PRINTED:	07/28/2023
FORM API	PROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

OT A TEMEN	T OF DEFICIENCIES					MB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155580	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/30/2023	
NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK			2350 T/	address, city, state, zip coi AFT ST IN 46404	D	
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOL	CTION ULD BE	(X5)
PREFIX	-	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	COMPLETION
TAG 0000	REGULATORY	OR LSC IDENTIFYING INFORMATION	TAG			DATE
0000						
Bldg. 00		the Investigation of Complaint 0410278, and IN00411300.	F 0000			
	-	05274 - Federal/state deficiencies gations are cited at F686.				
	Complaint IN004 the allegations are	10278 - No deficiencies related to e cited.				
	-	11300 - Federal/state deficiencies gations are cited at F568, F657,				
	Survey dates: Jun	e 29 and 30, 2023				
	Facility number: Provider number: AIM number: 20	155580				
	Census Bed Type					
	SNF/NF: 125					
	Total: 125					
	Census Payor Typ Medicare: 8 Medicaid: 115 Other: 2 Total: 125	pe:				
	These deficiencies accordance with 4	s reflect State Findings cited in 10 IAC 16.2-3.1.				
	Quality review co	ompleted on 7/5/23.				
0568	483.10(f)(10)(iii)					
SS=D		Records of Personal Funds				
Bldg. 00	-	i) Accounting and Records.				
	-			TITLE		

## Amy Maurice

Administrator

Any defiency statement 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.

PRINTED: 07/28/2023 FORM APPROVED OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 06/30/2023 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 (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 guarterly statements and upon request. Based on record review and interview, the facility F 0568 07/28/2023 The facility requests paper failed to ensure quarterly statements were compliance for this citation. provided for 2 of 3 residents reviewed for personal funds. (Residents G and D) This Plan of Correction is the center's credible allegation of Findings include: compliance. 1. The personal funds review was completed with Preparation and/or execution of the Financial Coordinator on 6/30/23 at 1:08 p.m. this plan of correction does not constitute admission or agreement The Financial Coordinator indicated the facility by the provider of the truth of the handled Resident G's funds. Statements were facts alleged or conclusions set provided quarterly to the residents or their forth in the statement of Responsible Party. deficiencies. The plan of correction is prepared and/or The record for Resident G was reviewed on executed solely because it is 6/29/23 at 11:25 a.m. Diagnoses included, but required by the provisions of were not limited to, dementia, anxiety, and federal and state law. schizophrenia. 1) Immediate actions taken for The Annual Minimum Data Set (MDS) those residents identified: assessment, dated 5/17/23, indicated the resident was cognitively impaired for daily decision Residents D and G have received updated copies of their making. statements. Interview with the Financial Coordinator on 6/30/23 at 1:10 p.m., indicated the quarterly 2) How the facility identified Event ID: 100W11 Facility ID: 008505 Page 2 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

	ATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         D PLAN OF CORRECTION       IDENTIFICATION NUMBER         155580		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 06/30/2023	
	PROVIDER OR SUPPLIE		2	TREET ADDRE 350 TAFT S ARY, IN 46			
		UN FARK		ART, IN 40	404		
X4) ID PREFIX TAG	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	PRE	D EFIX CRC AG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	2023 were mailed	ecember 2022 through March yesterday, however she didn't		othe	er residents:		
	being sent to the re She indicated she to keep a log of the	tation of any other statements esident's Responsible Party. was putting a new plan in place e statements that were mailed		all re info	updated statement was se esidents on June 29th. Tl rmation has been docume he RFMS statement log.	his	
	6/30/23 at 2:35 p.m	led by the Administrator on n., indicated the last			leasures put into place/ tem changes:		
	<ul><li>mailed to the resid</li><li>dated 7/28/22.</li><li>2. The personal function</li></ul>	but a quarterly statement being ent's Responsible Party was nds review was completed with dinator on 6/30/23 at 1:08 p.m.		requ final the	I has been educated on t uirement for the individual ncial record to be availabl resident through quarterly ements and upon request	e to	
	handled Resident I	rdinator indicated the facility D's funds. Statements were to the residents or their		the tare	g has been created to trac financial statements as th sent and or received by th dent or responsible party.	ey ne	
	6/29/23 at 11:30 a. not limited to, dem paranoid schizoph The Discharge Min assessment, dated	for Resident D was reviewed on m. Diagnoses included, but were nentia,, anxiety disorder, and renia. nimum Data Set (MDS) 6/18/23, indicated the resident itively impaired for daily		will An a will Adm mor thes Qua	low the corrective action be monitored: audit of the aforementione be completed by the ninistrator or designee on athly basis. The results of se audits will be reviewed ality Assurance Meeting	ed log a : in	
	6/30/23 at 1:10 p.m statements from D 2023 were mailed have any documen being sent to the re She indicated she	Financial Coordinator on n., indicated the quarterly ecember 2022 through March yesterday, however she didn't tation of any other statements esident's Responsible Party. was putting a new plan in place e statements that were mailed		aver grea mor iden mak	hthly x6 months or until an rage of 90% compliance ater is achieved x3 consect on ths. The QA Committee this any trends or patterns are recommendations to re plan of correction as indic	or cutive will s and vise	

