| PRINTED: | 09/14/2022 |
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| FORM API | PROVED |

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY, IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG F 0000 Bldg. 00 This visit was for a Recertification and State F 0000 Licensure Survey. This visit included the Investigation of Complaints IN00384672, IN00384824, IN00385007, IN00386306, and IN00387286. Complaint IN00384672 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686. Complaint IN00384824 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697 and F925. Complaint IN00385007 - Unsubstantiated due to lack of evidence. Complaint IN00386306 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387286 - Substantiated. Federal/State deficiencies related to the allegations are cited at F609 and F809. Survey dates: July 31, and August 1, 2, 3, 4, and 5,2022 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 126 Total: 126 Census Payor Type: Medicare: 9

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COM 08/ | te survey Mpleted 05/2022 |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------|------------|---------------------------------|
| | PROVIDER OR SUPPLI | | 2350 TA | address, city, state, zip AFT ST IN 46404 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 0550 SS=C Bldg. 00 | accordance with 4 Quality review co 483.10(a)(1)(2)(Resident Rights, §483.10(a) Resi The resident has existence, self-d communication v and services ins including those s §483.10(a)(1) A resident with resi each resident in environment that enhancement of recognizing each facility must prot the resident. §483.10(a)(2) Th access to quality diagnosis, sever source. A facility maintain identica regarding transfe provision of servall residents reg §483.10(b) Exer The resident has her rights as a resident con the resident has | mpleted on 8/10/22. b)(1)(2) /Exercise of Rights dent Rights. s a right to a dignified etermination, and with and access to persons ide and outside the facility, specified in this section. facility must treat each pect and dignity and care for a manner and in an t promotes maintenance or his or her quality of life, n resident's individuality. The ect and promote the rights of the facility must provide equal care regardless of ity of condition, or payment must establish and al policies and practices er, discharge, and the ices under the State plan for ardless of payment source. | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | <u>00</u> | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------|
| | PROVIDER OR SUPPLII | | | 2350 T | ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | | (X5) COMPLETION DATE | |
| | the resident can without interferen or reprisal from t §483.10(b)(2) Th free of interferen and reprisal from or her rights and facility in the exe required under th Based on observat failed to ensure ea maintained related and utensils for 6 the potential to aff the facility and red Findings include: 1. During the init 7/31/22 at 8:51 a.n serving breakfast. plate and bowl as knife. Interview with the they were serving were not enough p 2. On 7/31/22 at 1 delivered to the N on styrofoam plata plastic spoon and At 12:54 p.m., the the Memory Care | he resident has the right to be ce, coercion, discrimination, in the facility in exercising his to be supported by the preise of his or her rights as his subpart. tion and interview, the facility ich resident's dignity was to the use of disposable plates of 6 meals observed. This had feet the 126 residents residing in beiving food from the kitchen. ial kitchen sanitation tour, on n., Dietary Cook 1 was observed On each tray was a styrofoam well as a plastic spoon and Cook at that time, indicated on styrofoam because there olates for everyone. 12:17 p.m., the lunch trays were orth Unit. The meal was served as and each resident received a knife. | F 05 | 550 | Aperion- Tolleston Park Annual/Recertification Survey Compliance 09/04/2022 F 550 Dignity The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for | ent e | 09/04/202 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155580 B. WING 08/05/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 3. On 8/1/22 at 9:36 a.m., residents in the Memory Administrator purchased glass Care Unit were served their breakfast. Again, the plates, forks, and bowls to ensure breakfast meal was served on a styrofoam plate all resident's meals are served on and the hot and/or cold cereal was served in a dinnerware. styrofoam bowl. Plastic spoons and knives were provided. 2) How the facility identified other residents: 4. On 8/2/22 at 9:02 a.m., the breakfast trays were delivered to the Memory Care Unit. At 1:04 p.m., All residents could be affected by the lunch trays were delivered. For both meals, this deficient practice. An audit the food was served on styrofoam plates and inventory was completed for bowls. A plastic spoon and knife was provided. plates, bowls, and forks. Dietary Manager reviewed all residents 5. On 8/3/22 at 9:07 a.m., residents in the Memory order to identify residents that Care Unit were served their breakfast. Again, the have a standing order for breakfast meal was served on a styrofoam plate Styrofoam. If resident identified the and the hot and/or cold cereal was served in a Dietary Manager and DON will styrofoam bowl. Plastic spoons and knives were review to ensure resident's dignity provided. is not compromised. Interview with the Dietary Food Manager on 3) Measures put into place/ 8/3/22 at 10:33 a.m., indicated the facility was short System changes: on plates due to plates kept getting broken, she confirmed there were no plastic forks. She Education was provided to the indicated plates and utensils were being delivered Dietary Department to explain the tomorrow. importance of ensuring each resident's dignity is maintained by 3.1-3(t) providing all meals on dinnerware. The Dietary Department must contact Administrator and Dietary Manager prior to provide meals on Styrofoam plates. 4) How the corrective actions will be monitored: Dietary Manager/or designee will monitor meals weekly for a period of 6 months to ensure that all SKSY11 Facility ID: 008505

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155580 | A. BUILDING <u>00</u> B. WING | | COMPI 08/05 | leted 5/ 2022 |
| | PROVIDER OR SUPPLIE | | 2350 | T ADDRESS, CITY, STATE, ZIP TAFT ST | COD | |
| APERIO | N CARE TOLLEST | ON PARK | GARY | 7, IN 46404 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY) | RRECTION SHOULD BE APPROPRIATE | (X5) COMPLETION DATE |
| | | | | residents are receivin dinnerware. | g proper | |
| | | | | The results of these be reviewed in Qualit Assurance Meeting r months or until an av 100% compliance or achieved x3 consecu months. The QA Con will identify any trend patterns and make recommendations to plan of correction as | ty monthly x6 verage of greater is utive mmittee ds or previse the | |
| [:] 0609 SS=D Bldg. 00 | , | ged Violations ponse to allegations of xploitation, or mistreatment, | | 5) Date of compliant | ce: | |
