic drawer inside locked medication cart or completed as follows: 3 locked box in locked medication room)..." Medication rooms per wk for 8 weeks, then 3 Medication Rooms The U.S. Department of Justice Drug Enforcement monthly 4 months Administration Drugs of Abuse Guide, dated The results of these audits will be 2020, indicated dronabinol was a Schedule III reviewed in Quality Assurance medication. Meeting monthly for 6 months or until an average of 90%

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	00	COMPL	
		155580	B. W	ING		08/25/	/2023
	PROVIDER OR SUPPLIER		<u> </u>	2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
F 0804 SS=D Bldg. 00	-	pear, Palatable/Prefer			compliance or greater is achie x4 consecutive weeks. The Q Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	A Inds e	
Bidg. 00	§483.60(d)(1) Foo conserve nutritive appearance; §483.60(d)(2) Foo	eives and the facility od prepared by methods that value, flavor, and od and drink that is ve, and at a safe and					
	Based on observation interview, the facility recipe for scrambles for the 1 resident with the kitchen. (Main Interview) for the 1 resident with the kitchen. (Main Interview) for the 23/23 at 7:41 appreparing the pureer donned clean gloves scoops of scrambles blender. She blender stirred the contents, the egg mixture and the blender and stirred an aluminum pan. Suppose the stirred the stirred the contents of the blender and stirred the stirred the contents.	on, record review, and ty failed to follow the puree d eggs, sausage, and waffles ho received a pureed diet from	FO	804	I. What corrective action(s) wil accomplished for those reside found to have been affected by deficient practice; Dietary Manager/designee to re-educational dietary staff on following recipion for pureed diets.  II. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident who receives an alter diet have the potential to be affected by the alleged deficient practice.  III. What measures will be put place and what systemic chant will be made to ensure that the	nts y the ate es the athe into iges	09/22/2023

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155580		l í	UILDING	onstruction 00	(X3) DATE COMPI <b>08/25</b> ,	LETED	
	PROVIDER OR SUPPLIEF			2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	added 1/2 cup of pr mixture and blende blender and stirred into an aluminum p and the utensils in t then removed 3 coot table and put them together. She and with a knife, cu butter and placed it poured a 1/2 cup of blender and mixed removed the blender poured it into a pan.  The puree scramble was to be used to provide the blender and mixed to be used to provide to ast. The puree was to be dissolved to ast. The puree was butter were to be accompleted.	ed egg recipe indicated milk repare the eggs. The puree e indicated a pork or ham base in water and used as well as ffle recipe indicated syrup and			deficient practice does not recur; Dietary Manager/design re-educate dietary staff on following recipes for pureed di IV. How the corrective action(will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary Manager/designee to observe staff preparing pureer to ensure the recipe is being followed. Audits will be conducted 5x a week x 4 weeks, 2x a week for 4 weeks, then monthly x 4 months.  The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achievad consecutive weeks. The Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated	ets. s) e d food cted ek l be or eved A nds	
F 0812 SS=F Bldg. 00		e/Prepare/Serve-Sanitary afety requirements.					
	approved or consi federal, state or lo	ocure food from sources idered satisfactory by ocal authorities. de food items obtained					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155580	B. WI	NG		08/25	/2023
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			AFT ST		
A DEDION	N CARE TOLLESTO	ON DADK			IN 46404		
AFERIO	V CARE TOLLEST	ON FARK		GAN1,	111 40404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	directly from local	producers, subject to					
	applicable State and local laws or						
	regulations.						
	(ii) This provision	does not prohibit or prevent					
	facilities from usin	ng produce grown in facility					
	gardens, subject t	to compliance with					
	applicable safe gr	owing and food-handling					
	practices.						
		does not preclude residents					
	from consuming for	oods not procured by the					
	facility.						
	.,,,,	ore, prepare, distribute and					
		ordance with professional					
	standards for food	•					
		on and interview, the facility	F 08	312	I. What corrective action(s) will		09/22/2023
		serve food under sanitary			accomplished for those reside		
		o expired food in the reach in			found to have been affected b	•	
		hood, grease build up on the			deficient practice; Expired foo		
		uching food items with a			was disposed of. The oven ho		
	1 -	e lack of hand hygiene after			was cleaned. The grease build	-	
	_	is had the potential to affect the			on the stove was removed. Co		
		received their meals from the			#1 was educated on glove use	e and	
	kitchen. (The Mair	n Kitchen)			hand hygiene.		
	E' 1' ' 1 1				II. How other residents having		
	Findings include:				potential to be affected by the		
	1 Obsamistica desi	ng the initial kitchen town on			same deficient practice will be		
		ing the initial kitchen tour, on			identified and what corrective		
		n. with the Dietary Food andicated the following:			action(s) will be taken; All residents have the potential to	, ho	
	Manager (Drwi), in	idicated the following.			•		
	a There were 2 hav	wls of pudding, dated 8/16/23,			affected by the alleged deficie	111	
	in the reach in cool				practice.  III. What measures will be put	into	
	in the reach in cool	O1.			place and what systemic chan		
	h The flour scoon y	was stored directly in the flour.			will be made to ensure that the	-	
	o. The flour scoop	Stored directly in the flour.			deficient practice does not rec		
	c. The oven hood h	ad a heavy accumulation of			Dietary manager/designee wil		
	dirt and grease note				educate dietary staff on the po		
	ant and grease note	in an are siate.			"Food Storage (Dry, Refrigera	-	
	d There was a hear	vy accumulation of grease			and Frozen). Dietary staff will		
	G. THEIC WAS A HEAV	y accumulation of grease	1		and Flozen). Dietary stall Will	aisu	1

