| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155580 | A. BUILDING 00<br>B. WING | 07/20/2021 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00352219, IN00355156, and IN00358128.<br><br>Complaint IN00352219 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00355156 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00358128 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: July 13, 14, 15, 16, 19, and 20, 2021.<br><br>Facility number: 008505<br>Provider number: 155580<br>AIM number: 200064830<br><br>Census Bed Type:<br>SNF/NF: 89<br>SNF: 13<br>Total: 102<br><br>Census Payor Type:<br>Medicare: 13<br>Medicaid: 83<br>Other: 6<br>Total: 102<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 7/26/21. | F 0000 | | |

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

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| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>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.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his | | | |

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| | or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to dressing a dependent resident in too large of pants and his brief was exposed when standing for 1 of 1 residents reviewed for dignity. (Resident 193)<br><br>Finding includes:<br><br>On 7/13/21 at 10:30 a.m., Resident 193 was observed dressed in street clothes sitting in a chair in the special care dining/activity room. At that time, the resident's incontinent brief was exposed in the back, as the resident's pants were pulled down to his mid thigh. At 10:32 a.m., Activity Aide 1 stood the resident up and moved him to another chair at a different table. The resident's pants started to fall down, exposing his entire incontinent brief and lower legs. There were 5 other residents in the area at the time, and one resident stated, "Hey you gotta pull up his pants." The Activity Aide then pulled up the pants part way and helped him sit down. At 10:45 a.m., the resident remained seated in the chair in the dining room with his brief exposed due to his pants being too big.<br><br>The record for Resident 193 was reviewed on 7/15/21 at 1:48 p.m. The resident was admitted from another long term care facility on 6/28/21. Diagnoses included, but were not limited to, schizophrenia, dysphagia (difficulty swallowing), mild protein calorie malnutrition, major depressive disorder, anxiety, high blood pressure, and dementia with behaviors. | F 0550 | **Aperion- Tolleston Park**<br><br>**POC**<br>**Annual/Recertification**<br><br>**Compliance 08/09//2021**<br>**F550 Resident Rights**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br>Resident 193 clothing was observed for proper fit and replaced with appropriately sized clothing of resident's choice.<br><br>**2) How the facility identified other residents:**<br>All dependent residents who | 08/16/2021 |

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| | The Admission Minimum Data Set (MDS) assessment, dated 7/5/21, indicated the resident was not alert and oriented and had no behaviors. The resident needed extensive assist with 2 person physical assist for bed mobility, transfers, toileting, and dressing. He needed supervision with set up for eating. The resident had loss of liquids from his mouth when eating or drinking and held food in his mouth. The resident's weight was 217 pounds with no history of weight loss.<br><br>Interview with the South Unit Manager on 7/19/21 at 10:00 a.m., indicated the resident needed assistance with getting dressed in the morning and a CNA had put those pants on him.<br><br>3.1.3(t) | | reside in the facility have the potential to be affected by this deficient practice<br><br>**3) Measures put into place/ System changes:**<br>The facility will observe all dependent resident's clothing in the facility for proper size. Responsible parties were called to notify them if the resident needed a different size clothing.<br><br>**4) How the corrective actions will be monitored:**<br>The Executive Director or designee will observe 2 dependent residents daily 5 days a week during rounds for proper fitting clothing x's 6 weeks then 3x's a week for 3 weeks then weekly thereafter. The Executive Director is responsible for compliance. **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.**<br><br>**5) Date of compliance: 08/09/2021** | |

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| F 0623<br>SS=B<br>Bldg. 00 | 483.15(c)(3)-(6)(8)<br>Notice Requirements Before Transfer/Discharge<br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(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.<br>(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<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(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.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is | | | |

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| | required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill | | | |

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| | Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>Based on record review and interview, the facility failed to ensure a resident's Responsible Party was notified in writing related to a transfer to the hospital for 4 of 5 residents reviewed for hospitalization. (Residents 38, 88, 28, and 194)<br><br>Findings include:<br><br>1. The record for Resident 38 was reviewed on 7/19/21 at 9:45 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, type 2 diabetes, and chronic kidney disease.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/25/21, indicated the resident was cognitively impaired for daily decision making. | F 0623 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09/2021**<br><br>**F623 Transfer and Discharge Notices**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of* | 08/09/2021 |

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| | A Nurse Practitioner Progress Note, dated 5/28/21 at 4:01 p.m., indicated the resident was being sent to the hospital due to being in acute renal failure.<br><br>Nurses' Notes, dated 5/28/21 at 4:15 p.m., indicated a message was left with the resident's mother to call the unit for any information. There was no documentation indicating a transfer form had been sent to her.<br><br>Interview with the Assistant Director of Nursing on 7/19/21 at 11:30 a.m., indicated documentation of a transfer notice should have been completed.<br><br>2. The record for Resident 88 was reviewed on 7/15/21 at 10:11 a.m. Diagnoses included, but were not limited to, stroke, major depressive disorder, chronic obstructive pulmonary disease, abnormal posture, and vascular dementia with behavioral disturbance.<br><br>The 6/28/21 Medicare 5 day Minimum Data Set (MDS) assessment, indicated the resident was cognitively impaired for daily decision making.<br><br>The Change in Condition Form, dated 6/17/21, indicated the resident had altered mental status and she was complaining of not feeling well. The Nurse Practitioner was notified and orders were received to send the resident to the hospital. The resident's responsible party was notified. There was no documentation indicating the resident's responsible party had been sent a copy of the transfer form.<br><br>Interview with the Assistant Director of Nursing on 7/19/21 at 11:30 a.m., indicated the resident's responsible party should have been provided a copy of the transfer form.<br>3. The record for Resident 28 was reviewed on | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident 38 no longer resides in the facility. Residents 88,28,194 responsible parties called and notified for Transfer and discharge practices for the facility<br><br>**2) How the facility identified other residents:**<br><br>All newly discharged residents could be affected by this deficient practice. An audit was completed on all residents discharged in the last 30 days to ensure responsible parties are aware of the Transfer and discharge notices.<br><br>**3) Measures put into place/ System changes:**<br><br>Education will be provided to the IDT, SSD and Nursing Staff regarding and implementation of timely written notification of the | |

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| | 7/15/21 at 11:30 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, cerebral palsy, high blood pressure, heart failure, psychosis, dementia, type 2 diabetes, and anxiety disorder.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/21 indicated the resident was not alert and oriented.<br><br>Nurses' Notes, dated 6/15/21 at 2:31 a.m., indicated the resident was found on the floor in his room unresponsive. His vitals signs were checked at that time, and indicated an oxygen saturation of 75%, blood pressure of 89/53 and pulse 75. 911 was called as well as the physician and family.<br><br>Nurses' Notes, dated 6/16/21 at 9:27 a.m., indicated the resident was admitted to the hospital for transient ischemic attack (TIA).<br><br>There was no documentation in Nursing Progress Notes if or when the resident's family was notified in writing of the transfer and/or discharge.<br><br>The Notice of Transfer and Discharge, dated 6/15/21, was completed, however there was no documentation the information was mailed to the resident's responsible party.<br><br>Interview with the South Unit Manager on 7/16/21 at 2:40 p.m., indicated there was no documentation the transfer form had been sent to the resident's family.<br><br>4. The record for Resident 194 was reviewed on 7/15/21 at 9:55 a.m. The resident was admitted to the hospital on 6/22/21 and returned to the facility on 7/8/21. Diagnoses included, but were not limited to, respiratory failure, psychosis, dementia, | | Discharge/Transfer Notice<br><br>**4) How the corrective actions will be monitored:**<br><br>Administrator or Designee will review all new discharge residents to ensure the discharge Daily for 6 weeks 5 days a week for 3 weeks for 6 months. The DON will be responsible for compliance.<br><br>**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.**<br><br>**5) Date of compliance: 08/09/2021** | |

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| | stroke, dysphagia (difficulty swallowing), high blood pressure, major depressive disorder with psychotic symptoms, anxiety, anemia, schizoaffective disorder, and insomnia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/25/21, indicated the resident was not alert and oriented, and had no behaviors.<br><br>Nurses' Notes, dated 6/22/21, indicated the resident's PEG tube (a tube inserted directly into the stomach to provide nutrition) had become dislodged. The resident was sent to the hospital and admitted.<br><br>The Notice of Transfer and Discharge was completed on 6/22/21, however, there was no documentation the information was mailed to the resident's responsible party.<br><br>Interview with the South Unit Manager on 7/16/21 at 2:40 p.m., indicated there was no documentation the transfer form had been sent to the resident's family.<br><br>3.1-12(a)(6)(ii)<br>3.1-12(a)(6)(iii) | | | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident. | | | |

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| | (C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on record review and interview, the facility failed to ensure residents were invited to their Care Plan conferences as well as ensuring Care Plans were revised as needed for 3 of 23 Care Plans reviewed. (Residents 43, 56, and 194)<br><br>Findings include:<br><br>1. Interview with Resident 43 on 7/14/21 at 10:25 a.m., indicated she had not been invited to her Care Plan meetings.<br><br>The record for Resident 43 was reviewed on 7/19/21 at 11:06 a.m. Diagnoses included, but were not limited to, multiple sclerosis, hypertension, and anxiety.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/27/21, indicated the resident was cognitively intact for daily decision making. | F 0657 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09//2021**<br><br>**F657 Care Plan Timing and Revision**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement* | 08/09/2021 |