| | violations involvir exploitation or mi injuries of unknow misappropriation reported immedia hours after the al events that cause or result in serious than 24 hours if the allegation do not result in serious the administrator of the officials (including | sure that all alleged ag abuse, neglect, streatment, including vn source and of resident property, are ately, but not later than 2 legation is made, if the e the allegation involve abuse s bodily injury, or not later the events that cause the involve abuse and do not bodily injury, to the the facility and to other g to the State Survey t protective services where | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility F 0609 **Aperion- Tolleston Park** 09/04/2022 failed to ensure an allegation of alleged physical Annual/Recertification Survey abuse was reported immediately within 2 hours Compliance 09/04/2022 after the allegation was made to the Administrator This Plan of Correction is the for 1 of 3 allegations of abuse reviewed. (Resident center's credible allegation of H) compliance. Finding includes: Preparation and/or execution of this plan of correction does not During a confidential interview on 8/5/22, constitute admission or agreement Resident H had been identified as being by the provider of the truth of the "slapped" by a staff member and the incident facts alleged or conclusions set wasn't reported right away. forth in the statement of deficiencies. The plan of The record for Resident H was reviewed on $\frac{8}{3}/22$ correction is prepared and/or at 12:49 p.m. Diagnoses included, but were not executed solely because it is limited to, cognitive communication deficit and required by the provisions of dementia with behavioral disturbance. federal and state law. The facility requests paper The Quarterly Minimum Data Set (MDS) compliance for this citation. assessment, dated 7/14/22, indicated the resident had severe cognitive impairment. F609 Reporting Alleged Violation Nurses' Notes, dated 7/2/22 at 2:12 p.m., indicated 3) What measures will be put the resident's Responsible Party was called into place and what systemic concerning an incident that was reported to the changes will be made to writer and an investigation was in progress. ensure that the deficient practice does not recur. SKSY11

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE C A. BUILDING | construction <u>00</u> | (X3) DATE SURVEY COMPLETED | |
|---------|---------------------------------------------|-------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------|-------------------------------|--|
| | | 155580 | B. WING | | 08/05/2022 | |
| NAME OF | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP COD | - | |
| APERIO | N CARE TOLLEST | ON PARK | | TAFT ST /, IN 46404 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | IATE COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | | ed 7/2/22 at 3:11 p.m., indicated | | | | |
| | - | ited with minimal swelling to | | SSD, DON, or designee will | | |
| | - | wrist, no bruising was noted | | conduct audits of progress no | | |
| | | ntact. Facial grimacing was | | daily, on scheduled days of w | | |
| | noted with active range of motion (AROM), f | | | ongoing, in an effort to identif | | |
| | | lesting an x-ray. The Physician | | episodes/occurrences that co | uld | |
| | | rders were received for a STAT | | be considered abuse. If any | | |
| | (immediate) x-ray | to the right hand and wrist. | | situations are identified, staff | | |
| | T1 C '1'4 ' 4 | · · · · | | be interviewed to ensure prop | ber, | |
| | | igation indicated the | | timely reporting to the abuse | | |
| | | notified of the allegation on | | coordinator has been done. | Any | |
| | - | n. LPN 2 was suspended | | identified concerns will be | N | |
| | | ion, the local police department | | immediately addressed with t | | |
| | was notified, and for all staff. | ibuse education was initiated | | responsible individual(s), incl | - | |
| | for all staff. | | | but not limited to, provision o | í – | |
| | CNIA 1 had a same | | | re-education, as necessary. | | |
| | | ective action form, dated 7/2/22, | | | | |
| | - | ed to report an allegation of | | 4) How the corrective action | IS | |
| | - | e indicated she didn't witness | | will be monitored: The | | |
| | | ard one of her peers discussing cated she didn't report the | | Administrator /designee will | a | |
| | | he didn't believe it occurred. | | conduct random Abuse audit | | |
| | | a written warning. | | 5 residents per week for 4 we 3 resident for 8 weeks and 2 | eks. | |
| | The CNA received | i a written warning. | | residents 12 weeks to ensure | atoff | |
| | CNA 2 had a corre | ective action form, dated 7/2/22, | | | | |
| | | ed to report an allegation of | | compliance with Abuse Policy | <i>y</i> . | |
| | U U | timely manner. The CNA had | | Any reported issues will be handled per the Abuse Policy | / | |
| | e | to why she didn't report the | | Audits will continue until 6 m | | |
| | _ | NA was suspended pending | | of compliance is achieved. | | |
| | | eventually terminated. | | | | |
| | | | | In an effort to identify any sig | ns of | |
| | Interview with the | Director of Nursing (DON) on | | abuse of any kind, the facility | | |
| | | n., indicated the incident | | Administrator, or designee, w | | |
| | | ight shift on 7/1/22. The nurse | | responsible to monitor staff to | | |
| | | being rough with the resident, | | resident interactions. These | | |
| | | down because the resident | | observations will take place a | at | |
| | | ive. The resident was not | | least 5 times weekly, random | | |
| | - | A did not let the DON know until | | across all shifts, including | | |
| | | hen she found out, she | | weekends and holidays for 4 | | |
| | - | d the Administrator and the | | weeks. Any identified/observ | | |

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE A. BUILDING B. WING | DING <u>00</u> COMPLE 08/05/2 | | | |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--|
| | PROVIDER OR SUPPLIE | | 2350 | t address, city, state, zip (TAFT ST Y, IN 46404 | COD | | |
| (X4) ID PREFIX TAG | SUMMARY (EACH DEFICIE) REGULATORY O investigation was s was substantiated a | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION tarted. The allegation of abuse and the LPN was terminated. lates to Complaint IN00387286. | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION'S CROSS-REFERENCED TO THE DEFICIENCY) Concerns will be imme addressed with the re- individual(s), with inve- implemented, as nece Thereafter, these obse- take place at least 3 ti weekly, randomly, acr shifts, including weeks holidays for 8 weeks, least twice weekly, ran across all shifts, includ weekends and holiday weeks. Any identified concerns will be imme addressed with the re- individual(s), with inve- implemented, as nece Any concerns will be i addressed with the re- individual(s), with inve- implemented, as nece 5) Date of compliance | SHOULD BE APPROPRIATE ediately sponsible estigations essary. ervations will mes ross all ends and and then at ndomly, ding ys for 12 /observed ediately sponsible estigations essary. mmediately sponsible estigations essary. | (X5) COMPLETION DATE | |
| F 0677 SS=E Bldg. 00 | §483.24(a)(2) A r carry out activitie necessary servic nutrition, groomir hygiene; Based on observat interview, the facil residents were pro- of daily living (AL eating, nail care, sl | ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good ag, and personal and oral on, record review, and ity failed to ensure dependent wided assistance with activities DL's) related to assistance with naving, and showers for 10 of 12 for ADL's. (Residents H, 61, , 125, G and 41) | F 0677 | 09/04/2022 Aperion Care- Tolles Compliance 09/04/22 F 677 ADL Care Prov Dependent Residents The facility requests compliance for this c | ided for s paper | 09/04/202 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

| | ERS FOR MEDICARE & MEDICAID SERVICES | | - | | OMB NO. 0938-039 | |
|---------|----------------------------------------------------|----------------------------------|------------------|------------------------------------------------------------------------|------------------|--|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | | (X3) DATE SURVEY | |
| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 155580 | B. WING | | 08/05/2022 | |
| JAME OF | PROVIDER OR SUPPLIEI | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | TRO VIDER OR DOTTEIE | ς τ | 2350 T | AFT ST | | |