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If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	00	CON 06/2	te survey 19leted 30/2023
	PROVIDER OR SUPPLI		2350 T	ADDRESS, CITY, STATE, ZIP AFT ST , IN 46404	° COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 0657 SS=D Bldg. 00	Information provi 6/30/23 at 2:35 p. documentation ab mailed to the resid dated 7/28/22. This Federal tag r 3.1-6(g) 483.21(b)(2)(i)-(i Care Plan Timin §483.21(b)(2) A must be- (i) Developed wi of the comprehe (ii) Prepared by a includes but is n (A) The attendin (B) A registered the resident. (C) A nurse aide resident. (D) A member of staff. (E) To the exten	ded by the Administrator on n., indicated the last out a quarterly statement being lent's Responsible Party was elates to Complaint IN00411300. ii) g and Revision prehensive Care Plans comprehensive care plan thin 7 days after completion nsive assessment. an interdisciplinary team, that ot limited to g physician. nurse with responsibility for with responsibility for the i food and nutrition services a practicable, the				
	representative(s included in a res participation of the representative is for the developm plan.	ne resident and the resident's b. An explanation must be ident's medical record if the ne resident and their resident determined not practicable nent of the resident's care				
	disciplines as de needs or as requ (iii)Reviewed an	riate staff or professionals in termined by the resident's lested by the resident. d revised by the team after each assessment,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED 00 B. WING 06/30/2023 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 including both the comprehensive and quarterly review assessments. F 0657 The facility requests paper 07/28/2023 Based on record review and interview, the facility compliance for this citation. failed to ensure residents were invited to their Care Plan conferences for 2 of 3 residents This Plan of Correction is the reviewed for care planning. (Residents D and H) center's credible allegation of compliance. Findings include: Preparation and/or execution of 1. Resident D's record was reviewed on 6/29/23 at this plan of correction does not 11:30 a.m. Diagnoses included, but were not constitute admission or agreement limited to chronic obstructive pulmonary disease by the provider of the truth of the (COPD), diabetes mellitus, and dementia. facts alleged or conclusions set forth in the statement of The Discharge Minimum Data Set (MDS) deficiencies. The plan of assessment, dated 6/18/23, indicated the resident correction is prepared and/or was severely cognitively impaired for daily executed solely because it is decision making. required by the provisions of federal and state law. There was no documentation indicating the resident had been invited to her Care Conference 1) Immediate actions taken for after her 10/27/22 Quarterly MDS, 12/28/22 those residents identified: Quarterly MDS, and 3/28/23 Annual MDS Care plan meetings with assessments were completed. Responsible Parties were held for resident D and H. 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 2) How the facility identified Conferences, but the system they had used other residents: previously had failed. They were working on a new system and the Social Services Department A review of all resident was going to be solely responsible for the care assessments in the last 90 days plan meetings going forward. The resident's has been completed. Any representative was last sent an invitation for a resident or family not present for Care Conference in February of 2021. the most recent care plan review 2. Interview with Resident H on 6/29/23 at 10:00 was invited via phone or mail. a.m., indicated he had not been to any care plan meetings. 3) Measures put into place/ 100W11 Facility ID: 008505 If continuation sheet