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/25/2023 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE build up on the back splash of the stove. be educated on hand hygiene and glove use. A s e. The transportation cart that housed the dome IV. How the corrective action(s) lids for the plates was rusted out in many places. will be monitored to ensure the deficient practice will not recur Interview with the DFM at that time, indicated all i.e., what quality assurance of the above was in need of cleaning. program will be put into place; Dietary manager/designee will The current 2020 "Food Storage (Dry, conduct sanitations audits to Refrigerated, and Frozen)" policy, provided by the ensure compliance. Audits will DFM on 8/23/23 at 9:42 a.m., indicated discard include glove use and hand food that has passed the expiration date. hygiene. Audits will be completed Whipped topping prepared from a mix was to be 5x a week for 4 weeks, 2x a week discarded after 2 to 3 days. for 4 weeks, then monthly x 4 months. 2. On 8/23/23 at 7:41 a.m., Cook 1 was observed The results of these audits will be preparing the pureed meal. She donned a pair of reviewed in Quality Assurance clean gloves to both hands, however, she did not Meeting monthly for 6 months or perform hand hygiene. She added the scrambled until an average of 90% eggs to the blender and blended until smooth. She compliance or greater is achieved stirred the contents wearing the same gloves and x4 consecutive weeks. The QA with one of her gloved hands, she picked up a Committee will identify any trends piece of bread and added it to the mixture. or patterns and make After the eggs were finished, wearing the same recommendations to revise the gloves to both hands, she washed the blender in plan of correction as indicated. the 3 compartment sink. She proceeded to puree sausage and waffles wearing the same gloves and she wore them while cleaning the blender in the 3 compartment sink. She removed her gloves and threw them away, however, she did not perform hand hygiene. Cook 1 proceeded to check the temperatures of the food on the steam table with her bare hands. After completing the temperature checks, she donned a pair of clean gloves to both hands to start plating the food for breakfast and did not perform hand hygiene.

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Interview with the Dietary Food Manager on

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DEPARTMENT	FO	NTED: 09/29/2023 DRM APPROVED MB NO. 0938-039					
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	(X3) DATE SURVEY COMPLETED 08/25/2023	
	ROVIDER OR SUPPLIER		2350 T	address, city, state, zip c AFT ST IN 46404	OD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 0842 SS=D Bldg. 00	The current 2020 "If Glove Use" policy, 8/23/23 at 9:42 a.m washed before donr gloves.  3.1-21(i)(3)  483.20(f)(5), 483.7 Resident Records §483.20(f)(5) Resi (i) A facility may n is resident-identifiation (ii) The facility may resident-identifiation accordance with a agent agrees not find.	- Identifiable Information dent-identifiable information. ot release information that					

§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

itself is permitted to do so.