| PERIO | N CARE TOLLEST | ON PARK | GARY, | IN 46404 | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| REFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | | | | This Plan of Correction is the | | |
| | | 53 a.m., Resident H was in her | | center's credible allegation of | | |
| | | wheelchair. The resident's | | compliance. | | |
| | - | nd she was holding the | | | | |
| | | t contained her breakfast. The | | Preparation and/or execution | | |
| | | prward and it was under the | | this plan of correction does no | t | |
| | | ortly thereafter, the resident | | constitute admission or agree | | |
| | | n the floor. Staff removed the | | by the provider of the truth of t | he | |
| | - | . Staff did not wake the | | facts alleged or conclusions se | et | |
| | resident up to see if | she wanted more food. | | forth in the statement of | | |
| | | | | deficiencies. The plan of | | |
| | | dent H was reviewed on 8/3/22 | | correction is prepared and/or | | |
| | | noses included, but were not | | | | |
| | | ia (difficulty swallowing) and | | required by the provisions of | | |
| | dementia with beha | vioral disturbance. | | federal and state law. | | |
| | The Quarterly Mini | mum Data Set (MDS) | | 1) Immediate actions taken for | or | |
| | | /14/22, indicated the resident | | those residents identified: | | |
| | | e impairment. She required | | | | |
| | supervision with ea | ting with set up help only. | | 1. Resident H received assista | ince | |
| | - | ceived a therapeutic diet. | | with meals at the time of surve | ey, | |
| | | | | and ongoing. | | |
| | The Care Plan, date | d 1/29/22, indicated the | | 2. Resident #61 receiv | ed | |
| | resident had a ADL | self-care performance deficit | | assistance with meals at the ti | me | |
| | and she needed stat | f assistance with bed mobility, | | of survey, and ongoing. | | |
| | transfers, toileting, | and eating related to dementia. | | 3. Resident #78 receiv | ed | |
| | Interventions inclue | led, but were not limited to, | | assistance with meals at the ti | me | |
| | provide set up and | staff assistance as needed for | | of survey, and ongoing. | | |
| | eating, has a divide | d plate. | | 4. Resident #112 recei | ved | |
| | | | | nail care at the time of survey. | | |
| | Interview with the | Director of Nursing on 8/4/22 at | | 5. Resident #116 recei | | |
| | 9:00 a.m., indicated | I the resident should have been | | nail care at the time of survey. | | |
| | | and asked if she wanted | | 6. Resident #8 was | | |
| | something else to e | | | shaved at the time of survey. | | |
| | 6 | | | 7. Resident #74 receiv | ed | |
| | 2. On 7/31/22 at 9: | 17 a.m., Resident 61 was served | | assistance with meals at the ti | me | |
| | | Memory Care dining room. At | | of survey, and ongoing. | | |
| | | ent was eating his meal with his | | 8. Resident #125 was | | |
| | | n., the resident ate his entire | | assisted with the removal of fa | cial | |
| | meal with his fingers. No redirection was provided | | | hair at the time of survey. | | |

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SKSY11 Facility ID: 008505

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| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155580 | (X2) MUL A. BUII B. WIN | LDING | DNSTRUCTION C 00 | x3) date su comple 08/05/2 | TED |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------|
| | PROVIDER OR SUPPLIE | | STREET ADDRESS, CITY, STATE, ZIP CO 2350 TAFT ST GARY, IN 46404 | | AFT ST | | |
| X4) ID | T | STATEMENT OF DEFICIENCIE | | ID | | | (X5) |
| PREFIX | | JCY MUST BE PRECEDED BY FULL | PI | REFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | 1 | DATE |
| | by staff. On 8/1/22 at 9:36 a.m., the resident was seated on the side of his bed eating breakfast. The resident was feeding himself with his fingers. He did not use the plastic spoon that was provided. | | | | 9. Resident G was provided with the necessary AE care at the time of survey. | DL | |
| | | | | | 2) How the facility identified other residents: | | |
| | eating his pancakes proceeded to pick u finished eating then redirection was pro The record for Res at 9:49 a.m. Diagn | t.m., the resident was observed s with his fingers. He then up his bowl of grits and he n with his fingers. No wided by staff in the area. ident 61 was reviewed on 8/3/22 oses included, but were not a without behavioral | Dependent residents who require assistance with ADL completion have the potential to be affected. An audit was conducted to identify those residents. This plan of correction applies to those residents identified. | | n d. | | |
| | limited to, dementia without behavioral disturbance, mild protein calorie malnutrition, dysphagia (difficulty swallowing), and adult failure to thrive. | | | 3) Measures put into place/ System changes: | | | |
| | assessment, dated 5 had severe cognitiv | imum Data Set (MDS) 5/20/22, indicated the resident re impairment. He required ating with one person physical | | | Nursing staff was in-serviced or ADL Care Provided for Depend Residents, including but not limited to, ensuring assistance is provided to residents for eating nail care, and bathing, as well a | ent is | |
| The Care Plan, dated 2/25/22, indicated the resident had a ADL self-care performance deficit related to dementia, cancer of the brain, and failure to thrive. Interventions included, but were not limited to, provide set up and staff assistance as needed for eating. | | | | all other ADLs. The DON/Designee will complet Dignity Rounds at least 5 times weekly at varied times for 4 were to ensure residents are provide with assistance in eating, nail | eks | | |
| | A Physician's Order, dated 2/23/22, indicated th resident received a mechanical soft texture diet. | | | | care, and bathing. Any identifie concerns will be promptly addressed with the responsible | | |
| Interview with the Director of Nursing on 8/4/22 at 9:00 a.m., indicated the resident should have been redirected or provided assistance. | | | | individual(s). Thereafter, DON/Designee will complete Dignity Rounds at least 5 times per month at varied times for 2 | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
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| AND PLAN | OF CORRECTION PROVIDER OR SUPPLIE N CARE TOLLEST SUMMARY (EACH DEFICIE REGULATORY O 3. On 7/31/22 at 9 observed eating he drinking her cereal was provided by st On 8/2/22 at 9:10 a eating her waffle v redirection was pro- On 8/3/22 at 9:05 a pancakes with her eat some of her grif fingers. No redirection The record for Resa at 11:43 a.m. Diag limited to, adult fa | IDENTIFICATION NUMBER 155580 R CON PARK C STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 20 a.m., Resident 78 was br breakfast with her fingers and from her bowl. No redirection taff in the area. a.m., the resident was observed with her fingers. Again, no | A. BUILDING B. WING STREET 2350 1 | | COM 08/C 00D RECTION 10ULD BE PPROPRIATE CONCERNS assed with ual(s). actions udits will / onthly x6 erage of reater is ive mittee s or | IPLETED |