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
	155580		В.	WING	<u></u>	06/30	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	ER			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	TE	COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		sident H was reviewed on			System changes:		
		n., Diagnoses included, but were			Casial Camilas Directors have		
		onic obstructive pulmonary nfarction (stroke), and prostate			Social Service Directors been		
	cancer.	marchon (shoke), and prostate			educated on the policy/	or	
			1		requirement for residents and resident's representative to be		
	The Annual Minir	num Date Set (MDS)			invited to attend the scheduled		
		3/28/23, indicated the resident			meetings to review the	-	
	· · · · ·	tact for daily decision making.			comprehensive care plan. A c	vao	
	8 ,	5 6			of the care plan letters will be		
		umentation indicating the			retained in the resident's reco	rd.	
		invited to his Care Conference					
		arterly MDS, 11/2/22 Quarterly			4) How the corrective actions	5	
		uarterly MDS, 3/28/23 Annual			will be monitored:		
		Quarterly MDS assessments				4.	
	were completed.				An audit has been put in place ensure monthly invitations are		
	Interview with So	cial Service Director 1 (SSD 1) on			sent as required.		
		n., indicated that the last Care			Social Services or designee w	rill	
	Conference should	l have been in May of 2023. He			complete this audit monthly. T		
	was currently perf	orming an audit to check those			results of these audits will be		
	that may have bee	n missed.			reviewed in Quality Assurance	;	
					Meeting monthly x6 months or	-	
		cial Service Director 2 (SSD 2) on			until an average of 90%		
		n., indicated the front desk sent			compliance or greater is achie		
		based off of the MDS calendar.			x3 consecutive months. The C		
		de aware that the invitations			Committee will identify any tre	nds	
	were not sent.				or patterns and make	-	
	Interview with Di	rector of Nursing (DON) on			recommendations to revise the plan of correction as indicated		
		m., indicated she was aware that					
	-	ssed for Care Conferences.					
	This Federal tag re	elates to Complaint IN00411300.					
	3.1-35(d)(2)(B)						
686 S=D dg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs	) to Prevent/Heal Pressure					