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| | There was no documentation indicating the resident had been invited to her Care Conference after her 5/27/21 Quarterly MDS was completed.<br><br>Interview with the Social Service Director on 7/20/21 at 10:30 a.m., indicated he would have to see if the resident had a recent Care Conference.<br><br>Interview with the Administrator on 7/20/21 at 3:15 p.m., indicated there was no documentation to indicate if the resident had been invited to her most recent Care Conference. 2. The record for Resident 56 was reviewed on 7/15/21 at 3:29 p.m. Diagnoses included, but were not limited to, encephalopathy, chronic obstructive pulmonary disease (COPD), stroke, type 2 diabetes, cirrhosis of the liver, high blood pressure, atrial fibrillation, anemia, major depressive disorder, end stage renal disease, and dependence on renal dialysis.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 6/8/21, indicated the resident was not alert and oriented. The resident did not receive oxygen during the assessment period. He did receive dialysis while a resident at the facility. The resident weighed 158 pounds with no current weight loss. He received a therapeutic diet with no restrictions.<br><br>A Care Plan, updated 3/16/21, indicated the resident was on a 1500 cubic centimeters (cc) fluid restriction.<br><br>Physician's Orders, on the current 7/2021 order statement, indicated there were no orders for a fluid restriction.<br><br>A Registered Dietitian's Note, dated 6/22/21, indicated no documentation or information the resident was on a fluid restriction. | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident's 43, 56, 194 were offered care plan meetings and family members of their choice were invited.<br><br>**2) How the facility identified other residents:**<br><br>All residents could be affected by this deficient practice. An audit was completed on all residents not receiving care plans in the last 90 days. If the resident did not receive a care plan the resident was offered a care plan meeting and family members of their choice were invited.<br><br>**3) Measures put into place/ System changes:**<br><br>Education will be provided to the IDT and Social Services to ensure residents are invited to their care plans and revisions are made as needed to meet the needs of patient centered care. | |

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| | 155580 | A. BUILDING 00<br>B. WING | 07/20/2021 |

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

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| | Interview with the South Unit Manager on 7/19/21 at 9:55 a.m., indicated the resident's fluid restriction had been discontinued a while ago per dialysis. The care plan was outdated.<br><br>3. The record for Resident 194 was reviewed on 7/15/21 at 9:55 a.m. The resident was admitted to the hospital on 6/22/21 and returned to the facility on 7/8/21. Diagnoses included, but were not limited to, respiratory failure, psychosis, dementia, stroke, dysphagia (difficulty swallowing), high blood pressure, major depressive disorder with psychotic symptoms, anxiety, anemia, schizoaffective disorder, and insomnia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/25/21, indicated the resident was not alert and oriented, and had no behaviors. The resident needed extensive assist with 1 person physical assist for bed mobility, transfers, dressing, walking, toilet use and personal hygiene. The resident had not received any psychotropic medications in the last 7 days.<br><br>A Care Plan, dated 11/17/20, indicated the resident was receiving hospice services.<br><br>A Care Plan, dated 5/12/17 and updated on 11/4/20, indicated the resident was at risk for dehydration related to diuretic use.<br><br>Physician's Orders, dated 8/7/20, indicated the medication of Lasix (a diuretic) was discontinued.<br><br>Physician's Orders, dated 6/22/21, indicated hospice was discontinued.<br><br>Interview with the South Unit Manager on 7/16/21 at 2:40 p.m., indicated the Care Plans for hospice | | **4) How the corrective actions will be monitored:**<br><br>SSD/MDS Nurse or designee will review all MDS calendars weekly for a period of 6 months to ensure that all residents have an opportunity to have and attend a care plan meeting and that all revisions are accurate.<br><br>**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.**<br><br>**5) Date of compliance: 08/09/2021** | |

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| | and the diuretic medication were outdated.<br><br>3.1-35(d)(2)(B) | | | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to shaving and nail care for 3 of 6 residents reviewed for ADL's. (Residents 4, 59, and 193)<br><br>Findings include:<br><br>1. On 7/13/21 at 11:00 a.m., Resident 4 was observed with long discolored fingernails on both hands. Interview with the resident at that time, indicated she would like her nails cut.<br><br>On 7/14/21 at 11:30 a.m., the resident's fingernails remained long and she again indicated that she wanted them cut.<br><br>On 7/15/21 at 9:57 a.m., 11:50 a.m., and 2:25 p.m., the resident's fingernails remained long.<br><br>On 7/16/21 at 10:07 a.m., the resident's fingernails remained long.<br><br>On 7/19/21 at 10:07 a.m., the resident's fingernails remained long. The resident indicated she still wanted her fingernails cut.<br><br>The record for Resident 4 was reviewed on 7/15/21 | F 0677 | **Aperion- Tolleston Park**<br>**POC Annual Survey 2021**<br>**Compliance 08/09/2021**<br><br>**F 677 ADL Dependent Residents**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br>Resident 4s fingernails were cut down and manicured.<br>Residents' 59, 193 Facial hair was shaved, and preferences reviewed | 08/09/2021 |

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| | at 2:42 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, colon cancer, colostomy, and cardiac arrhythmia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 4/21/21, indicated the resident had moderate cognitive impairment and required extensive assistance with personal hygiene.<br><br>The current Care Plan, indicated the resident had an Activities of Daily Living (ADL) self care performance deficit related to activity intolerance and limited mobility related to cancer. Interventions included, but were not limited to, the resident was totally dependent on staff to provide a bath.<br><br>Personal hygiene documentation, dated 7/2-7/15/21, indicated the resident required one person physical assistance but did not indicate what type of personal hygiene services were provided.<br><br>Interview with the Assistant Director of Nursing on 7/19/21 at 11:30 a.m., indicated the resident's fingernails would be cut per her request.<br><br>2. On 7/14/21 at 11:14 a.m., Resident 59 was observed in her room in her wheelchair. The resident had a thick growth of facial hair. The resident indicated she wanted the facial hair removed.<br><br>On 7/15/21 at 9:57 a.m., 11:50 a.m., 1:20 p.m., and 2:25 p.m., the resident's facial hair remained.<br><br>On 7/16/21 at 10:07 a.m., the resident's facial hair remained.<br><br>On 7/19/21 at 10:05 a.m., the resident's facial hair | | for shaving was also completed.<br><br>**2) How the facility identified other residents:**<br>The facility completed and audit to identify any dependent residents need assistants with grooming and personal hygiene. The facility staff was provided grooming and personal care as needed.<br><br>**3) Measures put into place/ System changes:** The facility staff was in-services on providing ADL care for residents unable to carry out activities of daily living and to ensure that residents receive good nutrition, grooming and hygiene.<br><br>**4) How the corrective actions will be monitored:**<br>**The DON/Designee** will complete ADL/Dignity Rounds be completed at least 5 times weekly at varied times to ensure proper hygiene is maintained for facility residents.<br><br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6** | |

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| | remained. The resident again indicated she would like the facial hair removed.<br><br>The record for Resident 59 was reviewed on 7/15/21 at 1:39 p.m. Diagnoses included, but were not limited to, stroke, chronic respiratory failure, epilepsy, and hemiplegia (muscle weakness).<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 6/7/21, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for personal hygiene and bathing.<br><br>The current Care Plan, indicated the resident had an activities of daily living (ADL) self care performance deficit related to hemiplegia. Interventions included, but were not limited to, the resident was totally dependent on staff to provide a bath.<br><br>Interview with the Assistant Director of Nursing on 7/19/21 at 11:30 a.m., indicated the resident's facial hair would be removed. 3. On 7/13/21 at 10:30 a.m., Resident 193 was observed sitting in the special care dining/activity room. At that time, the resident had a large amount of facial hair on his face, chin and neck, he was unshaven.<br><br>On 7/14/21 at 10:45 a.m., on 7/15/21 at 9:50 a.m., 11:25 a.m., 1:20 p.m., on 7/16/21 at 9:10 a.m., 9:19 a.m., 12:30 p.m., and on 7/19/21 at 9:00 a.m., the resident was observed dressed in street clothes in the dining/activity room. The resident remained unshaven.<br><br>The record for Resident 193 was reviewed on 7/15/21 at 1:48 p.m. The resident was admitted from another long term care facility on 6/28/21. Diagnoses included, but were not limited to, | | **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.**<br><br>**5) Date of compliance: 08/09/2021** | |

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| | schizophrenia, dysphagia (difficulty swallowing), mild protein calorie malnutrition, major depressive disorder, anxiety, high blood pressure, and dementia with behaviors.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 7/5/21, indicated the resident was not alert and oriented and had no behaviors. The resident needed extensive assist with 2 person physical assist for bed mobility, transfers, toileting, and dressing. He needed supervision with set up for eating. The resident had loss of liquids from his mouth when eating or drinking and held food in his mouth.<br><br>The shower/bath report indicated the resident received a bed bath on 7/1, 7/5, 7/8, 7/12, and 7/15/21.<br><br>A Care Plan, dated 6/28/21, indicated the resident had an activity of daily living self care performance deficit related to orientation. The goal was for the resident to be neat and clean as possible.<br><br>Interview with the South Unit Manager on 7/19/21 at 10:00 a.m., indicated the resident should have been shaved in a more timely manner and at least with his bed baths.<br><br>3.1-38(a)(3)(D)<br>3.1-38(a)(3)(E) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the | | | |