(iii) Readily accessible; and

(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,

regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable

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	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	IB NO. 0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155580	B. W	ING		08/25	/2023
NAME OF I	DROVIDED OD SUDDI IE	SD.		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIE	CR.		2350 TA	AFT ST		
APERIO	N CARE TOLLEST	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	operations, as per compliance with a compliance with a coversight activities proceedings, law organ donation proceedings, and to be althous a compliance with a second sec	t, payment, or health care emitted by and in 45 CFR 164.506; alth activities, reporting of or domestic violence, health as, judicial and administrative enforcement purposes, surposes, research purposes, redical examiners, funeral avert a serious threat to as permitted by and in 45 CFR 164.512.					
	retained for-						
		time required by State law; or					
	. ,	m the date of discharge					
		requirement in State law; or					
	, ,	3 years after a resident e under State law.					
	Todolios legal age	c under otate law.					
	§483.70(i)(5) The	e medical record must					
	contain-						
	` '	mation to identify the					
	resident;						
	, ,	e resident's assessments;					
		ensive plan of care and					
	services provided						
		f any preadmission sident review evaluations and					
	1 20100111119 and 10	S.S.S. I STIGIT STAINGHOID WILL	1				1

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determinations conducted by the State; (v) Physician's, nurse's, and other licensed