| | assessment, dated had severe cogniti supervision with 2 eating and received A Care Plan, dated had a ADL self-ca bed mobility, trans to Alzheimer's. In not limited to, prov resident had diffict Interview with the 9:00 a.m., indicate redirected or provi 4. On 7/31/22 at 1 observed to have b | Director of Nursing on 8/4/22 at d the resident should have been | | recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/04/22 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155580 B. WING 08/05/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY, IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE his nails were too long and he would like them cut. On 8/1 at 3:55 p.m., 8/2 at 8:55 a.m., and 8/3/22 at 9:15 a.m., the resident's fingernails remained long. The record for Resident 112 was reviewed on 8/2/22 at 10:08 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/22, indicated the resident was cognitively intact for daily decision making. He required limited assistance with 1 person physical assist for personal hygiene. The resident had bed baths signed out as being completed on 7/23, 7/25, 7/28, and 8/1/22. There was no documentation to indicate if nail care had been offered or completed. Interview with the Director of Nursing on 8/4/22 at 9:00 a.m., indicated the resident's fingernails would be cut. 5. On 8/1/22 at 10:59 a.m., Resident 116 was observed in his room in bed. His fingernails were long with a brown substance underneath. On 8/2/22 at 1:13 p.m., the resident's fingernails remained long with a brown substance underneath. On 8/3/22 at 10:22 a.m., the resident's fingernails remained dirty. The record for Resident 116 was reviewed on 8/4/22 at 9:27 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and schizoaffective disorder. Event ID: SKSY11 Facility ID: 008505 Page 12 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | O8/ | te survey 19leted 05/2022 |
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| | PROVIDER OR SUPPLI | | 2350 TA | address, city, state, zip co AFT ST IN 46404 | OD | |
| (X4) ID PREFIX TAG | (EACH DEFICII | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) | IOULD BE | (X5) COMPLETIC DATE |
| | assessment, dated had severe cognit needed extensive physical assist for The Care Plan, da had an ADL self- needed staff assis transfers, toileting mobility, depressi included, but wer needed extensive showering. The resident had a 8/1/22. He refuse documentation if Interview with the 9:00 a.m., indicat to clean his nails. Resident 8 was of his room. The res hair on his face an Interview with the he needs assistant been shaved in lo The record for Re at 12:45 p.m. Dia limited to, type 2 disorder, intellect depressive disord | e resident at that time, indicated ce with shaving and he had not ng time. sident 8 was reviewed on 8/3/22 agnoses included, but were not diabetes, schizoaffective ual disabilities, and major | | | | |
| | assessment, dated | 7/15/22 indicated the resident npaired for cognition and needed | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | CON 08/ | te survey 1pleted 05/2022 |
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| | PROVIDER OR SUPPLI | | 2350 TA | address, city, state, zif AFT ST IN 46404 | , COD | |
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| | assistance with pe | | | | | |
| | | d 3/7/22, indicated the resident appliant with showers or baths as s. | | | | |
| | refused personal h being shaved, nor | e Plan indicating the resident aygiene such as periodically was there any documentation afused to be shaved. | | | | |
| | | Director of Nursing on 8/4/22 at ed the resident should have been e. | | | | |
| | observed lying in that time, there wa of him with his lu served chicken wi potatoes. His silv plastic spoons and in the napkin. Th | 12:58 p.m., Resident 74 was bed at a 30 degree angle. At as an over bed tray table in front nch meal. The resident was ngs, vegetables, and mashed erware which consisted of 2 I a plastic knife was wrapped up e resident was observed eating we with his fingers. There was m to redirect. | | | | |
| | in bed with an over was holding a spo at the breakfast for eaten any of the n eggs, pureed meat waffles were not of no butter or syrup fork on his tray. A not eaten anything | a.m., the resident was observed er bed table in front of him. He on in his right hand and staring od in front of him. He had not heal. He was served scrambled the was served scrambled the hot cereal, and 2 waffles. The exit up and were still whole with on them. There was also no At 9:20 a.m., the resident still had g on the tray. The Director of ralked by the room and saw the | | | | |
| | resident was not e entered his room a | alked by the room and saw the ating from the hallway. She and started to feed the resident. is food after being fed by staff. | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| AND PLAN | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | COI 08/ | ite survey Mpleted 105/2022 |
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| | PROVIDER OR SUPPLI | | 2350 TA | address, city, state, zip c AFT ST IN 46404 | OD | |
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| | lying in bed with table in front of h was holding a spo not eating anythir potatoes and grav and a dessert. Not him. At 1:05 p.m his room and repo and eat his lunch. into the room wit resident to eat his open his eyes. Sh 1:38 p.m., the res and had not eaten observed to go an eating. The record for Re at 9:45 a.m. Diag limited to, metabo acute respiratory malnutrition, dep end stage renal di The Admission M assessment, dated was severely cog was an extensive assist for bed mol eating. A family indicated it was v listen to music, be participate in his A Care Plan, upda | linimum Data Set (MDS) 5/31/22, indicated the resident nitively impaired. The resident assist with 1 person physical bility, transfers, dressing and member was interviewed and ery important for the resident to e around pets, go outside, and favorite activities. | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY, IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE In the CNA Task Section, for the last 7 days, the following was documented under eating: the resident needed set up help only on 7/26, supervision on 7/27, supervision, limited assist, and dependent on staff on 7/28, independent and supervision on 7/29, supervision and dependent on staff on 7/30, dependent on staff on 7/31, and independent on 8/1/22. Interview with the Director of Nursing on 8/4/22 at 8:45 a.m., indicated staff should have assisted the resident with meals as needed. 8. On 8/1/22 at 1:36 p.m., Resident 125 was observed in bed with a moderate amount of facial hair on her chin. Interview with the resident at that time, indicated she had just came back from the hospital and no staff had assisted her with the removal of the facial hair. The record for Resident 125 was reviewed on 8/2/22 at 9:20 a.m. Diagnoses included, but were not limited to, bipolar disorder, type 2 diabetes, auditory hallucinations, heart disease, anxiety, major depressive disorder, and schizoaffective disorder. The resident was discharged to the neuropsychiatric hospital on 7/14/22 and returned on 7/22/22. The Quarterly Minimum Data Set (MDS) assessment, dated 6/28/22, indicated the resident had some mild cognition deficits and was an extensive assist with a 1 person physical assist for personal hygiene. The Care Plan, updated 6/10/22, indicated the resident was resistive to care related to showers and baths. Event ID: SKSY11 Facility ID: 008505 Page 16 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM 08/ | te survey Mpleted 05/2022 |
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| | PROVIDER OR SUPPLI | | 2350 T | ADDRESS, CITY, STATE, ZIP AFT ST IN 46404 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIC DATE |
| | - | dated 6/10/22, indicated the DL self care deficit related to and weakness. | | | | |
| | personal hygiene. | e Plan the resident refused There was no documentation red assistance with the trimming her facial hair. | | | | |
| | | Director of Nursing on 8/4/22 at ed the resident's facial hair should ed during care. | | | | |
| | observed lying in oxygen tubing up his ears. He was on the blanket. T | 0:20 a.m., Resident G was bed. He was holding the to his nose as it was not behind crooked in bed and was laying he resident had long dirty arge amount of facial hair on his | | | | |
| | he had not had a s however, the staff good." He indicat | e resident at that time, indicated hower since he had been there, Thad cleaned him up "real ted his hair had not been long time, nor had he been | | | | |