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| | facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, record review, and interview, the facility failed to ensure foot rests were applied to a wheelchair for 1 of 1 residents reviewed for positioning. (Resident 88)<br><br>Finding includes:<br><br>On 7/13/21 at 10:39 a.m., Resident 88 was observed in her room in her wheelchair. There were no foot rests in use and the resident's feet were not able to touch the floor.<br><br>On 7/14/21 at 10:54 a.m., the resident was observed in her wheelchair. No foot rests were in use and the resident's feet were not able to touch the floor.<br><br>On 7/15/21 at 9:55 a.m., 11:50 a.m., and 2:25 p.m., the resident was in her room in her wheelchair. No foot rests were in use and the resident's feet were not able to touch the floor.<br><br>On 7/19/21 at 10:02 a.m., the resident was in her room in her wheelchair. No foot rests were in use and the resident's feet were not able to touch the floor. Interview with CNA 5 at that time, indicated the resident didn't have any foot rests for her wheelchair and she needed some due to her feet dangling.<br><br>The record for Resident 88 was reviewed on 7/15/21 at 10:11 a.m. Diagnoses included, but were not limited to, stroke, major depressive disorder, chronic obstructive pulmonary disease, abnormal posture, and vascular dementia with | F 0684 | **Aperion- Tolleston Park**<br>**POC Annual/Recertification Compliance 08/09/2020**<br><br>**F684 Quality Of Care**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident #88's wheelchair was assessed, reviewed for positioning. Outcome documented and monitored.<br><br>**2) How the facility identified** | 08/09/2021 |

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| | behavioral disturbance.<br><br>The Medicare 5 day Minimum Data Set (MDS) assessment, dated 6/28/21, indicated the resident was cognitively impaired for daily decision making, was totally dependent on staff for transfers and she utilized a wheelchair for mobility.<br><br>The current Care Plan, indicated the resident had an activity of daily living (ADL) self care performance deficit related to hemiplegia (muscle weakness) and shortness of breath. Interventions included, but were not limited to, resident needed extensive to total assist due to hemiplegia (muscle weakness) of 1-2 staff for bed mobility, transfers, toileting, and eating.<br><br>Interview with the Assistant Director of Nursing on 7/19/21 at 11:30 a.m., indicated some foot rests would be located for the resident's wheelchair.<br><br>3.1-37(a) | | **other residents:**<br><br>All residents have the potential to be affected. Facility wide sweep of wheels completed on all current resident to ensure that other residents are not affected by the same deficient practice.<br><br>**3) Measures put into place/ System changes:**<br><br>Staff will be re-educated regarding identification, reporting, missing equipment from wheelchairs and durable medical equipment<br><br>**4) How the corrective actions will be monitored:**<br><br>The Director of Nursing or designee will observe at least 3 residents per week to ensure that missing leg rest and Durable Medical Equipment is identified and replaced timely.<br><br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the** | |

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| | | | **plan of correction as indicated.**<br><br>**5) Date of compliance: 08/09/2021** | |
| F 0686 SS=D Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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<br>(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.<br>Based on observation, record review and interview, the facility failed to ensure pressure ulcer treatments were completed as ordered for 1 of 2 residents reviewed for pressure ulcers. (Resident 86)<br><br>Finding includes:<br><br>On 7/13/21 at 12:10 p.m., Resident 86 was observed in his room in bed. A gauze dressing was observed on his left foot.<br><br>The record for Resident 86 was reviewed on 7/15/21 at 3:17 p.m. Diagnoses included, but were | F 0686 | **Tolleston Park Aperion Care Annual Recertification 2021 Compliance 08/09/2021**<br>**F 686 Treatment/Svcs to Prevention/Heal Pressure Ulcer**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of* | 08/09/2021 |

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| | not limited to, type 2 diabetes, closed fracture of left femur, and hypertension.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 6/29/21, indicated the resident was moderately impaired for daily decision making, totally dependent on staff for bed mobility and transfers, and he had one stage 4 pressure area.<br><br>The Care Plan, dated 4/28/21, indicated the resident had a pressure ulcer to the left heel. Interventions included, but were not limited to, observe dressing to ensure it was intact and adhering. Report loose dressings to the treatment nurse.<br><br>An Initial Wound Evaluation, completed by the Wound Physician on 4/26/21, indicated the resident had an unstageable deep tissue injury to the left posterior heel which measured 3.4 centimeters (cm) x 4.8 cm. Orders were obtained at that time for Santyl (a debriding agent), apply to left heel topically every day shift for 30 days. Clean the area with normal saline, apply Santyl, cover with calcium alginate and wrap the area with gauze for 30 days.<br><br>The April 2021 Treatment Administration Record (TAR), indicated the treatment was not entered into the computer until 4/29/21, three days after being ordered.<br><br>A Physician's Order, dated 5/14/21, indicated the resident's left heel was to be cleansed daily with wound wash, Santyl was to be applied, and the area was to be topped with calcium alginate and wrapped with gauze.<br><br>The June 2021 TAR, indicated the treatment was | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br>Resident 86 skin ulcer was observed and treated as ordered.<br>**2) How the facility identified other residents:**<br>All residents in the facility with alteration in skin or high risk of skin alterations have the potential to be affected by the same alleged deficient practice. All skin integrity orders were check to ensure proper physicians orders<br><br>**3) Measures put into place/ System changes:**<br>A. Nursing staff were in serviced on the importance of ensuring that an appropriate treatment is in place, and the importance of completing/changing treatments timely according to the Physicians' Order.<br>1.A QA tool has been implemented to ensure compliance to these measures.<br><br>**4) How the corrective actions will be monitored:** | |

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| | not signed out as being completed on 6/12, 6/13, 6/14, and 6/18/21.<br><br>The July 2021 TAR, indicated the treatment was not signed out as being completed on 7/1, 7/4, and 7/10/21.<br><br>Interview with the Administrator and Director of Nursing on 7/19/21 at 12:20 p.m., indicated there was a delay in starting the resident's treatment in April due to the orders not being put into the computer.<br><br>Interview with the Wound Nurse on 7/20/21 at 2:30 p.m., indicated the resident's treatments should have been completed as ordered.<br><br>3.1-40(a)(2) | | The DON or designee will complete an audit of 2 residents with pressure injuries 5x's a week randomly to validate that the current treatment is in place and correctly dated x's 6 weeks then 3x's a week for 4 weeks then weekly thereafter. The DON is responsible for compliance. **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.**<br><br>**5) Date of compliance: 08/09/2021** | |
| F 0688 SS=D Bldg. 00 | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility<br>§483.25(c) Mobility.<br>§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<br><br>§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. | | | |

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| | 155580 | A. BUILDING 00<br>B. WING | 07/20/2021 |

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

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| | §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.<br>Based on observation, record review and interview, the facility failed to ensure a resident with a contracture received the necessary treatment and services to prevent further decline for 1 of 2 residents reviewed for limited range of motion (ROM). (Resident 75)<br><br>Finding includes:<br><br>On 7/13/21 at 2:40 p.m., Resident 75 was observed in bed. Both of her hands were closed in the shape of fists. There was no anticontracture device noted in either hand.<br><br>On 7/14/21 at 1:30 p.m., the resident was observed in bed. Both of her hands were closed in the shape of fists. There was no anticontracture device noted in either hand.<br><br>On 7/15/21 at 11:00 a.m., and 1:30 p.m., the resident was observed in bed. Both of her hands were closed in the shape of fists. There was no anticontracture device noted in either hand.<br><br>On 7/16/21 at 9:44 a.m., the resident was observed in bed. Both of her hands were closed in the shape of fists. There was no anticontracture device noted in either hand.<br><br>The record for Resident 75 was reviewed on 7/16/21 at 11:50 a.m. Diagnoses included, but were not limited to, acute respiratory failure, cardiac arrest, anoxic brain damage, | F 0688 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09/2021**<br><br>**F688 ROM**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident was given ROM and palm protectors were applied to | 08/09/2021 |

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| | encephalopathy, seizures, tracheostomy, and high blood pressure.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 6/23/21, indicated the resident was rarely understood or understands. The resident was totally dependent on staff for all activities of daily living. She had impairment to both sides in range of motion for upper and lower extremities and received oxygen and had a tracheostomy while a resident.<br><br>The Care Plan, dated 1/13/21, indicated the resident was at risk for skin impairment related to the use of bilateral palm protectors. An approach was for the bilateral palm protectors to be worn at all times.<br><br>Physician's Orders, dated 1/13/21, indicated the resident was to wear bilateral palm protectors at all times. Off for daily hygiene and skin checks.<br><br>There was no documentation on how the palm protectors were being monitored for donning and doffing.<br><br>Interview with the South Unit Manager on 7/19/21 at 10:00 a.m., indicated the resident was to have the palm protectors at all times except for hygiene purposes.<br><br>3.1-42(a)(2) | | prevent decline in ROM and skin breakdown<br>**2) How the facility identified other residents:**<br>All residents who have contractures or at risk for contractures have the potential to be affected by the alleged deficient practice. An audit was completed on all resident that require the use of anti-contracture devices. Care plans were updated as needed.<br><br>**3) Measures put into place/ System changes:**<br>Nursing staff will be re-educated on Range of Motion related to Splints by the DON/designee by 08/09/21. Splint placement will be checked during rounds by the Charge Nurses and Managers daily (M-F). Manager findings will be documented on the Angel Rounds sheet and reviewed at the daily meetings. The DON is responsible for compliance.<br><br>**4) How the corrective actions will be monitored:**<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br><br>**5) Date of compliance:** | |

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| | | | **08/09/2021** | |
| F 0692 SS=D Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>Based on observation, record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed as well as diets not provided as ordered for residents who were nutritionally at risk for 2 of 2 residents reviewed for nutrition. (Residents 38 and 193)<br><br>Findings include:<br><br>1. The record for Resident 38 was reviewed on | F 0692 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09/2021**<br><br>**F692 Nutrition/Hydration**<br><br>*This Plan of Correction is the center's credible allegation of compliance.* | 08/09/2021 |

