STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	06/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00405274, IN00410278, and IN00411300. Complaint IN00405274 - Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00410278 - No deficiencies related to the allegations are cited. Complaint IN00411300 - Federal/state deficiencies related to the allegations are cited at F568, F657, and F688. Survey dates: June 29 and 30, 2023 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 125 Total: 125 Census Payor Type: Medicare: 8 Medicaid: 115 Other: 2 Total: 125 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/5/23.	F 0000		
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records.			

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

Amy Maurice | Administrator | 07/21/2023

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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	(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on record review and interview, the facility failed to ensure quarterly statements were provided for 2 of 3 residents reviewed for personal funds. (Residents G and D) Findings include: 1. The personal funds review was completed with the Financial Coordinator on 6/30/23 at 1:08 p.m. The Financial Coordinator indicated the facility handled Resident G's funds. Statements were provided quarterly to the residents or their Responsible Party. The record for Resident G was reviewed on 6/29/23 at 11:25 a.m. Diagnoses included, but were not limited to, dementia, anxiety, and schizophrenia. The Annual Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was cognitively impaired for daily decision making. Interview with the Financial Coordinator on 6/30/23 at 1:10 p.m., indicated the quarterly	F 0568	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents D and G have received updated copies of their statements. **2) How the facility identified**	07/28/2023

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	statements from December 2022 through March 2023 were mailed yesterday, however she didn't have any documentation of any other statements being sent to the resident's Responsible Party. She indicated she was putting a new plan in place to keep a log of the statements that were mailed out. Information provided by the Administrator on 6/30/23 at 2:35 p.m., indicated the last documentation about a quarterly statement being mailed to the resident's Responsible Party was dated 7/28/22. 2. The personal funds review was completed with the Financial Coordinator on 6/30/23 at 1:08 p.m. The Financial Coordinator indicated the facility handled Resident D's funds. Statements were provided quarterly to the residents or their Responsible Party. The closed record for Resident D was reviewed on 6/29/23 at 11:30 a.m. Diagnoses included, but were not limited to, dementia,, anxiety disorder, and paranoid schizophrenia. The Discharge Minimum Data Set (MDS) assessment, dated 6/18/23, indicated the resident was severely cognitively impaired for daily decision making. Interview with the Financial Coordinator on 6/30/23 at 1:10 p.m., indicated the quarterly statements from December 2022 through March 2023 were mailed yesterday, however she didn't have any documentation of any other statements being sent to the resident's Responsible Party. She indicated she was putting a new plan in place to keep a log of the statements that were mailed out.		**other residents:** An updated statement was sent to all residents on June 29th. This information has been documented on the RFMS statement log. **3) Measures put into place/ System changes:** BOM has been educated on the requirement for the individual financial record to be available to the resident through quarterly statements and upon request. A log has been created to track the financial statements as they are sent and or received by the resident or responsible party. **4) How the corrective actions will be monitored:** An audit of the aforementioned log will be completed by the Administrator or designee on a monthly basis. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Information provided by the Administrator on 6/30/23 at 2:35 p.m., indicated the last documentation about a quarterly statement being mailed to the resident's Responsible Party was dated 7/28/22. This Federal tag relates to Complaint IN00411300. 3.1-6(g)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment,			

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	including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure residents were invited to their Care Plan conferences for 2 of 3 residents reviewed for care planning. (Residents D and H) Findings include: 1. Resident D's record was reviewed on 6/29/23 at 11:30 a.m. Diagnoses included, but were not limited to chronic obstructive pulmonary disease (COPD), diabetes mellitus, and dementia. The Discharge Minimum Data Set (MDS) assessment, dated 6/18/23, indicated the resident was severely cognitively impaired for daily decision making. There was no documentation indicating the resident had been invited to her Care Conference after her 10/27/22 Quarterly MDS, 12/28/22 Quarterly MDS, and 3/28/23 Annual MDS assessments were completed. Interview with Social Services Director 2 (SSD 2) on 6/20/23 at 10:25 a.m., indicated the front desk used to send out the invitations to the Care Conferences, but the system they had used previously had failed. They were working on a new system and the Social Services Department was going to be solely responsible for the care plan meetings going forward. The resident's representative was last sent an invitation for a Care Conference in February of 2021. 2. Interview with Resident H on 6/29/23 at 10:00 a.m., indicated he had not been to any care plan meetings.	F 0657	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Care plan meetings with Responsible Parties were held for resident D and H. **2) How the facility identified other residents:** A review of all resident assessments in the last 90 days has been completed. Any resident or family not present for the most recent care plan review was invited via phone or mail. **3) Measures put into place/**	07/28/2023

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	The record for Resident H was reviewed on 6/29/23 at 9:00 a.m., Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, cerebral infarction (stroke), and prostate cancer. The Annual Minimum Date Set (MDS) assessment, dated 3/28/23, indicated the resident was cognitively intact for daily decision making. There was no documentation indicating the resident had been invited to his Care Conference after his 8/2/22 Quarterly MDS, 11/2/22 Quarterly MDS, 12/28/22 Quarterly MDS, 3/28/23 Annual MDS, and 5/23/23 Quarterly MDS assessments were completed. Interview with Social Service Director 1 (SSD 1) on 6/29/23 at 3:01 p.m., indicated that the last Care Conference should have been in May of 2023. He was currently performing an audit to check those that may have been missed. Interview with Social Service Director 2 (SSD 2) on 6/30/23 at 9:23 a.m., indicated the front desk sent out the invitations based off of the MDS calendar. They were just made aware that the invitations were not sent. Interview with Director of Nursing (DON) on 6/30/23 at 2:05 p.m., indicated she was aware that residents were missed for Care Conferences. This Federal tag relates to Complaint IN00411300. 3.1-35(d)(2)(B)		**System changes:** Social Service Directors been educated on the policy/ requirement for residents and or resident's representative to be invited to attend the scheduled meetings to review the comprehensive care plan. A copy of the care plan letters will be retained in the resident's record. **4) How the corrective actions will be monitored:** An audit has been put in place to ensure monthly invitations are sent as required. Social Services or designee will complete this audit monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer			