| | in bed and eating needed a napkin s (DON), who was brought him a nap asked the resident his nails. The DO hair, as he had not | a.m., the resident was observed breakfast. He indicated he o the Director of Nursing standing outside the door, okin. At that time, the DON if she could shave him and trim N was asked about washing his thad that washed in a very long t agreed to everything and did | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DA' | TE SURVEY |
|-----------|-----------------------|----------------------------------------------------------------|-----------------|-------------------------------------------------|-------------------------------|-----------|
| | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | | IPLETED |
| | | 155580 | B. WING | <u></u> | |)5/2022 |
| | | | STREET | ADDRESS, CITY, STATE, ZI | P COD | |
| NAME OF I | PROVIDER OR SUPPLIEF | ł | 2350 T | AFT ST | | |
| APERIO | N CARE TOLLEST | ON PARK | GARY, | , IN 46404 | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | | PROVIDER'S PLAN OF CORRECTION | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T | HE APPROPRIATE | COMPLETIC |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY |) | DATE |
| | The record for Resi | dent G was reviewed on 8/3/22 | | | | |
| | at 10:25 a.m. The 1 | resident was admitted to the | | | | |
| | facility on 7/23/22. | Diagnoses included, but were | | | | |
| | not limited to, strok | e, type 2 diabetes, atrial | | | | |
| | fibrillation, chronic | kidney disease, aphasia, and | | | | |
| | facial weakness. | | | | | |
| | The Admission Mit | nimum Data Set (MDS) was in | | | | |
| | progress. | | | | | |
| | The Care Plan date | ed $7/23/22$, indicated the | | | | |
| | | L self-care performance | | | | |
| | | eakness and a stroke. | | | | |
| | deficit related to we | carness and a stroke. | | | | |
| | The resident receiv | ed a bed bath on 7/25, 7/28, | | | | |
| | | sident did not have his hair | | | | |
| | washed on any of the | | | | | |
| | washed on any of th | lose bath days. | | | | |
| | There is no docume | entation the resident had his | | | | |
| | nails trimmed or he | was shaved. | | | | |
| | Interview with the | DON on 8/3/22 at 9:57 a.m., | | | | |
| | | d, trimmed his nails and | | | | |
| | | e resident should have his hair | | | | |
| | | ned and shaved with the bed | | | | |
| | | w with Resident 41 on 7/31/22 | | | | |
| | | ated he needed a shower and | | | | |
| | | ed staff to attend to his dirty | | | | |
| | and dry feet. | ce start to attend to his unity | | | | |
| | und dry loot. | | | | | |
| | The record for Resi | dent 41 was reviewed on 8/2/22 | | | | |
| | at 9:00 a.m. Diagn | oses included, but were not | | | | |
| | - | lung disease, heart failure, and | | | | |
| | high blood pressure | | | | | |
| | The Quarterly Mini | mum Data Set (MDS) | | | | |
| | · · | $\frac{1}{10/22}$, indicated the resident | | | | |
| | | | | | | |
| | | paired for daily decision making | | | | |
| | _ | vive assistance for bed mobility ce on staff for transfers and | | | | |
| | and total dependent | to on stan for transfers and | 1 | 1 | | 1 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM 08/ | TE SURVEY MPLETED 105/2022 |
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| | PROVIDER OR SUPPLI | | 2350 TA | ADDRESS, CITY, STATE, ZIP C AFT ST IN 46404 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | bathing. | | | | | |
| | resident had an ac care performance weakness, chronic Interventions inclu | vised on 1/9/22, indicated the tivities of daily living (ADL) self deficit due to generalized e lung disease, and heart failure. uded, but were not limited to, otally dependent on one staff to howers. | | | | |
| | resident was resist baths. Intervention | vised on 3/7/22, indicated the tive to care with showers or as included, but were not limited buld be compliant and receive ths twice a week. | | | | |
| | received showers each week. The ta on 7/2/22, 7/6/22, | tasks indicated the resident on Wednesday and Saturday sks were marked as completed 7/13/22, and 7/20/22. The record tion of showers received or and 7/16/22. | | | | |
| | 10:59 a.m., indica refused showers, l | e Director of Nursing on 8/4/22 at ted the resident frequently but the record lacked any refusals on 7/9/22 and | | | | |
| | 3.1-38(a)(2)(A) 3.1-38(a)(2)(D) 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) | | | | | |
| ⁼ 0679 SS=D Bldg. 00 | §483.24(c) Activ §483.24(c)(1) Th | nterest/Needs Each Resident ities. ne facility must provide, based ensive assessment and care | | | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and F 0679 **Aperion- Tolleston Park** 09/04/2022 interview, the facility failed to ensure a resident Annual/ Recertification Survey was invited and taken to activities for 1 of 2 Compliance 09/04/22 residents reviewed for activities. (Resident 74) **F679 Activities Meets** Finding includes: Interest/Needs On 7/31/22 at 12:58 p.m., Resident 74 was The facility requests paper observed lying in bed at a 30 degree angle. At compliance for this citation. that time, there was an over bed tray table in front of him with his lunch meal. The lights were turned This Plan of Correction is the off and the curtains were pulled. There was no center's credible allegation of television or radio on in the room. At 2:20 p.m., compliance. the resident remained in bed with no television or radio turned on. Preparation and/or execution of this plan of correction does not On 8/1/22 at 9:30 a.m., the resident was leaving for constitute admission or agreement dialysis. by the provider of the truth of the facts alleged or conclusions set On 8/2/22 at 9:00 a.m., 9:20 a.m., 12:54 p.m., 1:05 forth in the statement of p.m., and 1:38 p.m. the resident was observed in deficiencies. The plan of bed dressed in a hospital gown. The resident's correction is prepared and/or television was turned on. At 2:17 p.m., the staff executed solely because it is had gotten the resident out of bed and he was required by the provisions of sitting in a wheelchair in front of the nurses' federal and state law. station. No staff took the resident down to the activity room or assisted him to participate. 1) Immediate actions taken for those residents identified: The record for Resident 74 was reviewed on 8/2/22 at 9:45 a.m. Diagnoses included, but were not Resident 74 was invited to attend limited to, metabolic encephalopathy, dysphagia, activities, and care plans was

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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE acute respiratory failure, protein calorie updated. Resident 74 will be malnutrition, dependence on renal dialysis and offered to listen to music, end stage renal disease. channels to watch that meet specific interests, such as animal The Admission Minimum Data Set (MDS) channel, and going outside. assessment, dated 5/31/22, indicated the resident was severely cognitively impaired. The resident 2) How the facility identified was an extensive assist with 1 person physical other residents: assist for bed mobility, transfers, dressing and eating. A family member was interviewed and All residents could be affected by indicated it was very important for the resident to this deficient practice. An audit of listen to music, be around pets, go outside, and 100% of residents was completed participate in his favorite activities. on 8/22/22 to ensure all residents are invited and receiving activities. The Care Plan, revised on 5/25/22, indicated the Staff will complete assessments resident was dependent on staff for meeting and update care plans as needed emotional, intellectual, physical, and social needs for each resident to ensure they related to physical