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| | 7/19/21 at 9:45 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, type 2 diabetes, and chronic kidney disease.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/25/21, indicated the resident was cognitively impaired for daily decision making, needed limited assistance for eating, and had a significant weight loss.<br><br>A Care Plan, dated 6/4/21, indicated the resident was at risk for fluctuations in weight related to receiving a therapeutic mechanically altered diet. Interventions included, but were not limited to, provide and serve diet as ordered. Monitor intake and record every meal.<br><br>A Physician's Order, dated 1/27/21, indicated the resident was to receive a no added salt, mechanical soft diet.<br><br>The food consumption documentation for July 2021, indicated the resident's dinner intake was not documented on 7/1, 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/12, 7/17, and 7/18/21.<br><br>Interview with the Director of Nursing on 7/20/21 at 8:50 a.m., indicated the resident's food intake should have been documented. 2. On 7/16/21 at 9:19 a.m., Resident 193 was served his breakfast tray. He was served scrambled eggs, ground sausage, 1 piece of toast, a cup of orange juice and coffee. He had no hot or cold cereal. The portions were not doubled.<br><br>On 7/16/21 at 12:30 p.m., the resident was served his lunch tray. He was served one serving of mashed potatoes, shredded meat, a serving of peas and a dessert. He had juice to drink. The | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br>Residents 38 no longer resides in the facility. Resident 193 was diet was assessed to meet his needs with RD and Physician.<br>**2) How the facility identified other residents:**<br>All residents who have special diet orders in the facility have the potential to be affected by the alleged deficient practice.<br>An audit was completed to identify other residents that have supplement orders to ensure the same deficient practice does not occur.<br><br>**3) Measures put into place/ System changes:**<br>A. The Nursing and Dietary staff will be re-educated on diets and reading meal tickets including where to look for them on meal tickets. All residents that have special diet orders will be followed | |

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| | serving portions were not doubled.<br><br>The record for Resident 193 was reviewed on 7/15/21 at 1:48 p.m. The resident was admitted from another long term care facility on 6/28/21. Diagnoses included, but were not limited to, schizophrenia, dysphagia (difficulty swallowing), mild protein calorie malnutrition, major depressive disorder, anxiety, high blood pressure, and dementia with behaviors.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 7/5/21, indicated the resident was not alert and oriented and had no behaviors. The resident needed extensive assist with 2 person physical assist for bed mobility, transfers, toileting, and dressing. He needed supervision with set up for eating. The resident had loss of liquids from his mouth when eating or drinking and held food in his mouth. The resident's weight was 217 pounds with no history of weight loss.<br><br>A Care Plan, dated 6/29/21, indicated the resident received a regular mechanically altered diet. An approach indicated to provide diet as ordered.<br><br>The documented weight on admission was 217 pounds. Another weight obtained on 7/6/21 was 203 pounds.<br><br>A Registered Dietitian (RD) assessment, dated 7/1/21, indicated the resident was on a mechanical soft/double portions diet and consumed 75-100% at most meals. His Body Mass Index (BMI) was 25.1 which was normal. He was on the appropriate diet to help meet nutritional needs. Will monitor weights as needed.<br><br>The food intake record for 6/2021 through 7/2021 indicated the lunch meal had not been | | at the Nutrition At Risk meeting weekly for a minimum of 4 weeks.<br>B. Audit food consumption documentation 5 days a week to ensure complete and accurate food consumption information for all residents including residents who are nutritionally at risk.<br><br>The DON/designee will complete audits on all on resident's meal consumptions for documentation 15 times weekly at different meals to ensure that the deficient practice is corrected. The DON/Designee is responsible for compliance.<br><br>**4) How the corrective actions will be monitored:**<br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**<br><br>**5) Date of compliance:**<br>**08/09/2021** | |

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| | documented on 7/6 and the dinner had not been documented on 7/5, 7/6, 7/8, 7/9, and 7/10/21.<br><br>Physician's Orders, dated 6/28/21, indicated general diet, mechanical soft texture with double portions.<br><br>Interview with the South Unit Manager on 7/19/21 at 10:00 a.m., indicated the resident was to receive double portions for every meal. She indicated the meal consumption logs should have been completed for all three meals.<br><br>Interview with the South Unit Manager on 7/20/21 at 10:15 a.m., indicated the resident should have been weighed weekly for the first 4 weeks. His weight today was 205 pounds, however, documentation from the previous facility, dated 6/23/21, indicated the resident's weight was 206 pounds. The South Unit Manager had no idea where the resident's admission weight of 217 pounds came from.<br><br>3.1-46(a) | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation, record review and interview, the facility failed to provide proper | F 0695 | | 08/09/2021 |

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| | respiratory care and services related to oxygen at the correct flow rate, changing and dating the oxygen tubing and monitoring of humidification bottles for 2 of 2 residents reviewed for oxygen. (Residents 56 and 75)<br><br>Findings include:<br><br>1. On 7/14/21 at 11:05 a.m., Resident 56 was observed sitting in a wheelchair in his room. The resident was wearing oxygen at 2.5 liters per nasal cannula on the oxygen concentrator. There was no date on the oxygen tubing. There was a water humidification bottle on the night stand with no date but it had been opened.<br><br>On 7/15/21 at 3:07 p.m., the resident had come back from dialysis and was eating lunch in his room. He was wearing oxygen at 2.5 liters per nasal cannula, there was no date on the tubing.<br><br>On 7/16/21 at 9:40 a.m., the resident was observed in the wheelchair in his room eating breakfast. He was wearing oxygen at 2.5 liters per nasal cannula, there was no date on the tubing.<br><br>On 7/19/21 at 6:46 a.m., the resident was observed in bed with his eyes closed. His oxygen tubing was on the floor and not in his nose.<br><br>On 7/19/21 at 9:00 a.m., the resident was observed in his wheelchair eating breakfast. He was wearing oxygen at 2.5 liters per nasal cannula, there was no date on the tubing.<br><br>The record for Resident 56 was reviewed on 7/15/21 at 3:29 p.m. Diagnoses included, but were not limited to, encephalopathy, chronic obstructive pulmonary disease (COPD), stroke, type 2 diabetes, cirrhosis of the liver, high blood | | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09/2021**<br><br>**F695 Respiratory/Trach**<br><br>**The facility requests paper compliance for this citation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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* | |

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| | pressure, atrial fibrillation, anemia, major depressive disorder, end stage renal disease, and dependence on renal dialysis.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 6/8/21, indicated the resident was not alert and oriented. The resident did not receive oxygen during the assessment period. He did receive dialysis while a resident at the facility. The resident weighed 158 pounds with no current weight loss. He received a therapeutic diet with no restrictions.<br><br>A Care Plan, updated on 3/16/21, indicated the resident had altered respiratory difficulty and breathing related to COPD and shortness of breath. A nursing approach, indicated oxygen as ordered and change the tubing and humidifier bottle weekly on Sundays.<br><br>Physician's Orders, dated 1/8/21, indicated apply oxygen per nasal cannula prn (as needed) and check oxygen saturation every shift, every 8 hours as needed for preventative. Another order, dated 1/8/21, indicated to check oxygen saturation every shift.<br><br>Physician's Orders, dated 7/16/21, indicated oxygen at 2 liters via nasal cannula continuously.<br><br>The 7/2021 Medication Administration Record (MAR), indicated the resident's oxygen saturation was completed every shift and ranged from 97 to 99%. The prn oxygen was signed out as being administered on 7/3/21 at 12:06 a.m., with an oxygen saturation of 98% and then again on 7/10/21 at 3:17 a.m., with an oxygen saturation of 97%. There was no documentation of any rate the oxygen should have been set to. | | *correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident's 56, 75 orders were reviewed with the MD. The O2 tubing was replaced for Residents 56 and 75. The water Humidification bottle was change and dated.<br><br>**2) How the facility identified other residents:**<br><br>All residents who receive oxygen have the potential to be affected by the alleged deficient practice.<br><br>An audit was completed on all residents who receive oxygen therapy to ensure physician order is followed and all tubing hand humidification bottles were changed and dated properly.<br><br>**3) Measures put into place/ System changes:** | |

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| | Interview with the South Unit Manager on 7/19/21 at 9:55 a.m., indicated the order was clarified by the Physician on 7/16/21 for oxygen at 2 liters continuously.<br><br>2. On 7/13/21 at 2:40 p.m., Resident 75 was observed in bed. She had a tracheostomy with an oxygen mask over it for continuous flow and mist. There was a water humidification bottle connected to the tank dated 7/4/21.<br><br>On 7/14/21 at 1:30 p.m., the resident was observed in bed. She had a tracheostomy with an oxygen mask over it for continuous flow and mist. There was a water humidification bottle connected to the tank dated 7/4/21.<br><br>On 7/15/21 at 11:00 a.m., the resident was observed in bed. She had a tracheostomy with an oxygen mask over it for continuous flow and mist. The water humidification bottle connected to the tank was now dated 7/14/21, but was almost empty.<br><br>The record for Resident 75 was reviewed on 7/16/21 at 11:50 a.m. Diagnoses included, but were not limited to, acute respiratory failure, cardiac arrest, anoxic brain damage,encephalopathy, seizures, tracheostomy, and high blood pressure.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 6/23/21, indicated the resident was rarely understood or understands. The resident was totally dependent on staff for all activities of daily living. She had impairment to both sides in range of motion for upper and lower extremities and received oxygen and had a tracheostomy while a resident. | | The nursing staff will be re-educated on Oxygen use per physician order by the DON/designee by 8/09/21 and as needed. During Angel Rounds residents who receive oxygen will be observed to ensure the setting is concurrent with the physician's order. The dates will also be observed on both the O2 tubing and Humidification bottles. Concerns will be immediately addressed with a nurse. Findings will be documented on the Angel Rounds Checklist and reviewed during daily (M-F) meetings. The DON/designee will complete random audits on random shifts a minimum of 3 times weekly. The DON/Designee is responsible for compliance.<br><br>**4) How the corrective actions will be monitored:**<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br><br>**5) Date of compliance: 08/09/2021** | |