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 06/30/2023	
	PROVIDER OR SUPPLIE		2350	T ADDRESS, CITY, STATE, ZIP COI TAFT ST	)	
APERIC	N CARE TOLLEST	ON PARK	GAR	Y, IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE ROPRIATE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	§483.25(b) Skin §483.25(b)(1) Pri Based on the cor a resident, the fa (i) A resident recor- professional stam pressure ulcers a pressure ulcers a condition demon- unavoidable; and (ii) A resident with necessary treatm with professional promote healing, new ulcers from Based on observat interview, the faci with pressure ulcer treatment and serv to not obtaining tra- injury (DTI) for 1 pressure ulcers. (R Finding includes: On 6/30/23 at 10:1 removed the blank foot. There was not the time, and the la the mattress. The r round darkened ar Manager indicated	Integrity essure ulcers. mprehensive assessment of cility must ensure that- eives care, consistent with dards of practice, to prevent and does not develop unless the individual's clinical strates that they were the pressure ulcers receives nent and services, consistent standards of practice, to prevent infection and prevent developing. ion, record review, and lity failed to ensure residents rs received the necessary ices to promote healing, related eatment orders for a deep tissue of 3 residents reviewed for	F 0686	The facility requests pap compliance for this citate <i>This Plan of Correction is</i> <i>center's credible allegatic</i> <i>compliance.</i> <i>Preparation and/or exect</i> <i>this plan of correction do</i> <i>constitute admission or a</i> <i>by the provider of the tru</i> <i>facts alleged or conclusic</i> <i>forth in the statement of</i> <i>deficiencies. The plan o</i> <i>correction is prepared ar</i> <i>executed solely because</i> <i>required by the provision</i> <i>federal and state law.</i>	on. s the on of ution of es not ogreement th of the ons set f od/or it is	07/28/20
	exiting the room, t heel protector boo	he 100 Unit Manager applied a		1) Immediate actions ta those residents identifie		
		oses included, but were not of the left femur, diabetes failure.		Resident J was provided heal protector boot. Trea orders for resident J wer	atment	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			06/30	/2023
NAME OF	PROVIDER OR SUPPLIE	D	S	TREET A	ADDRESS, CITY, STATE, ZIP COD		
					AFT ST		
APERIC	N CARE TOLLEST	ON PARK		GARY,	IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIE	П		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T	AG		haa	DATE
	The Admission M	inimum Data Set (MDS)			and updated The plan of care been updated to reflect the use		
		6/23/23, indicated the resident			skin prep and heal protector to		
		tact for daily decision making.			foot.		
		sive assistance with one person					
	physical assist for	bed mobility, dressing, toilet			2) How the facility identified		
		nygiene. She had limited range			other residents:		
	of motion to one s	ide on the lower extremities.					
					An audit of all residents with		
	A Care Plan, dated	6/20/23, indicated the resident			pressure injuries was complete	ed	
	-	er. Interventions included, but			to ensure proper treatments we	ere	
		o, administer treatments as			in place and reflected in the or	ders	
	ordered and monit	or for effectiveness.			and on the care plan. No like		
					concerns were identified.		
		nent Details Report, dated					
		m., indicated the resident had an			3) Measures put into place/		
		re ulcer to the left heel that			System changes:		
		firm, and 100% adherent. The					
		7.5 centimeters (cm) by 4.8 cm. ent plan was to apply skin prep			All licensed nurses have been educated to ensure residents v	vith	
	every shift.	ent plan was to apply skin prep			pressure injuries have appropr		
	every sint.				treatments in place and that al		
	A Wound Assessm	nent Details Report, dated			interventions are noted in the	1	
		n., indicated the resident had an			treatment record and on the ca	are	
		are ulcer to the left heel that			plan.		
	0 1	firm, and 100% adherent. The			<sup>•</sup>		
		7.5 cm by 4.8 cm. The treatment					
		ue with the current plan of care.			4) How the corrective actions	;	
					will be monitored:		
	There were no ord	ers for the DTI wound					
	treatment.				An audit has been put into plac		
					to ensure appropriate intervent		
		rs or monitoring in place for the			for pressure injuries are in place		
	heel protector boot	t.			and noted in the treatment reco		
	<b>.</b>				and on the plan of care. This a		
		Director of Nursing on 6/30/23			will be completed weekly by th		
	-	cated there were no orders for			DON/ designee for no less tha		
		e left heel DTI and there was no			mos. The results of these audi	ts	
		the treatment having been			will be reviewed in Quality		
	completed as mult	ated. There was no monitoring			Assurance Meeting monthly x6	,	