limitations. The approaches are offered activities that meet were to invite the resident to scheduled activities their needs and interests. and ensure the activities the resident was attending were compatible with physical and 3) Measures put into place/ mental capabilities and known interests and System changes: preferences. Activity staff will be re-educated A 5/26/22 Activity Assessment, indicated the on the importance of providing resident's current interests were television, pets, daily activities, as well as crafts and exercise. documenting activity preferences, assessments and care planning. The Activity Participation logs for July and In addition, Activity Staff will August 2022 indicated the resident did not provide resident activities seven participate in any activities. days a week, including but not limited to, group activities, The July and August Activity Calendar indicated sensory, as well as individual on Sundays, Tuesdays and Thursdays activities. A guide will be created throughout the calendar there were exercises, arts each month outlining the and crafts, and sensory groups. foundation for these activities and times they are aimed to start. Interview with the Activity Director on 8/4/22 at 1:30 p.m., indicated she had no documentation the 4) How the corrective actions resident participated in activities for the months of will be monitored:

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE C A. BUILDING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | | |
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| AND FLAN | OF CORRECTION | 155580 | B. WING | 00 | _ | B/05/2022 | |
| NAME OF | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP C | OD | | |
| APERIO | N CARE TOLLEST | ON PARK | | AFT ST , IN 46404 | | | |
| (X4) ID PREFIX | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | RECTION HOULD BE APPROPRIATE | (X5) COMPLETIC | |
| TAG | 7/2022 and 8/2022 | R LSC IDENTIFYING INFORMATION . The resident was dependent ' participation and was not its. | TAG | The Activity Director or designee will be respondent to the audit tool for complete the audit tool for complete the audit tool for compliance with foll resident preferences a participation with activit tool will be completed with an ongoing basis to end continued compliance. concerns identified will corrected upon discover findings documented or log. All findings will be monthly in the facility of Assurance Process Im (QAPI) meeting to ensite compliance for a minim months and until the famintains 90% compliance for a months. 5) Date of compliance | r other nsible to to monitor lowing nd ties. The weekly, on sure Any be ery and n tracking reviewed Quality provement ure ongoing num 6 icility ance for two | DATE | |
| [:] 0684 SS=D Bldg. 00 | applies to all treat facility residents. comprehensive a facility must ensu- treatment and car professional stan comprehensive p and the residents Based on observati- interview, the facil bruising and arteria monitored. The facil | a fundamental principle that tment and care provided to Based on the ssessment of a resident, the re that residents receive re in accordance with dards of practice, the erson-centered care plan, | F 0684 | Aperion- Tolleston Pa Annual/Recertification | | 09/04/202 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ordered for 2 of 2 residents reviewed for skin Compliance 09/04/2022 conditions (non-pressure related). (Residents 116 and G) F684 Quality of Care Findings include: The facility requests paper 1. On 8/1/22 at 11:00 a.m., a fading reddish/purple compliance for this citation. discoloration was observed on Resident 116's lower left shin. This Plan of Correction is the center's credible allegation of On 8/3/22 at 1:01 p.m., the fading discoloration compliance. remained to the resident's left lower shin. Preparation and/or execution of The record for Resident 116 was reviewed on this plan of correction does not 8/4/22 at 9:27 a.m. Diagnoses included, but were constitute admission or agreement not limited to, dementia with behavior disturbance by the provider of the truth of the and schizoaffective disorder. facts alleged or conclusions set forth in the statement of The Quarterly Minimum Data Set (MDS) deficiencies. The plan of assessment, dated 6/30/22, indicated the resident correction is prepared and/or had severe cognitive impairment. The resident executed solely because it is needed limited assistance with 1 person physical required by the provisions of assist for bed mobility and transfers. federal and state law. A Physician's Order, dated 4/18/22, indicated the 1) Immediate actions taken for resident received Aspirin 81 milligrams (mg) those residents identified: chewable daily. The Physician was notified of The Weekly Skin Observation sheet, dated bruise for resident 116 and 7/28/22, indicated the resident's skin was intact assessment was completed. and there was no documentation of bruising. Resident G had wound assessments and treatments Interview with the 200 Unit Manager on 8/4/22 at completed, as ordered. 3:00 p.m., indicated she would assess the resident's left lower leg, she was aware of the 2) How the facility identified resident having a skin tear but not aware of any other residents: bruising. Full house skin sweep completed Nurses Notes' dated, 8/4/22 at 3:16 p.m., indicated to identify any other skin the resident was noted to have a small area of concerns. This Plan of Correction

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| NIERS FOR | R MEDICARE & MEDI | CAID SERVICES | | | OMB NO. 0938-039 |
|-----------|-----------------------|------------------------------------|-----------------|----------------------------------------------------------------------|------------------|
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED |
| | | 155580 | B. WING | | 08/05/2022 |
| | | | STREET | ADDRESS, CITY, STATE, ZIP COD | |
| NAME OF I | PROVIDER OR SUPPLIE | ER | | AFT ST | |
| APERIO | N CARE TOLLEST | ON PARK | GARY, | , IN 46404 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR | COMPLETION |
| TAG | REGULATORY C | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE |
| | bruising to the left | lower leg. No complaints of | | applies to all those identified | with |
| | pain or discomfort | expressed. | | skin conditions. | |
| | A Physician's Ord | er, dated 8/4/22, indicated to | | 2) Maggurog put into place/ | |
| | | ng to the left lower leg until | | 3) Measures put into place/ | |
| | | ift. 2. On 8/1/22 at 10:20 a.m., | | System changes: | |
| | | bserved lying in bed. He was | | Lippopod Nursing Staff will b | |
| | | n tubing up to his nose as it | | Licensed Nursing Staff will be | |
| | e | s ears. He was crooked in bed | | re-educated on Quality of Ca | |
| | | the blanket. The resident | | including but not limited to | ,f |
| | | ould not see very well and had | | assessment and monitoring of | |
| | | on since after breakfast. | | skin conditions and ensuring | 4 |
| | been in uns positio | on since after breakfast. | | treatments are completed an | |
| | Interview with the | resident at that time, indicated | | documented. Director of Nur | - |
| | | are sores on his back, shoulder | | or designee will conduct rand visual observation rounds at | |
| | | sident was asked to raise both | | | least |
| | - | s could be observed. The right | | three times weekly times 4 | |
| | - | with a black deep tissue injury. | | weeks, then weekly times 4 weeks to ensure treatments | ara in |
| | | lage nor was there any pressure | | | |
| | | on his feet. LPN 1 was asked to | | place as ordered. DON, or | |
| | - | for a skin assessment. The | | designee, will audit all skin assessments 3x week times | 4 |
| | | itioned onto his right side and | | | 4 |
| | | ar observed to his lower back | | weeks then weekly times 4 weeks. | |