(vi) Laboratory, radiology and other diagnostic

professional's progress notes; and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155580	B. Wl	ING		08/25	/2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	₹			AFT ST		
APERIC	N CARE TOLLEST	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
	services reports as required under §483.50.						
	Based on record review and interview, the facility		F 08	342	I. What corrective action(s) wi		09/22/2023
	failed to maintain clinical records that were				accomplished for those reside		
	_	rately documented related to			found to have been affected b	-	
		stration and a dialysis access			deficient practice; Residents 2		
		ents reviewed for unnecessary			and 46 had no adverse outcom		
		of 1 residents reviewed for			related to the alleged deficien	t	
	dialysis. (Resident	s 24 and 46)			practice.		
	F: 1:				II. How other residents having		
	Findings include:				potential to be affected by the		
	1.00				same deficient practice will be	;	
		Resident 24 was reviewed on			identified and what corrective		
		. Diagnoses included, but were			action(s) will be taken; All	_	
		rosclerotic heart disease,			residents have the potential to		
	congestive heart far	ilure, and hypertension.			affected by the alleged deficie	ent	
	TI O ( 1 MC)	D ( C (MDC)			practice.		
		imum Data Set (MDS)			III. What measures will be put		
		5/6/23, indicated the resident			place and what systemic char	-	
		paired and he had received an			will be made to ensure that th		
	_	during the assessment			deficient practice does not red		
	reference period.				DON/designee to educate nur	rsing	
	A Dhyssician's Ondo	m dated 5/5/32 indicated the			staff on the policy for signing		
	-	r, dated 5/5/23, indicated the			controlled substances out to		
		eive Norco (a narcotic pain milligrams (mg), 1 tablet three			include MAR/flow sheet documentation. Nurses will al	00	
	times a day for chro						
	unies a day for Chro	эне раш.			be educated on the procedure	7 101	
	The August 2022 N	Medication Administration			signing out all	TAP	
	_	icated the resident's Norco was			treatments/procedures on the after completion.="" bdon=""		
	' '	ne following dates and times:			designee="" to="" educate="		
	- 8:00 a.m. on 8/5/2	· ·			nursing="" staff="" on=""		
	- 2:00 p.m. on 8/1,				the="" policy="" for=""		
	_	9, 8/20, 8/21, and 8/22/23			signing="" controlled=""		
	10.00 p.m. on 0/1	, , , , , , , , , , , , , , , , , , ,			substances="" out="" mar='		
	The Norco had bee	n signed out as being given on			and="" medication=""		
	the controlled medi				flowsheet.="" will="" also="		
	and I sha oned medi				be="" educated="" all=""		
	Interview with the	Director of Nursing on 8/25/23			procedures="" treatments="		
		ted the medication should have			tar="" when="" completed.<		
	-	the MAR as well as the			p="">		
	1 Seem Signed Out On		1		1 P '		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, ,		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED
		155580	B. WI	NG		08/25/2023
NAME OF I	PROVIDER OR SUPPLIER	· ?	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•
					AFT ST	
APERIO	N CARE TOLLESTO	ON PARK		GARY,	IN 46404	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	narcotic sheet.	11 . 46			="" bdon="" designee="" to=	
		esident 46 was reviewed on			educate="" nursing="" staff=	
	8/24/23 at 9:45 a.m. Diagnoses included, but were not limited to, end stage renal disease and				on="" the="" policy="" for="	
	dependence on rena	_			signing="" controlled=""	
	dependence on rena	ai diaiysis.			substances="" out="" mar=" and="" medication=""	
	The 7/26/23 Quarte	erly Minimum Data Set (MDS)			flowsheet.="" will="" also="	
	assessment, indicate	•			be="" educated="" all=""	
		nd received dialysis while a			procedures="" treatments="	
	resident.	na received diarysis winte a			tar="" when="" completed.<	
	Testaent.				p="">="" bdon="" designee="	