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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 06/30/2023	
	PROVIDER OR SUPPLIE		2350	<sup>°</sup> address, city, state, zip coi TAFT ST ′, IN 46404	)	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETION DATE
= 0688 SS=D Bldg. 00	in place for the her only a preventative A Policy titled, "P Condition Assessm noted as current, in ordered treatments on the electronic T Record after each measures not invo documented in the nurses notes" This Federal tag re 3.1-40(a)(2) 483.25(c)(1)-(3) Increase/Prevent §483.25(c) Mobil §483.25(c)(1) Th resident who ent range of motion of reduction in rang resident's clinical that a reduction i unavoidable; and §483.25(c)(2) A t	RE TOLLESTON PARK SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Datace for the heel protectors because it was y a preventative measure. Policy titled, "Pressure Injury and Skin ndition Assessment," revised on 1/17/18 and ed as current, indicated "18. Physician ered treatments shall be initialed by the staff the electronic Treatment Administration cord after each administration. Other nursing asures not involving medications shall be rumented in the weekly wound assessment or ses notes" s Federal tag relates to Complaint IN0040527440(a)(2) 3.25(c)(1)-(3) rease/Prevent Decrease in ROM/Mobility 33.25(c)(1) The facility must ensure that a ident who enters the facility without limited ge of motion does not experience uction in range of motion unless the ident's clinical condition demonstrates t a reduction in range of motion is		months or until an avera compliance or greater is x3 consecutive months. Committee will identify a or patterns and make recommendations to rev plan of correction as indi	ge of 90% achieved The QA ny trends ise the	DATE
	services to increat prevent further de §483.25(c)(3) A receives appropri- assistance to mai with the maximum unless a reduction demonstrably un	ase range of motion and/or to ecrease in range of motion. resident with limited mobility iate services, equipment, and intain or improve mobility m practicable independence n in mobility is	F 0688	The facility requests pap	er	07/28/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	· · · · · · · · · · · · · · · · · · ·	X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUM 155580		IDENTIFICATION NUMBER 155580	A. BUILDING <u>00</u> B. WING		COMPLETED 06/30/2023	
NAME OF	PROVIDER OR SUPPLIE	R		r address, city, state, zip cod TAFT ST		
APERIC	N CARE TOLLEST	ON PARK		7, IN 46404		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		nge of motion exercises were		compliance for this citation.		
	-	3 residents reviewed for limited COM). (Resident D)		This Plan of Correction is the		
	range of motion (R	(Resident D)				
	Finding includes:			center's credible allegation of compliance.		
	T maning menudes.			compliance.		
	Resident D's close	d record was reviewed on		Preparation and/or execution o	f	
		m. Diagnoses included, but were		this plan of correction does not		
		nic obstructive pulmonary		constitute admission or agreem		
	disease (COPD), d	iabetes mellitus, and dementia.		by the provider of the truth of th		
				facts alleged or conclusions se	t l	
	The Discharge Min	nimum Data Set (MDS)		forth in the statement of		
		6/18/23, indicated the resident		deficiencies. The plan of		
		itively impaired for daily		correction is prepared and/or		
	-	She was totally dependent on		executed solely because it is		
		ity, transfers, dressing, toilet		required by the provisions of		
	use, bathing and pe	ersonal hygiene.		federal and state law.		
	A Care Plan, revis	ed on $5/2/22$ , indicated the		1)Immediate actions taken for	,	
	resident had an Ac	tivities of Daily Living (ADL)		those residents identified:		
	self-care performa	nce deficit related to impaired				
	cognition, COPD,	diabetes mellitus, schizophrenia,		ROM with ADL care was remo	ved	
	-	emia. Interventions included,		from the care plan for Resident	D.	
		ed to, perform active range of				
		o bilateral upper extremities with		2) How the facility identified		
	ADL care.			other residents:		
	There was no docu	mentation related to AROM		A review of all residents with Al	DL	
	being completed w			care plans that included ROM a		
				an intervention were receiving		
	Interview with the	Director of Nursing on 6/30/23		ROM with ADLs and that the		
	-	ated the resident was on a		intervention was documented		
		n in the past and the care plan		appropriately. If this was no		
		updated. She was unable to		longer an appropriate intervent		
		ntation of the AROM being		it has been removed from the c	are	
	completed.			plan.		
	This Federal tag re	elates to Complaint IN00411300.		3) Measures put into place/ System changes:		
	3.1-42(a)(1)					
	J.1-72(a)(1)					

NTERS FOR MEDICARE & MEDICAID 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>	(X3) DATE COMP	MB NO. 0938-039 E SURVEY LETED D/2023	
	ROVIDER OR SUPPLIE		2350	t address, city, state, zip cod TAFT ST /, IN 46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
				<ul> <li>Nurses and CNAs have bee educated on the requirement ensure ROM with ADL care followed if it is documented plan of care as an appropriation to prevent further decrease in range of motion Additionally, any resident with decreased mobility should bin referred to therapy for approtive treatment to increase range motion.</li> <li>4) How the corrective action will be monitored: An audit has been put in platensure that residents with R with ADL care in place as an intervention receive ROM and appropriate documentation if place. This audit will also in the referral for therapy when is a decline in ROM. The aforementioned audit will be completed by the DON or designee for all admissions aresidents on different units monthly. The results of these audits will be reviewed by th QAPI committee monthly un average of 90% compliance greater is achieved X3 constructs.</li> </ul>	t to is in the te er of <b>ns</b> nce to OM n d that s in clude there and 10 e e til an or	

IOOW11 Facility ID: 008505

If continuation sheet

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