| | with no bandage. | ar observed to his lower back | | weeks. | |
| | with no bundage. | | | 4) How the corrective action | IS |
| | Interview with LP | N 1 at that time, indicated he did | | will be monitored: | |
| | not look at or asse | ss the resident's skin tears or | | The results of these audits | will |
| | heels yesterday (7/ | (31/22), and was not told by any | | be reviewed in Quality | |
| | CNA the bandages | s had come off, nor was he told | | Assurance Meeting monthly | / x6 |
| | in report the banda | ages had come off. The resident | | months or until an average | |
| | did not have a trea | tment order for the right heel as | | 90% compliance or greater | |
| | that was a new wo | und. | | achieved x3 consecutive | |
| | | | | months. The QA Committee | e l |
| | The record for Res | sident G was reviewed on 8/3/22 | | will identify any trends or | |
| | at 10:25 a.m. The | resident was admitted to the | | patterns and make | |
| | facility on 7/23/22 | . Diagnoses included, but were | | recommendations to revise | the |
| | not limited to, stro | ke, type 2 diabetes, atrial | | plan of correction as indica | ted. |
| | fibrillation, chroni | c kidney disease, aphasia, and | | | |
| | facial weakness. | · · · · · | | 5) Date of compliance: | |
| | Inclus in culture bot | | | J) Date of compliance. | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY, IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE The Admission Minimum Data Set (MDS) was in progress. The Care Plan, dated 8/1/22, indicated the resident had skin tears to the lower back and a deep tissue injury to the right heel. The approaches were to administer treatments as ordered and monitor dressing (right lower back) to ensure it was intact and adhering. Report lose dressing to nurse Immediately. Provide a pressure reducing/relieving mattress. (LAL mattress). Off load pressure from bilateral heels with the use of extra pillows or foam boots The Nursing Admission Assessment, dated 7/23/22, indicated there were 2 skin tears on the resident's back. One measured 2 centimeters (cm) by 1 cm and the other measured 2 cm by 2 cm. Physician's Orders, dated 7/23/22, indicated cleanse areas to right lateral back, with normal saline, apply Calmoseptine and cover with dry dressing daily. The Treatment Administration Record (TAR) for 7/2022, indicated the above treatment was not signed out as being completed on 7/24/22. Physician's Orders, dated 7/26/22, indicated cleanse both areas to lateral back with normal saline, apply duoderm to area and cover with dry dressing every day shift Monday, Wednesday, and Friday. The Wound Report, dated 8/2/22, indicated the following: - right lower back skin tear 100% pink non-granulating tissue that measured 2.5 centimeters (cm) by 2.5 cm SKSY11 Event ID: Facility ID: 008505 Page 25 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | A. BUIL B. WINC | DING | NSTRUCTION 00 | CO | ite survey Mpleted 105/2022 |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-------------------|-------------------------------------------------------------------------------------------------------------|------|-----------------------------------|
| NAME OF I | PROVIDER OR SUPPLIE | R | | 2350 TA | | | |
| APERIO | N CARE TOLLEST | ON PARK | | GARY, I | N 46404 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION | | ID EFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR(DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | | ssue injury 100% necrotic hard ed 2.5 cm by 3.5 cm. | | | | | |
| | 8/2/22, which indi | doppler scan was performed on cated the resident was modynamically significant at leg. | | | | | |
| | 3:00 p.m., indicate the skin tear treatm 7/24/22. The right acquired wound an | Director of Nursing on 8/3/22 at ad there was no documentation nents were completed on theel deep tissue injury was an ad had not been treated prior to neel was an arterial ulcer. | | | | | |
| | Assessment and M Non-Pressure" pol Nursing on 8/5/22 which were applie wounds, and lesion licensed nurse who Dressings will be o | vised 6/8/18 "Skin Condition lonitoring Pressure and icy, provided by the Director of at 1:45 p.m., indicated dressings d to pressure ulcers, skin tears, ns shall include the date of the performed the procedure. checked daily for placement, gns and symptoms of infection. | | | | | |
| | 3.1-37(a) | | | | | | |
| F 0685 SS=D Bldg. 00 | §483.25(a) Vision To ensure that re treatment and as | esidents receive proper sistive devices to maintain g abilities, the facility must, | | | | | |
| | §483.25(a)(1) In | making appointments, and | | | | | |
| | to and from the c | arranging for transportation ffice of a practitioner e treatment of vision or | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility F 0685 09/04/2022 Aperion- Tolleston Park failed to ensure residents with impaired vision Annual/Recertification received the necessary services related to Compliance 09/04/2022 following up with referrals to an Ophthalmologist for 1 of 1 residents reviewed for vision. (Resident F 685 Treatment/Devices to 71) Maintain Hearing/Vision Finding includes: This Plan of Correction is the center's credible allegation of Interview with Resident 71 on 7/31/22 at 1:44 p.m., compliance. indicated he had a cataract and he would like to see the eye doctor. Preparation and/or execution of this plan of correction does not The record for Resident 71 was reviewed on 8/2/22constitute admission or agreement at 10:40 a.m. Diagnoses included, but were not by the provider of the truth of the limited to, type 2 diabetes mellitus and end stage facts alleged or conclusions set renal disease. forth in the statement of deficiencies. The plan of The Quarterly Minimum Data Set (MDS) correction is prepared and/or assessment, dated 5/26/22, indicated the resident executed solely because it is was moderately impaired for daily decision required by the provisions of making. His vision was listed as adequate with no federal and state law. corrective lenses. 1) Immediate actions taken for There was no current Care Plan related to vision those residents identified: services. Resident 71 is scheduled to see an Ophthalmologist on September The resident signed a consent for vision services 22 at 3:45pm. on 4/3/19. 2) How the facility identified A Physician's Order, dated 12/17/21, indicated the other residents: resident was to have an Eye Consult. The facility completed and audit to identify residents that need to see There was no documentation indicating the the eye Doctor or require a follow resident had been by the Ophthalmologist (eye up appointment. All residents have doctor). the potential to be affected by the same deficient practice.¿¿

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| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | CONSTRUCTION | (X3) DATE SURVEY | | |
|-----------|---------------------|----------------------------------|-----------------|----------------------------------------------------|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COM | COMPLETED | |
| | | 155580 | B. WING | | 08/05/2022 | | |
| NAME OF 1 | PROVIDER OR SUPPLIE | D | STREET | ADDRESS, CITY, STATE, ZIP | COD | | |
| | | | | TAFT ST | | | |
| APERIO | N CARE TOLLEST | ON PARK | GARY | , IN 46404 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CO | ORRECTION | (X5) | |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD BE | COMPLETION | |
| TAG | REGULATORY C | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE | |
| | Interview with the | Director of Nursing on 8/4/22 at | | 3) Measures put into | place/ | | |
| | 1:15 p.m., indicate | d the resident had not seen the | | System changes: | | | |
| | eye doctor for his | cataract. | | Social Service will er | nsure that | | |
| | | | | residents are see anr | nually. If a | | |