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| | The Care Plan, updated 12/16/19, indicated the resident had a tracheostomy. The nursing approach was to change the change oxygen tubing and humidifier bottles weekly and prn (as needed).<br><br>Physician's Orders, dated 10/20/19 and the current 7/2021 order statement, indicated to change oxygen humidifier 500 cubic centimeters (cc) and oxygen tubing every Sunday night.<br><br>The Treatment Administration Record for 7/2021, indicated the oxygen tubing and humidification bottle was signed out as being completed on 7/11/21.<br><br>Interview with the South Unit Manager on 7/19/21 at 10:00 a.m., indicated the humidification bottles and tubing were to be changed every Sunday.<br><br>3.1-47(a)(6) | | | |
| F 0698 SS=D Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on record review and interview, the facility failed to provide the necessary care and services for residents who received Hemodialysis related to not assessing bruit and thrill for 1 of 1 residents reviewed for dialysis. (Resident 56)<br><br>Finding includes:<br><br>The record for Resident 56 was reviewed on | F 0698 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09//2021** | 08/09/2021 |

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| | 155580 | A. BUILDING 00<br>B. WING | 07/20/2021 |

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

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| | 7/15/21 at 3:29 p.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, end stage renal disease, and dependence on renal dialysis.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 6/8/21, indicated the resident was not alert and oriented. The resident did not receive oxygen during the assessment period. He did receive dialysis while a resident at the facility. The resident weighed 158 pounds with no current weight loss. He received a therapeutic diet with no restrictions.<br><br>A Care Plan, updated 3/16/21, indicated the resident received Hemodialysis 3 times per week. The nursing approaches were to check the bruit and thrill every shift and record, check the graft/fistula site for bleeding, and observe for pain, numbness, tingling, change in color or temperature of extremity.<br><br>Physician's Orders, dated 2/22/21, indicated dialysis every Tuesday, Thursday, and Saturday at 10:45 a.m.<br><br>The Medication Administration Record (MAR) for the months of 5/2021, 6/2021 and 7/2021, indicated there was no monitoring or documentation of assessing the bruit and thrill and observation of any potential side effects of the graft/fistula.<br><br>Interview with the South Unit Manager on 7/16/21 at 2:40 p.m., indicated there was no documentation the resident's fistula was assessed at least every shift for the bruit, thrill and any complications.<br><br>The current and updated 2/13/18 "Dialysis Monitoring and Observations" policy, provided by the Director of Nursing on 7/20/21 at 3:20 p.m., indicated listen using a stethoscope for the bruit | | **F698- Dialysis**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Resident 56 bruit and trill was assessed and reviewed with the MD. Orders placed to monitor for potential side effects of the graft/fistula.<br><br>**2) How the facility identified other residents:**<br><br>All residents requiring dialysis services have the potential to be affected by this deficient practice. All dialysis resident that have a port (bruit and trill) were assessed and orders reviewed to ensure that the alleged practice does not occur | |

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| | and thrill of the fistula once each shift. While listening for the bruit and thrill, observe the skin condition for any increased redness or swelling.<br><br>3.1-37(a) | | **3) Measures put into place/ System changes:**<br><br>Nursing staff will be educated in the completion of bruit and thrill, vitals and assessments before and after dialysis appointment.<br><br>**4) How the corrective actions will be monitored:**<br><br>DON or designed will review daily (M-F) during clinical meeting to ensure compliance. for a period of 6 weeks and 3 times a week for the next 5 months.<br><br>**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.**<br><br>**5) Date of compliance: 08/09/2021** | |
| F 0758 SS=D | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN | | | |

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| Bldg. 00 | Use<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's | | | |

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| | medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>Based on record review and interview, the facility failed to ensure there was an indication for the use of psychotropic medications related to the administration of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 194)<br><br>Finding includes:<br><br>The record for Resident 194 was reviewed on 7/15/21 at 9:55 a.m. The resident was admitted to the hospital on 6/22/21 and returned to the facility on 7/8/21. Diagnoses included, but were not limited to, psychosis, dementia, stroke, high blood pressure, major depressive disorder with psychotic symptoms, anxiety, schizoaffective disorder, and insomnia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/25/21, indicated the resident was not alert and oriented, and had no behaviors. The resident needed extensive assist with 1 person physical assist for bed mobility, transfers, dressing, walking, toilet use and personal hygiene. The resident had not received any psychotropic medications in the last 7 days.<br><br>A Care Plan, updated on 1/13/20, indicated the resident had a behavior problem of verbal aggression and resistive to care related to psychosis and schizoaffective disorder. | F 0758 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Exit 08/09/2021**<br><br>**Compliance 08/09/2021**<br><br>**F 758 Unnec Psych meds**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br>Resident 194 no longer resides in the facility | 08/09/2021 |

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| | Prior to the resident's last hospitalization of 6/22/21, the resident was receiving hospice services and was not receiving any psychotropic medications.<br><br>Physician's Orders, dated 11/2/20, indicated Risperidone (an antipsychotic medication) 0.25 milligrams (mg) 1 tablet by mouth at bedtime for visual hallucinations. The medication was discontinued on 11/9/20.<br><br>Physician's Orders, dated 7/9/21, indicated Risperidone 1 mg by mouth every evening shift.<br><br>Physician's Progress Notes, dated 7/9/21 at 12:42 p.m., indicated the resident was sent to the hospital with peg tube dysfunction, at that time she was on hospice. She had her peg tube replaced 6/24/21. She did have an upper gastrointestinal bleed with associated thrombocytopenia and her blood pressure was low in the 70's. She was ultimately deemed stable and transferred back to the facility for further management and was no longer on hospice.<br><br>Nurses' Notes, dated 7/9/21 at 2:42 p.m., 7/10/21 at 10:14 a.m., 7/10/21 at 7:31 p.m., 7/11/21 at 2:37 a.m., 7/11/21 at 1:46 p.m., 7/11/21 at 7:42 p.m., and 7/12/21 at 6:38 a.m., indicated there were no concerns with mood or behavior.<br><br>There was no other documentation in nurses's notes from 7/13-7/16/21 that the resident had any verbal aggressions, hallucinations or any other type of behaviors warranting the use of the antipsychotic medication of Risperidone.<br><br>The 7/2021 Medication Administration Record (MAR) indicated the resident received the Risperidone 7/9-7/18/21. | | **2) How the facility identified other residents:**<br>**All resident that are prescribed antipsychotic medication are at risk for the same deficient practice. A review of all resident with an order for antipsychotics were reviewed to ensure that they an appropriate diagnosis and documented behaviors that support the need for antipsychotic medication.**<br><br>**3) Measures put into place/ System changes:**<br>**All nursing staff and admission staff were educated that psychotropic drugs are prescribed to treat a specific condition as diagnosed and documented in clinical record.**<br><br>**4) How the corrective actions will be monitored:**<br>**The DON/Designee will review all new admissions for psychotropic drugs and proper diagnosis. The DON/Designee will also review new psychotropic medication orders to ensure resident has the appropriate diagnosis.** | |

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| | Interview with the South Unit Manager on 7/16/21 at 2:40 p.m., indicated there was no documentation to support the administration of the Risperidone after the resident had returned from the hospital. The resident has had no behaviors since returning from the hospital.<br><br>Interview with the Administrator on 7/19/21 at 7:30 a.m., indicated the resident had many behaviors in the hospital and that was one of the reasons she had been put back on the Risperidone and they had left her on it. There was no documentation from nursing or the physician the resident had behaviors after returning from the hospital.<br><br>3.1-48(a)(4) | | **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.**<br><br>**5) Date of compliance: 08/09/2021** | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs | | | |

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| | listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation, record review and interview, the facility failed to ensure medications were not left unattended at the bedside for 2 of 2 residents reviewed for medication storage. (Residents 10 and 55)<br><br>Findings include:<br><br>1. On 7/14/21 at 11:50 a.m., Resident 10 was observed in his room in bed. A medication cup which contained one pill was on his over bed table. The resident indicated it was his phosphorus binder and he took the pill with his meals.<br><br>The record for Resident 10 was reviewed on 7/16/21 at 11:51 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, and renal dialysis dependent.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 4/20/21, indicated the resident was cognitively intact.<br><br>The July 2021 Physician's Order Summary, indicated the resident did not have an order to self administer medications.<br><br>Interview with the Administrator on 7/20/21 at 3:00 p.m., indicated the resident's medication should not have been left at the bed side. | F 0761 | **Aperion- Tolleston Park**<br>**POC Annual Survey 2021**<br>**Compliance 08/09/2021**<br><br>**F761 Sig/Medication Error**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1.Immediate actions taken for those residents identified:**<br><br>**Residents 10 and 55 bedsides were observed for medications**<br><br>**2) How the facility identified other residents:** | 08/09/2021 |

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| | 2. On 7/16/21 at 10:12 a.m., Resident 55 was observed in her room sitting on the side of her bed. Eight pills were observed on the resident's over bed table and 1 pill was observed in a medication cup. The resident was taking one pill at a time followed by a drink of water. No staff were in the room at the time.<br><br>The record for Resident 55 was reviewed on 7/20/21 at 10:05 a.m. Diagnoses included, but were not limited to, intellectual disabilities, type 2 diabetes, and convulsions.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 6/3/21, indicated the resident was cognitively impaired for daily decision making.<br><br>The July 2021 Physician's Order Summary, indicated there was no order for the resident to self administer medications.<br><br>Interview with the Director of Nursing on 7/19/21 at 2:30 p.m., indicated the medications should not have been left in the resident's room.<br><br>The Medication Storage policy, provided by the Director of Nursing on 7/20/21 at 3:30 p.m., indicated the facility should not administer/provide bedside medications or biologicals without a Physician order and approval by the Interdisciplinary Care Team and facility administration.<br><br>3.1-25(b) | | All residents receiving oral medications have a potential to be affected.<br><br>**1.Measures put into place/ System changes:**<br><br>All licensed nurses and QMA's were re-educated on Medication administration, including storage of medication.<br><br>**4) How the corrective actions will be monitored:**<br><br>DON/Designee will conduct 6 medication pass audits a week on various shifts x's 4 weeks then 3x's a week for 4 weeks, then one time a week for 2 weeks to ensure accuracy of medication administration.<br><br>**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.**<br><br>**5) Date of compliance: 08/09/2021** | |