A Care Plan, revised on 8/1/22, indicated the				to="" educate="" nursing=""		
	· ·	emodialysis three times a week.			staff="" on="" the="" policy=""	
		re to check the perma cath			for="" signing="" controlled=""	
		t) site every shift and record			substances="" out="" mar=""	
	and to encourage di	· ·			and="" medication=""	
					flowsheet.="" will="" also="" be	e=""
	Physician's Orders,	dated 4/27/23, indicated			educated="" all="" procedures	
	hemodialysis three	times a week on Tuesday,			treatments="" tar="" when=""	
	Thursday, and Satu	rday. Check the site of the			completed.="" p="">IV. How tl	ne
	dialysis catheter eve	ery shift for drainage and			corrective action(s) will be	
	condition of dressir	ng, indicate: N=no drainage			monitored to ensure the defici	ent
	dressing intact and	Y=see progress note and			practice will not recur i.e., wha	at
	notify the doctor.				quality assurance program wil	I be
					put into place; DON/designee	will
		ninistration Record (TAR) for			audit narcotics flow sheets to	
		ne documentation for checking			include MAR documentation.	
	· ·	sis catheter every shift for			audits will be completed to en	sure
	_	tion of dressing, indicate:			all procedures/treatments are	
	-	ssing intact and Y=see			signed out on TAR when	
		totify the doctor was			completed. Audits will be as	4
		vas documented on the day			follows: 8 residents a week x	
		4, 8/7-8/13, 8/15, 8/17, and			weeks, 4 residents per week	<b>I</b>
		n the evening shift for 8/10,			weeks, then 4 residents month	піу х
	8/12, 8/13, 8/19, an	u 0/22/23.			4 months. ="" bdon="" designee="" to=	
	There was no doors	mentation in Nursing Progress			_	
		y drainage or anything about			educate="" nursing="" staff= on="" the="" policy="" for="	
	the catheter site.	y dramage or anything about			signing="" controlled=""	
	and cameter site.				signing= controlled=   substances="" out="" mar="	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					ОМ	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		155580	B. WING		08/25/	2023
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R	2350 T	AFT ST		
APERIO	N CARE TOLLEST	ON PARK	GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		Director of Nursing on 8/24/23		and="" medication=""		
	_	ated the nurses were incorrectly		flowsheet.="" will="" also=""		
	placing a "Y" inste	ad of a "N" for checking the		be="" educated="" all=""		
	dialysis catheter site.			procedures="" treatments=""	•	
				tar="" when="" completed.<=	=""	
	3.1-50(a)(2)			p="">="" bdon="" designee=""	1	
				to="" educate="" nursing=""		
				staff="" on="" the="" policy=""		
				for="" signing="" controlled=""		
				substances="" out="" mar=""		
				and="" medication=""		
			flowsheet.="" will="" also="" be	e=""		
				educated="" all="" procedures	=""	
				treatments="" tar="" when=""		
				completed.="" p="">		
				The results of these audits will	be	
				reviewed in Quality Assurance	)	
				Meeting monthly for 6 months	or	
				until an average of 90%		
				compliance or greater is achie	ved	
				x4 consecutive weeks. The Q	Α	
				Committee will identify any tre	nds	
				or patterns and make		
				recommendations to revise the	Э	
				plan of correction as indicated		
E 0021	492.00/:\					
F 0921 SS=E	483.90(i)	Conitany/Comfortable Carriers				
SS−E Bldg. 00		Sanitary/Comfortable Environ				
blug. 00	- ,,	Environmental Conditions				
		orovide a safe, functional,				
		of the public				
	residents, staff ar		F 0021	LIM/hat corrective action/slavill	ha	00/22/2022
		on and interview, the facility	F 0921	I.What corrective action(s) will		09/22/2023
				accomplished for those reside		
		repair related to dirty and		found to have been affected by	-	
		marred walls, stained privacy		deficient practice; Room 106-v		
		boards, and improper storage		were repaired, rust stains rem		
	or wash basins and	bed pans for 3 of 3 units.		from bathroom floor, bedpan a	ına	