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	§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing, related to not obtaining treatment orders for a deep tissue injury (DTI) for 1 of 3 residents reviewed for pressure ulcers. (Resident J) Finding includes: On 6/30/23 at 10:19 a.m., the 100 Unit Manager removed the blanket covering Resident J's left foot. There was no heel protector boot in place at the time, and the left foot was resting directly on the mattress. The resident's left foot had a large round darkened area noted to heel. The 100 Unit Manager indicated staff had been applying skin prep to the DTI and leaving it open to air. Before exiting the room, the 100 Unit Manager applied a heel protector boot to the left foot. The record for Resident J was reviewed on 6/29/23 at 2:51 p.m. Diagnoses included, but were not limited to, fracture of the left femur, diabetes mellitus, and heart failure.	F 0686	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident J was provided with a heal protector boot. Treatment orders for resident J were reviewed	07/28/2023

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	The Admission Minimum Data Set (MDS) assessment, dated 6/23/23, indicated the resident was cognitively intact for daily decision making. She required extensive assistance with one person physical assist for bed mobility, dressing, toilet use, and personal hygiene. She had limited range of motion to one side on the lower extremities. A Care Plan, dated 6/20/23, indicated the resident had a pressure ulcer. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness. A Wound Assessment Details Report, dated 6/21/23 at 11:40 a.m., indicated the resident had an unstageable pressure ulcer to the left heel that was necrotic hard, firm, and 100% adherent. The wound measured 7.5 centimeters (cm) by 4.8 cm. The current treatment plan was to apply skin prep every shift. A Wound Assessment Details Report, dated 6/29/23 at 9:24 a.m., indicated the resident had an unstageable pressure ulcer to the left heel that was necrotic hard, firm, and 100% adherent. The wound measured 7.5 cm by 4.8 cm. The treatment plan was to continue with the current plan of care. There were no orders for the DTI wound treatment. There was no orders or monitoring in place for the heel protector boot. Interview with the Director of Nursing on 6/30/23 at 12:10 p.m., indicated there were no orders for the skin prep to the left heel DTI and there was no documentation of the treatment having been completed as indicated. There was no monitoring		and updated The plan of care has been updated to reflect the use of skin prep and heal protector to left foot. **2) How the facility identified other residents:** An audit of all residents with pressure injuries was completed to ensure proper treatments were in place and reflected in the orders and on the care plan. No like concerns were identified. **3) Measures put into place/ System changes:** All licensed nurses have been educated to ensure residents with pressure injuries have appropriate treatments in place and that all interventions are noted in the treatment record and on the care plan. **4) How the corrective actions will be monitored:** An audit has been put into place to ensure appropriate interventions for pressure injuries are in place and noted in the treatment record and on the plan of care. This audit will be completed weekly by the DON/ designee for no less than 3 mos. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6	

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	in place for the heel protectors because it was only a preventative measure. A Policy titled, "Pressure Injury and Skin Condition Assessment," revised on 1/17/18 and noted as current, indicated "...18. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses notes..." This Federal tag relates to Complaint IN00405274. 3.1-40(a)(2)		months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on record review and interview, the facility	F 0688	The facility requests paper	07/28/2023

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	failed to ensure range of motion exercises were completed for 1 of 3 residents reviewed for limited range of motion (ROM). (Resident D) Finding includes: Resident D's closed record was reviewed on 6/29/23 at 11:30 a.m. Diagnoses included, but were not limited to chronic obstructive pulmonary disease (COPD), diabetes mellitus, and dementia. The Discharge Minimum Data Set (MDS) assessment, dated 6/18/23, indicated the resident was severely cognitively impaired for daily decision making. She was totally dependent on staff for bed mobility, transfers, dressing, toilet use, bathing and personal hygiene. A Care Plan, revised on 5/2/22, indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit related to impaired cognition, COPD, diabetes mellitus, schizophrenia, depression, and anemia. Interventions included, but were not limited to, perform active range of motion (AROM) to bilateral upper extremities with ADL care. There was no documentation related to AROM being completed with the resident. Interview with the Director of Nursing on 6/30/23 at 3:15 p.m., indicated the resident was on a restorative program in the past and the care plan should have been updated. She was unable to locate any documentation of the AROM being completed. This Federal tag relates to Complaint IN00411300. 3.1-42(a)(1)		compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** ROM with ADL care was removed from the care plan for Resident D. **2) How the facility identified other residents:** A review of all residents with ADL care plans that included ROM as an intervention were receiving ROM with ADLs and that the intervention was documented appropriately. If this was no longer an appropriate intervention, it has been removed from the care plan. **3) Measures put into place/ System changes:**	

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			Nurses and CNAs have been educated on the requirement to ensure ROM with ADL care is followed if it is documented in the plan of care as an appropriate intervention to prevent further decrease in range of motion. Additionally, any resident with decreased mobility should be referred to therapy for appropriate treatment to increase range of motion. **4) How the corrective actions will be monitored:** An audit has been put in place to ensure that residents with ROM with ADL care in place as an intervention receive ROM and that appropriate documentation is in place. This audit will also include the referral for therapy when there is a decline in ROM. The aforementioned audit will be completed by the DON or designee for all admissions and 10 residents on different units monthly. The results of these audits will be reviewed by the QAPI committee monthly until an average of 90% compliance or greater is achieved X3 consecutive mos.	