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| F 0803 SS=E Bldg. 00 | 483.60(c)(1)-(7)<br>Menus Meet Resident Nds/Prep in Adv/Followed<br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>Based on observation, record review, and interview, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect 4 residents in the facility who received a pureed diet. (The Main Kitchen)<br><br>Finding includes:<br><br>On 7/19/21 at 11:30 a.m., Dietary Cook 1 was observed preparing pureed carrots. The cook indicated the facility had 4 pureed diets, however, | F 0803 | **Aperion- Tolleston Park**<br>**POC Annual Survey 2021**<br>**Compliance 08/09/2021**<br><br>**F803 Menus meet residents Nds/Prep**<br><br>*This Plan of Correction is the center's credible allegation of compliance.* | 08/09/2021 |

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| | she would be making 5 servings.<br><br>The cook placed five 4 ounce servings of cooked carrots into the processor. The carrots were blended until smooth. She removed the lid and stirred. She added 1/4 cup of chicken broth to the mix and blended again until smooth. She removed the lid and stirred and added 1 piece of white bread and blended until smooth. She removed the lid and stirred and determined it was not as thick as she wanted it so she added another piece of bread and blended. She removed the lid and stirred the mixture and still determined it was not thick enough so she added another piece of white bread. The cook blended the mixture until smooth and poured it into a pan.<br><br>The recipe for 5 servings of pureed carrots indicated to add 2 and 1/2 cups of buttered carrots and 2 tablespoons of butter into the processor and blend until smooth. No liquid or bread was indicated in the recipe.<br><br>Interview with Dietary Cook 1 at that time, indicated she was taught to add the chicken stock for flavor and then to add bread if the food needed to be thickened. She was aware she did not follow the recipe.<br><br>3.1-21(i)(1) | | *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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Pureed food was prepared as per recipe<br><br>**2) How the facility identified other residents:**<br><br>All residents on special diets have the potential to be affected by this deficient practice.<br><br>**3) Measures put into place/ System changes:**<br><br>Dietitian educated dietary staff how to prepare pureed foods by following the pureed recipe.<br><br>**4) How the corrective actions will be monitored:**<br><br>Dietary manager/designees will audit 3 meals a day 5 times a | |

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| | | | week to insure proper following of pureed recipe.<br><br>**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.**<br><br>**5) Date of compliance: 08/09/2021** | |
| F 0812<br>SS=E<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents | | | |

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| | from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, record review, and interview, the facility failed to store, serve and prepare food under sanitary conditions related to the lack of hair restraints, dirty food equipment, racks and bins, old food and debris behind the stove and oven, and undated and unmarked food in the food pantries on the nursing units for 1 of 1 kitchens observed and for 3 of 3 units. (The Main Kitchen, North, South and PCU units)<br><br>Findings include:<br><br>1. During the brief kitchen sanitation tour on 7/13/21 at 9:24 a.m. with the Dietary Manager (DM) the following was observed:<br><br>a. There was a heavy accumulation of dust and rust on the 4 tiered wire rack that housed clean dishes.<br><br>b. There was a heavy accumulation of grease and dirt under the steam table top.<br><br>c. The outside of the flour and sugar bins were sticky to touch.<br><br>d. The oven hood slats were dirty and dusty.<br><br>e. There was a heavy accumulation of food particles and dirt behind the convection oven, stove and counter areas.<br><br>f. The garbage can lid was noted on the floor next to the can. | F 0812 | **POC Annual/Recertification 2021**<br><br>**Compliance 08/09/2021**<br><br>**F812 Food/Procurement**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>**1) Immediate actions taken for those residents identified:**<br><br>Dust was removed the 4 tired wire rack that houses the clean dishes The light above this area was also dusted and cleaned.<br>The grease and dirt were removed from under the steam table.<br>The flour and sugar bins were cleaned on the outside to remove | 08/09/2021 |

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| | 2. During the full kitchen tour on 7/19/21 at 11:15 a.m. with the DM, the following was observed:<br><br>a. Dietary Cook 1 was observed with her pony tail on the outside of her hair restraint.<br><br>b. There was a large amount of dust on the outside of the lights above the wired rack that housed the clean dishes.<br><br>Interview with the DM on 7/19/21 at 11:50 a.m., indicated all of the above was in need of cleaning.<br><br>3. During observations on 7/20/21 at 10:33 a.m. of the food pantries on the all three units, the following was observed:<br><br>North<br><br>a. There was 1 bag containing a jar of opened pickles and chicken salad. The bag was not labeled with a name or date.<br><br>b. There were 2 bags of a cooked meal of leftover sausage, cabbage and corn with no name or date.<br><br>c. There was a leftover sandwich with no date.<br><br>d. There were opened bottles of soda, fruit punch, and water with no name or date.<br><br>South<br><br>a. There were 2 open containers of fresh fruit with no date or name.<br><br>b. There were open bottles of soda, sweet tea, | | the sticky substance.<br>The oven hood was cleaned from dirt and dust.<br>Food particles were removed from behind the convection oven, stove and counter area.<br>Garbage lid was pick up off the floor and cleaned.<br>Kitchen staff was re in serviced on how to wear hair restraints, beard guards and PPE.<br>The cook was immediately re-in serviced on wearing beard guard properly and wearing gloves when touching food.<br>The food was removed from the North, PCU and South Unit refrigerators without names and dates.<br><br>**2) How the facility identified other residents:**<br>All residents receiving oral diet have the potential to be affected by this deficient practice.<br><br>**3) Measures put into place/ System changes:**<br>All dietary staff was educated on cleaning schedules for equipment to prevent buildup of dust and dirt on equipment and walls and to prevent contamination of food.<br>Staff was also educated on proper use of beard guard, hair nets, using utensils to pick up food and proper hand washing technique.<br>The kitchen and floor staff were in serviced on labeling name and date for all food put in refrigerator | |

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| | and water with no name or date.<br><br>PCU<br><br>a. There was a cup of iced coffee with no name or date.<br><br>b. There was 1 bag of leftover food with no name or date.<br><br>The current and updated 6/3/19 "Food items brought from outside" policy, provided by the Assistant Director of Nursing (ADON) on 7/20/21 at 12:55 p.m., indicated food stored must be labeled with the resident's name and dated.<br><br>Interview with the Assistant Director of Nursing on 7/20/21 at 12:55 p.m., indicated all food brought in by visitors must have a name and date.<br><br>3.1-21(i)(3) | | on the units per facility policy<br><br>**4) How the corrective actions will be monitored:**<br>Dietary manager/designees will conduct observation audits in the kitchen 5 times per week at various times to ensure proper sanitation, and infection control is maintained.<br><br>**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.**<br><br>**5) Date of compliance:**<br>**08/09/2021** | |
| F 0880<br>SS=E<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program. | | | |

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| | The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or | | | |

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| | their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed before and after glove removal, not wearing the appropriate personal protective equipment (PPE) before entering a transmission based precaution (TBP) room and while completing tracheostomy care with a continuous aerosol, removing PPE inside a TBP room, touching medications with bare hands, urinals and bed pans that were not contained, and TBP not initiated for random observations for infection control for 3 of 3 residents in TBP (Residents 193, 75 and 244), 2 of 6 residents observed during medication pass (Residents 247 and 61), and 2 of 2 units observed during environmental tour. (North and South)<br><br>Findings include: | F 0880 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09/2021**<br><br>**F880 Infection control**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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* | 08/09/2021 |

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| | 1. On 7/13/21 at 12:20 p.m., Resident 194 was observed sitting in the special care dining room, she was not wearing a face mask and she was seated at a table with 4 other residents. There was a sign on the resident's door which indicated she was in TBP. Before entering the resident's room, all persons were to donn clean gloves, an isolation gown, a N95 face mask, and a face shield.<br><br>Interview with CNA 4 at that time, indicated she was unaware the resident could not come out of her room.<br><br>Interview with the South Unit Manager at that time, indicated the resident was a readmission from the hospital on 7/8/21. The resident was not vaccinated against COVID-19.<br><br>On 7/14/21 at 10:42 a.m., CNA 2 was observed coming out of Resident 193's room. The CNA was wearing a surgical face mask.<br><br>Interview with the CNA at that time, indicated she had just provided incontinence care to the resident. She wore a gown and gloves before entering the room, however, she did not wear a face shield and did not change her surgical face mask and wear a N95 face mask.<br><br>On 7/15/21 at 9:47 a.m., 10:52 a.m., and 1:15 p.m., the resident was dressed and seated in a wheelchair just inside her room in the doorway. She was wearing a face mask over her mouth only, her nose was uncovered. CNA 4 was observed sitting within 6 feet of the resident just outside of the room. The CNA was wearing a KN95 face mask, however, she was not wearing a face shield.<br><br>On 7/16/21 at 9:27 a.m., LPN 5 was preparing to | | *deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br>Resident 194 is no longer resides in the Facility<br>CNA 1,CNA 2, CNA 3, CNA 4,LPN 1, LPN2, LPN 3, LPN4, LPN 5 was re in-serviced immediately on infection Control Policies<br>Resident 244 insolation set up was placed outside the door and signage was posted<br>**2) How the facility identified other residents:**<br><br>All residents have the potential to be affected by this deficient practice.<br><br>**3) Measures put into place/ System changes:**<br><br>Facility IDT team completed a root cause analysis and Infection Control Self-Assessment with the Corporate Infection Control Preventionist. Reviewed findings and developed action plan and education materials based on findings.<br><br>Staff will be re-educated regarding spread of infections as is relates to infection control policies | |