FORM CMS-2567(02-99) Previous Versions Obsolete

(North, South and PCU)

Event ID:

5Z4Q11

Facility ID: 008505

basin and cleaned stored properly. Room 111-spillage on

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155580	B. W	ING		08/25/	2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		2350 TA			
ADEDIO	N CARE TOLLESTO				IN 46404		
AFERIO	V CARE TOLLEST	JN FARK		GART,	IN 40404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				tube feeding pump cleaned, ce	eiling	
					cleaned, walls repaired, black		
	During the environmental tour with the				discoloration removed, bathroo	om	
	Maintenance and Housekeeping Supervisors on				floor cleaned, rust removed fro	om	
	8/25/23 at 1:12 p.m., the following was observed.				tile around toilet. Room		
					112-bathroom floor cleaned; w	/alls	
	1. North Unit				repaired. Room 113-bathroor	n	
					ceiling fan cleaned. Room		
	· ·	e room walls and bathroom			119-privacy curtain cleaned,		
		There were rust stains on the			baseboards cleaned, tile floor		
	floor around the toi	let and there was a yellow			cleaned, bathroom floor cleane	ed.	
	bedpan and pink wa	ash basin on the floor under			Room 120-floor tile		
		room. The bed pan was placed			cleaned/replaced, walls repair	ed,	
	inside the wash bas	in. There were 2 residents in			bathroom floors cleaned. Was	h	
	the room and shared	d the bathroom.			basin replaced and stored		
					properly; knobs placed on clos	et	
		e tube feeding pole located next			doors. Room 121-floors		
		ube feeding spillage on the			cleaned/repaired, walls marred	d,	
		o dried tube feeding on the			floor tiles in bathroom		
	_	be feeding pump. The wall			cleaned/repaired. Room 123-	wall	
		narred and there was black			repaired, walls cleaned, baseb	oard	
		e tile floor under the oxygen			repaired, bathroom floor /walls	;	
		oathroom floor was scuffed			cleaned, caulk repaired around	b	
	<u>-</u>	as rust on the floor tile located			bathroom sink. Room 127- tile		
		Two residents resided in the			cleaned, overbed table cleane	d,	
	room and shared the	e bathroom.			knob replaced on closet door,		
					bathroom tile cleaned/repaired		
	· ·	e bathroom floor was scuffed			privacy curtain cleaned. Roon		
		The walls in the room were			129- privacy curtain cleaned, t		
		ents resided in the room and			cleaned, bathroom walls repai	red,	
	shared the bathroon	n.			rust removed from cold water	knob	
					on sink, baseboards cleaned.		
		e bathroom ceiling vent was			Room 205- walls/tile repaired,		
	dusty. Two resident	ts shared the bathroom.			bathroom tile cleaned. Room		
					312-walls repaired, bed side s	tand	
		e privacy curtain was soiled			replaced.		
		There was an accumulation of			II. How other residents having	the	
		build up along the baseboard			potential to be affected by the		
		m. The tile floor throughout			same deficient practice will be		
	the room was dirty.	The bathroom floor tile was			identified and what corrective		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W	ING		08/25	/2023
			1	CTDEET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIEF	₹		2350 TA	ADDRESS, CITY, STATE, ZIP COD		
∧DEDI∩•	N CARE TOLLESTO				IN 46404		
AFERIUI	N CARE TULLEST			GART,	IIN 40404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dirty with a black substance underneath the sink				action(s) will be taken; The		
	and around the toilet. Two residents resided in				Maintenance		
	the room and shared the bathroom.				Director/Housekeeping Super	visor	
				performed a 100% audit of the			
	f. In Room 120, the floor tile throughout the room				facility regarding any needs fo	r	
		ty. The bathroom floor was			wall repair, cleaning of tube		
	_	were marred. A wash basin			feeding spillage, and overall		
		oor underneath the bathroom			condition of each room. =""		
		e present on the closet doors.			span="">		
		led in this room and shared the			="" b="">		
	bathroom.				III. What measures will be pu		
					into place and what systemic	C	
		e floors were dirty and stained.			changes will be made to		
		marred. The floor tile in the			ensure that the deficient		
		ed and dirty. Two residents			practice does not recur;		
	resided in the room	and shared the bathroom.			Administrator/designee to		
					educate Maintenance		
		e wall behind bed 1 was marred.			Director/Housekeeping		
		was observed on the wall next			Supervisor on ensuring a		
		. The baseboard was pulling			comfortable environment for	•	
	away from the wall				all residents to include wall		
	_	g unit. The bathroom floor			repairs, painting and		
		ack substance. There was also			cleanliness.="" b=""> ="" b="">		
		room floors and walls. The			1	·/-\	
		and paint was peeling around A dark substance was			IV. How the corrective action will be monitored to ensure t		
		e base of the toilet. Two				-	
		the room and shared the			deficient practice will not rec	ur	
	bathroom.	the room and shared the			i.e., what quality assurance program will be put into place	٠٠.	
	batinoom.				Maintenance Director/design		
	i In Room 127 the	e tile floor throughout the room			will audit 5 resident rooms a		
		ed. The base of the overbed			5 common area weekly for a		
		a thick accumulation of a black			necessary repairs. Audits wi	-	
		was missing on the closet			be completed x 6 months.=""		
		throughout the bathroom was			b="">		
		The privacy curtain was			The results of these audits w	vill	
		ood spillage. Two residents			be reviewed in Quality		
		and shared the bathroom.			Assurance Meeting monthly	for	
	1351aca in tins 100ii	Sharea are outinoons.			6 months or until an average		
	i. In Room 129 the	e privacy curtain was stained.			of 90% compliance or greate		
1	ı ,, un	1	1		1 Du /u dupiiailou di gicatt		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  08/25/2023	
	ROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  room was dirty, stained, and	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  is achieved x4 consecutive	(X5) COMPLETION DATE
	had an accumulation walls were marred at The cold water knot accumulation of rust accumulation of direct baseboard in the baseboard.	The tile floor in the room was dirty, stained, and an accumulation of crumbs. The bathroom walls were marred and the floor tile was stained. The cold water knob on the sink had an accumulation of rust build up. There was an accumulation of dirt and debris along the baseboard in the bathroom. Two residents resided in the room and shared the bathroom.		weeks. The QA Committee videntify any trends or patter and make recommendations revise the plan of correction indicated.	ns s to
	The wall next to the marred. A piece of bathroom. The floor	vall behind bed 1 was marred. e side of the bed was also floor tile was missing in the or tile in the bathroom was tine odor was present. One this room.			
		vall behind bed 1 was marred. A g from the bed side stand. Two this room.			
	all of the above wer repair. The Houseko the floor stripper wa	Maintenance and ervisors at that time, indicated re in need of cleaning and eeping Supervisor indicated as broken and they were ne and it should be delivered			
	This Federal tag rel	ates to Complaint IN00415961.			
F 0000	3.1-19(f)				
F 9999					
Bldg. 00	3.1-14 PERSONNE	EL	F 9999	. What corrective action(s) wil	ll be 09/22/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5Z4Q11