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| | enter the resident's room. He performed hand hygiene, and donned a clean isolation gown, a N95 face mask and then a face shield over his face. He placed his used surgical face mask in his pant's pocket. He donned a pair of clean gloves and entered the room. After he was finished, he opened the door and removed his gloves and gown and threw them away inside the room. He walked out of the room by the door way and removed the face shield and set it on top of the plastic bin. He walked over to the medication cart and picked up his computer and wrist blood pressure cuff and started walking towards the dining room on the special care unit. He turned around and removed his N95 face mask and pulled his surgical face mask out of his pocket and placed it on his face. At this time, LPN 5 had not performed any hand hygiene after removing the PPE. He picked up the computer and blood pressure cuff and entered the dining room.<br><br>On 7/16/21 at 12:49 p.m., LPN 5 was sitting in a chair right outside of the resident's room. He was charting on his computer. The resident was in the doorway sitting in a wheelchair and indicated she had to go to the bathroom. LPN 5 stopped what he was doing and told the resident he would take her to the bathroom. He donned a pair of clean gloves, a gown and then removed his surgical face mask and placed it in the plastic bag, pulled out a N95 face mask, placed that over his mouth and nose and then placed the face shield over his face and walked into the resident's room. He did not perform hand hygiene at any time.<br><br>On 7/19/21 at 6:45 a.m., CNA 1 was observed walking the resident out of her room and into the dining room. The CNA indicated she got her up and dressed and walked her to the dining room. The CNA was unaware the resident was | | **4) How the corrective actions will be monitored:**<br><br>The Director of Nursing or designee will (See Action Plan for the recommended monitoring)<br><br>**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 achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**<br><br>**5) Date of compliance: 08/09/2021** | |

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supposed to stay inside her room while on TBP. The resident did not have a face mask over her mouth or nose.

The record for Resident 194 was reviewed on 7/15/21 at 9:55 a.m. The resident was admitted to the hospital on 6/22/21 and returned to the facility on 7/8/21. Diagnoses included, but were not limited to, respiratory failure, psychosis, dementia, stroke, high blood pressure, major depressive disorder with psychotic symptoms, anxiety, schizoaffective disorder, and insomnia.

Physician's Orders, dated 7/19/21 indicated the resident was to be in droplet isolation.

The resident had not been fully vaccinated against COVID-19.

Interview with the Director of Nursing on 7/19/21 at 1:30 p.m., indicated staff were not to place their face mask in their pockets and reuse them. The resident was not supposed to be out of her room while in TBP. Hand hygiene was to be performed before and after resident care.

2. On 7/14/21 at 1:30 p.m., LPN 6 and CNA 3 donned PPE to enter Resident 75's room. There was a sign on the resident's door which indicated she was in TBP. Before entering the resident's room, all persons were to donn clean gloves, an isolation gown, a N95 face mask and a face shield. CNA 3 donned clean gloves to both hands, and removed her surgical mask and placed it into her pant's pocket and placed a N95 face mask on. She then donned an isolation gown and face shield. She did not perform hand hygiene at any time. After providing care to the resident, they both removed their gloves and walked over by the door where there was a trash can. They both

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| | removed their isolation gowns and threw them away. CNA 3 removed her N95 face mask and pulled out her surgical face mask from her pocket and put it on her face, she then removed her face shield all inside the room. LPN 6 removed her N95 face mask inside the room and her surgical face mask was already under that one. She removed her face shield as well inside the room and threw it away. They both left the room and performed hand hygiene right outside of the room.<br><br>On 7/19/21 at 6:07 a.m., LPN 3 and LPN 4 donned PPE and were preparing to perform tracheostomy care for the resident. Before entering the room, LPN 3 donned the appropriate PPE and LPN 4 donned an isolation gown, face shield and clean gloves. She was wearing a surgical face mask and did not change that out and place a N95 face mask on. LPN 4 was observed within 6 feet of the resident helping LPN 3 clean around the tracheostomy, change the ties and put a new oxygen mask over the trach.<br><br>Interview with LPN 4 on 7/19/21 at 6:40 a.m., indicated she was aware she was supposed to wear a N95 face mask into the room. She indicated she had not been vaccinated for COVID-19.<br><br>The record for Resident 75 was reviewed on 7/16/21 at 11:50 a.m. Diagnoses included, but were not limited to, acute respiratory failure, cardiac arrest, anoxic brain damage, encephalopathy, seizures, tracheostomy, and high blood pressure.<br><br>Physician's Orders, on the current 7/2021 order statement, indicated the resident was to be droplet isolation due to continuous aerosol with the tracheostomy. | | | |

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| | Interview with the South Unit Manager on 7/19/21 at 10:00 a.m., indicated LPN 4 should have worn an N95 face mask while performing tracheostomy care. The CNA should not have placed her surgical face mask in her pocket and the face shields and face masks were to be removed outside of the room, not inside the room.<br><br>The current and undated "Transmission Based Precautions" policy, provided by the Director of Nursing on 7/20/21 at 3:28 p.m., indicated hands were to be washed immediately after glove removal. 3. On 7/19/21 at 9:22 a.m., LPN 1 was observed preparing Resident 247's medications. The resident's room had an isolation bin outside the door and isolation signage posted indicating she was on contact and droplet precautions. LPN 1 took the prepared medications and entered the resident's room without donning any additional PPE. He was wearing a surgical mask. At 9:25 a.m., the Director of Nursing called LPN 1 out of the room and reminded him the resident was under contact and droplet isolation. LPN 1 then donned the correct PPE and re-entered the room. Interview with LPN 1 at the time, indicated he had forgotten to donn the appropriate PPE.<br><br>4. On 7/14/21 at 10:21 a.m., Resident 244 was observed lying in bed. There was no isolation set up outside his room door and no isolation signage posted.<br><br>On 7/14/21 at 11:19 a.m., Resident 244 was observed lying in bed. A staff member was in his room providing nail care. The staff member was wearing a surgical mask but no additional PPE. There was no isolation set up outside the room door and no isolation signage posted.<br><br>On 7/15/21 at 9:49 a.m., the resident was observed | | | |

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| | lying in bed. There was an isolation bin outside the room door and yellow zone isolation signage posted on the door indicating the resident was on contact and droplet precautions.<br><br>Interview with LPN 2 on 7/15/21 at 10:04 a.m., indicated the resident was on 14 day isolation due to being a new admission and he still had a couple days left. She indicated she had worked the same hall yesterday and the resident did not have an isolation bin outside his room or isolation signage posted on his door.<br><br>Resident 244's record was reviewed on 7/10/21 at 11:45 a.m. The resident was admitted to the facility on 7/2/21. A Physician's Order, dated 7/2/21, indicated "Covid: Quarantine Precautions (contact and droplet) every shift x 14 days."<br><br>A facility policy, "Infection Control-interim policy addressing healthcare crisis related to Human Corona Virus", was provided by the Administrator as current, and indicated, ".... Yellow Zone-observation area...Ensure the resident under observation is isolated and cared for using all recommended COVID-19 PPE (gloves, gown, N95/KN95 mask, and eye protection) ...."<br><br>5. On 7/19/21 at 9:34 a.m., LPN 1 was observed preparing Resident 61's medications. As he was popping a pill out of the blister pack, he dropped it on top of the medication cart. He picked up the pill with his bare hands and placed it inside the medication cup and prepared to give the medications to the resident. The resident then indicated he did not want two of his medications. LPN 1 then removed those 2 pills out of the medication cup with his bare hands, touching the remaining pills in the cup, and gave the rest of the medications to the resident to take. | | | |

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A facility policy, "Medication Pass Process and Procedure" was provided by the Director of Nursing as current, and indicated, "....8. Prepare medication, general instructions: Do not touch medication or inside of souffle cup..."

6. On 7/15/21 at 1:19 p.m., the South Unit Manager was observed completing Resident 67's wound care. She washed her hands, donned gloves, and removed the dressing to the resident's right hip. She disposed of the old dressing in the garbage along with her gloves. She then donned a new pair of gloves without completing hand hygiene. She cleaned the wound, applied the treatment to the right hip, and placed a new dressing over the wound without changing her gloves in between. She removed her gloves, washed her hands, and donned new gloves. She removed the dressing to the resident's sacrum. She disposed of the old dressing in the garbage along with her gloves. She then donned a new pair of gloves without completing hand hygiene. She cleaned the wound, applied the treatment to the sacrum, and placed a new dressing over the wound without changing her gloves in between. She then removed her gloves and washed her hands.

Interview with the South Unit Manger on 7/15/21 at 1:48 p.m., indicated she should have completed hand hygiene when changing gloves. She thought she had changed her gloves after cleaning the wound and before applying the treatment to the wounds.

A facility policy, "Dressing Change", was provided by the Director of Nursing as current, and indicated, "....10. Remove soiled dressing and place in plastic trash bag. 11. Remove soiled

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| | gloves and place in plastic trash bag. 12. Wash hands, or if hands are not visibly soiled, an alcohol based hand gel may be used to decontaminate the hands...13. Apply clean gloves..."<br><br>7. During the Environmental Tour on 7/20/21, from 1:55 p.m. through 2:20 p.m. with the Maintenance Director, the following was observed:<br><br>North Unit:<br><br>a. Room 109-2: An uncovered, unlabeled urinal was on the back of the toilet tank in the bathroom. Two residents resided in the room.<br><br>b. Room 125-1: An uncovered, unlabeled pink basin was on the back of the toilet tank. There were two unlabeled urinals in the basin. There was an uncovered, unlabeled pink bedpan tucked inside the grab bar in the bathroom. Two residents resided in the room.<br><br>South Unit:<br><br>a. Room 218-1: There was an uncovered, unlabeled urinal hanging on the bathroom grab bar. Two residents resided in the room.<br><br>Interview with Maintenance Director on 7/20/21 at 2:20 p.m., indicated the above items should have probably been labeled and covered. He would speak to the Director of Housekeeping about it.<br><br>3.1-18(b) | | | |
| F 0921<br>SS=E<br>Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions | | | |

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| | The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to ensure the kitchen was clean and in good repair related to marred walls, missing base boards, dirt, crumbs, and debris, dirty PVC pipes, and burnt out light bulbs for 1 of 1 kitchens (Main Kitchen) and the residents' environment was clean and in good repair related to dirty floor tiles, marred walls, holes in walls, and stained curtains for 2 of 3 units. (North and South)<br><br>Findings include:<br><br>1. During the brief kitchen sanitation tour on 7/13/21 at 9:24 a.m. with the Dietary Manager (DM) the following was observed:<br><br>a. The ceiling was peeling away by the corner wall.<br><br>b. There were 3 lights that were burned out.<br><br>c. The base board was missing under the dish machine.<br><br>d. The white PVC pipes under the 3 compartment sink were dirty with dried food.<br><br>e. The walls were marred throughout the kitchen.<br><br>f. There was no drainer stopper for the middle compartment in the 3 compartment sink. There was a towel noted in place of the stopper.<br><br>g. There was heavy accumulation of food and debris behind the shelves and on the floor in the dry food storage room | F 0921 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification 2021**<br><br>**Compliance 08/09/2021**<br>**F-921**<br>**Safe/Functional/Sanitary/Comfortable Environment**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br>*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.*<br><br>**1.Immediate actions taken for those residents identified:**<br>**All of the identified concerns below were identified and corrected:**<br><br>In the kitchen:<br>**All the identified concerns below were identified and corrected:** | 08/09/2021 |

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| | Interview with the DM on 7/19/21 at 11:50 a.m., indicated all of the above was in need of cleaning and or repair.2. During the Environmental Tour on 7/20/21, from 1:55 p.m. through 2:20 p.m. with the Maintenance Director, the following was observed:<br><br>North Unit:<br><br>a. Room 102-2: There were no knobs on the closet doors, part of the window blinds were missing, there was residue from non-skid strips on the floor, the walls were marred, and there was lime buildup on the bathroom faucet. The plastic on the right arm rest of the resident's wheelchair was cracked. One resident resided in the room.<br><br>b. Room 109-2: There was a hole in the outside of the bathroom door, lime buildup on the bathroom faucet, the closet doors were off the track and resting inside the closet, the right side cushion of the resident's broda chair was torn, and the floor mat was dirty and torn. There was a dried brown substance on the wall next to the bathroom sink. Two residents resided in the room.<br><br>c. Room 112-2: There was a hole in the bathroom wall and small hole in the bathroom door. There was no light fixture cover in the bathroom. Two residents resided in the room.<br><br>d. Room 113-2: The resident's headboard was scratched and marred, the floor tiles were dirty and cracked, the bathroom floor tile was discolored, there was lime buildup on the bathroom faucet, there was no toilet paper roll holder in the bathroom, and the privacy curtain was stained. Two residents resided in the room.<br><br>e. Room 115-1: The floor tiles were dirty and | | a.The ceiling was peeling away by the corner wall.<br>b. There were 3 lights that were burned out.<br>c. The base board was missing under the dish machine.<br>d. The white PVC pipes under the 3 compartment sink were dirty with dried food.<br>e. The walls were marred throughout the kitchen.<br>f. There was no drainer stopper for the middle compartment in the 3 compartment sink. There was a towel noted in place of the stopper.<br>g. There was heavy accumulation of food and debris behind the shelves and on the floor in the dry food storage room<br><br><u>On the units</u><br>North Unit:<br>a. Room 102-2: There were no knobs on the closet doors, part of the window blinds were missing, there was residue from non-skid strips on the floor, the walls were marred, and there was lime buildup on the bathroom faucet. The plastic on the right arm rest of the | |

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| | cracked, the bathroom walls were marred, and the privacy curtain was stained. One resident resided in the room.<br><br>f. Room 120-2: The walls were marred, the wall next to the closet door was gouged and chipped, the floor tiles were dirty and cracked, the bathroom walls were marred, and the privacy curtain was stained. One resident resided in the room.<br><br>South Unit:<br><br>a. Room 204-2: The walls were marred and the bathroom floor tiles were discolored. One resident resided in the room.<br><br>b. Room 211-2: The air conditioner was hanging off the wall and there was a dried brown substance on the tube feeding pole. One resident resided in the room.<br><br>c. Room 218-1: The bathroom walls were marred. Two residents resided in the room.<br><br>Interview with Maintenance Director on 7/20/21 at 2:20 p.m., indicated the above was in need of cleaning or repair.<br><br>3.1-19(f) | | resident's<br>wheelchair was cracked. One resident resided in<br>the room.<br>b. Room 109-2: There was a hole in the outside<br>of the bathroom door, lime buildup on the<br>bathroom faucet, the closet doors were off the<br>track and resting inside the closet, the right side<br>cushion of the resident's broda chair was torn,<br>and the floor mat was dirty and torn. There was a<br>dried brown substance on the wall next to the<br>bathroom sink. Two residents resided in the<br>room.<br>c. Room 112-2: There was a hole in the<br>bathroom wall and small hole in the bathroom<br>door. There was no light fixture cover in the<br>bathroom. Two residents resided in the room.<br>d. Room 113-2: The resident's headboard was<br>scratched and marred, the floor tiles were dirty<br>and cracked, the bathroom floor tile was<br>discolored, there was lime buildup on the<br>bathroom faucet, there was no toilet paper roll<br>holder in the bathroom, and the | |

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| | | | privacy curtain<br>was stained. Two residents<br>resided in the room.<br>e. Room 115-1: The floor tiles<br>were dirty and<br>cracked, the bathroom walls were<br>marred, and<br>the privacy curtain was stained.<br>One resident<br>resided in the room.<br>f. Room 120-2: The walls were<br>marred, the wall<br>next to the closet door was<br>gouged and chipped,<br>the floor tiles were dirty and<br>cracked, the<br>bathroom walls were marred, and<br>the privacy<br>curtain was stained. One resident<br>resided in the<br>room.<br>South Unit:<br>a. Room 204-2: The walls were<br>marred and the<br>bathroom floor tiles were<br>discolored. One<br>resident resided in the room.<br>b. Room 211-2: The air conditioner<br>was hanging<br>off the wall and there was a dried<br>brown<br>substance on the tube feeding<br>pole. One<br>resident resided in the room.<br>c. Room 218-1: The bathroom<br>walls were<br>marred. Two residents resided in<br>the room.<br>Interview with Maintenance<br>Director on 7/20/21 at | |

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| | | | 2:20 p.m., indicated the above was in need of cleaning or repair.<br>**2) How the facility identified other residents:**<br>**All residents are at risk for the same deficient practice.**<br><br>**3)Measures put into place/ System changes:**<br>**Staff was in-serviced on notifying Maintenance Director and staff when environment needs to be repaired.**<br>**4)How the corrective actions will be monitored:**<br>**The Administrator/designee monitor corrective actions & sustain compliance; Competing rounds 5 days a week to ensure the facility is a safe comfortable and sanitary environment. 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.**<br>**5) Date of compliance:**<br>**08/09/2021** | |

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| F 9999<br><br>Bldg. 00 | 3.1-14 PERSONNEL<br><br>(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:<br>(1) Residents' rights.<br>(5) Needs of specialized populations served.<br>(6) Care of cognitively impaired residents.<br><br>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.<br><br>This rule was not met as evidenced by:<br><br>Based on record review and interview, the facility failed to ensure annual resident rights, abuse training, and dementia training was completed for 2 of 5 employee records reviewed. (LPN 7 and Dietary Aide 1)<br><br>Finding includes:<br><br>The employee records were reviewed on 7/20/21 at 12:00 p.m., and indicated the following:<br><br>a. LPN 7, who was hired on 5/25/16, had no documentation indicating she had received her | F 9999 | **Aperion- Tolleston Park**<br><br>**POC Annual/Recertification**<br><br>**Compliance 08/09/2021**<br><br>**F9999 Personnel**<br><br>**1) Immediate corrective action(s) for those residents affected by the deficient practice:**<br>Dietary Aide 1 and LPN 7 completed annual abuse and resident rights in-service and 3 hours of Dementia training<br><br>**2) Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:**<br>HRD/designee to review employee files for all staff to ensure Resident Right, abuse and dementia training have been completed accurately.<br><br>**3) Facility measures and systemic changes to ensure the deficient practice does not recur:**<br>All staff was in serviced on the | 08/09/2021 |

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| | annual resident rights and abuse inservices. The LPN had also not received 3 hours of annual dementia training.<br><br>b. Dietary Aide 1, who was hired on 6/18/18, had no documentation indicating he had received his annual resident rights and abuse inservices. The Dietary Aide had also not received 3 hours of annual dementia training.<br><br>Interview with the Human Resources Director on 7/20/21 at 1:47 p.m., indicated the employees did not have the 2020 inservices or dementia training. | | need for annual Dementia , Resident Rights and Abuse training.<br><br>**4) Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:**<br>**An audit of employee files will be completed within 7 days of hire to ensure Dementia and Res/rights and Abuse are completed. Upon annual review of hire.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.**<br><br>**5) Date of compliance:**<br>**08/09/2021** | |