Facility ID: 008505

If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  08/25/2023			
NAME OF T	DROUDER OF CURRY WA		STREET	TADDRESS, CITY, STATE, ZIP COD	•			
NAME OF F	PROVIDER OR SUPPLIEF	<b>K</b>		TAFT ST				
APERION CARE TOLLESTON PARK			GARY, IN 46404					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP				
TAG			TAG	DEFICIENCY)	DATE			
	(k) There shall be an organized ongoing inservice education and training program planned in			accomplished for those residuand to have been effected	<b>I</b>			
				found to have been affected	-			
				deficient practice; CAN 1, A	-			
	advance for all personnel. This training shall include, but not be limited to, the following:			Aide 3, Housekeeper 1 and	<b>I</b>			
	(1) Residents' rights.			1 will have all training completed by date of compliance				
	(1) Residents rights. (5) Needs of specialized populations served.			II. How other residents having the				
	(6) Care of cognitively impaired residents.			potential to be affected by the	-			
				same deficient practice will				
	(u) In addition to the required inservice hours in			identified and what corrective	<b>I</b>			
	` ′	who have regular contact with		action(s) will be taken; The				
		a minimum of six (6) hours of		director will compete a 100%	<b>I</b>			
		raining within six (6) months of		on all employees to ensure their				
	•	or within thirty (30) days for		annual/new hire training has been				
		to the Alzheimer's and		completed by date of compliance.				
	dementia special care unit, and three (3) hours			III. What measures will be p	l l			
	annually thereafter to meet the needs or			place and what systemic changes				
	preferences, or both, of cognitively impaired			will be made to ensure the				
	residents and to gain understanding of the current			deficient practice does not				
	standards of care for residents with dementia.			recur; ="" b="">The HR director				
	This rule was not met as evidenced by:			will compete a 100% audit of				
				employees to ensure their				
				annual/new hire training has been				
	Based on record review and interview, the facility			completed.				
	failed to ensure annual resident rights, abuse			IV. How the corrective action	n(s)			
	training, and dementia training was completed for		will be monitored to ensure th		the			
	4 of 5 employee records reviewed. (CNA 1,			deficient practice will not recur				
	Activity Aide 3, Housekeeper 1, and QMA 1)			i.e., what quality assurance				
	Findings include:  The employee records were reviewed on 8/25/23 at			program will be put into place	ce; HR			
				Director will conduct an emp	oloyee			
				training audit as follows: All	<b>I</b>			
				hire employee training to be	<u> </u>			
1:10 p.m., and indicated the following:			audited weekly x 6 months and 10					
			current employee training fil					
a. CNA 1, hired on 9/25/20, had only completed 1				completed each week until 100%				
hour of annual dementia training for 2022.				compliant. ="" b="">				
			The results of these audits v					
b. Activity Aide 3, hired on 5/5/21, had only			reviewed in Quality Assuran	<b>I</b>				
completed 2 hours of annual dementia training for 2022.				Meeting monthly for 6 month	hs or			
			1	until an average of 90%				

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

PRINTED: 09/29/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/25/2023		
NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK			STREET ADDRESS, CITY, STATE, ZIP COD 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		PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	c. Housekeeper 1, hired on 12/15/18, did not complete annual training for resident rights, abuse or dementia for 2022.  d. QMA 1, hired on 1/5/21, did not complete annual training for resident rights, abuse or dementia for 2022.  Interview with the Human Resource Director on 8/25/23 at 1:50 p.m., indicated she was aware the above employees did not complete the required annual training for 2022.				compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5Z4Q11 Facility ID: 008505 If continuation sheet Page 52 of 52