| | 3.1-39(a)(1) | | | resident is referred to | o an eye | | |
| | | | | specialist Nursing wil | I make the | | |
| | | | | appointment within 24 | 4 business | | |
| | | | | hours. | | | |
| | | | | After facility wide aud | lit, the Social | | |
| | | | | Service/designee will | audit weekly | | |
| | | | | for 4 weeks then mor | nthly | | |
| | | | | thereafter to ensure t | hat orders are | | |
| | | | | carried out appropriat | tely. | | |
| | | | | 4) How the correctiv | e actions | | |
| | | | | will be monitored: | | | |
| | | | | The results of the aud | dit will be | | |
| | | | | reviewed in the Quali | ty Meeting | | |
| | | | | monthly for 6 months | or until | | |
| | | | | 100% compliance is a | achieved. The | | |
| | | | | QA committee will ide | entify any | | |
| | | | | trends or pattern and | | | |
| | | | | recommendations to | revise the | | |
| | | | | plan of correction as | indicated | | |
| | | | | 5) Date of complian 09/04/2022 | ce: | | |
| | | | | 00/04/2022 | | | |
| 0686 | 483.25(b)(1)(i)(ii) | | | | | | |
| SS=D | | o Prevent/Heal Pressure | | | | | |
| Bldg. 00 | Ulcer | | | | | | |
| | §483.25(b) Skin | ntegrity | | | | | |
| | §483.25(b)(1) Pr | | | | | | |
| | Based on the cor | nprehensive assessment of | | | | | |
| | | cility must ensure that- | | | | | |
| | | eives care, consistent with | | | | | |
| | ., | dards of practice, to prevent | | | | | |
| | | ind does not develop | | | | | |
| | | inless the individual's clinical | | | | | |
| | condition demon | strates that they were | | | | | |
| | 1 | - | | | | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE unavoidable: and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and F 0686 Aperion Care Tolleston Park 09/04/2022 interview, the facility failed to ensure a resident **Annual/ Recertification** with a pressure ulcer received the necessary Compliance 09/04/2022 treatment and services to promote healing related to treatments not done as ordered and missing F 686 Treatment/Svcs to bandages on open sores for 1 of 3 residents Prevention/Heal Pressure Ulcer reviewed for pressure ulcers. (Resident G) The facility requests paper Finding includes: compliance for this citation. On 8/1/22 at 10:20 a.m., Resident G was observed This Plan of Correction is the lying in bed. He was holding the oxygen tubing center's credible allegation of up to his nose as it was not behind his ears. He compliance. was crooked in bed and was laying on the blanket. The resident indicated that he could not see very Preparation and/or execution of well and had been in this position since after this plan of correction does not breakfast. constitute admission or agreement by the provider of the truth of the Interview with the resident at that time, indicated facts alleged or conclusions set he had open pressure sores on his back, shoulder forth in the statement of and thigh. He was asked to pull down his gown deficiencies. The plan of around his shoulder. There was a large open area correction is prepared and/or on his right shoulder with no bandage covering executed solely because it is the ulcer. The open wound was black in color with required by the provisions of no drainage. The resident was asked to lift his federal and state law. gown by his thigh as well. There was a large black and open area observed to his right hip that 1) Immediate actions taken for also had no bandage. LPN 1 was asked to come those residents identified: to the room for a skin assessment. The resident Resident G had appropriate was repositioned onto his right side and his brief treatments administered and was removed. There was a large sacral pressure preventative skin interventions implemented at the time of survey. ulcer observed with yellow slough (necrotic tissue). The pressure sore had no bandage covering it and there was bowel movement noted 2) How the facility identified SKSY11

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

| STATEMENT OF DEFICIENCE X1) PROVIDERSUPPLIENCLA X2) MUTURE CONSTRUCTION X2) DATE SUPPLY AND PLAN OF CORRECTION UNERTIFICATION NUMBER BUILDING COUNTER CORRECTION NAME OF PROVIDER OR SUPPLIER BSEET ADDRESS, CITY, STATE, ZIP COD 2300 TATE ST APERNON CARE TOLLESTON PARK CANDER SCIENT, STATE, ZIP COD 2300 TATE ST CM 10 SUMMAY STATEMENT OF DEFICIENCIE ID Contract State St | CENTERS FO | RS FOR MEDICARE & MEDICAID SERVICES | CAID SERVICES | | | OMB NO. 0938-039 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------|---------------------------------|-----------------|--------------------------------------------------------------------|------------------|
| 15580 It WING 08/05/2022 NAME OF ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP COD 2350 TAFT ST APERION CARE TOLLESTON PARK STREET ADDRESS, CITY, STATE, ZP COD 2350 TAFT ST GARY, IN 46404 SUMMARY STATEMENT OF DEPICIENCIE ID NOMERON TART STATEMENT OF DEPICIENCIE D TAG REGULATORY OR USE DEPITYING INFORMATION D COMPLETION DATE COMPLETION DATE TAG Residents with altered skin integrity, or those at high risk of altered skin integrity, have the potential to be affected by this practice. The medical records of the identified residents have been reviewed to ensure treatment orders are present and appropriate interventions for prevention of altered skin integrity are documented. COMPLETION DATE The record for Resident G was reviewed on 8/3/22 at 10:25 a.m. The resident was altring the bindages had come off. nor was be told in the bindages had come off. nor was be told in the facility on 72/3/22. Diagnoses included, but were net re-educated relative to Treatment/Svs to Prevent/Heal Pressure Ucer, including but not indention period healing, including treatment administrution per orders and ensuring residents with pressure ucers receive the necessary treatment and services to provent healing, including treatment administruction period hease stan or gright on the orde | STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | CONSTRUCTION | (X3) DATE SURVEY |
| NAME: OF PROVIDER OR SUPPLIER STREET ADDRESS, CTV, STATE, ZP COD APERION CARE TOLLESTON PARK CARE TOLLESTON PARK CASE PROVIDER ALL OF COMPLETING COMPLETING CVD ID SUMMARY STATEMENT OF DEPICIENCIE D D COMPLETING COMPLETING TAG BEGULATORY DAY INCEMENTION THE PRICENCY MUST BE PRECEDED IN YULL D D COMPLETING COMPLETING TAG In the wound. The resident was laying on a regular mattress and had no pressure relieving devices such as pillows or blankets on those arress. Other residents: Residents with altered skin integrity, or those at high risk of altered skin integrity, are botomato to be affected by this practice. The medical records of the identified resident have been reviewed to RS/322 at 10.25 a.m. The resident was admitted to the facility on 723/22. Diagnoses included, but were not facility on 723/22. Indicated the resident had a pressure vice reducing the high right should a measure of consing facility in 723/22. indicated the resident had a pressure vice reducing the high right should a measure of the right high right should a pressure vice reducing relieving mattress. (LAL mattress) 3) Measures put into place/ space reducing/relieving mattress. (LAL matrens) 3) Measures put into place/ space for 60 we | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED |
| XMME OF REVUIDER GENERATE 2350 TAFT ST APERION CARE TOLLESTON PARK 2350 TAFT ST GARY, IN 48004 SIMMARY STATION'N OF DEDUCTINCH (EACH DEDUCTINCY MIST BLERECTORD BY IVID.) DB TAG REQUATORY OF SCHEMENT ST COMPLICTINC (EACH DEDUCTINCY MIST BLERECTORD BY IVID.) DB TAG REQUATORY OF SCHEMENT ST COMPLICTINC (EACH DEDUCTINCY MIST BLERECTORD BY IVID.) DD TAG REQUATORY OF SCHEMENT SCHEMENT ST COMPLICTINC (CACH DEDUCTINCY MIST BLERECTORD BY IVID.) DD TAG REGULATORY OF SCHEMENT SCH | | | 155580 | B. WING | | 08/05/2022 |
| APERION CARE TOLLESTON PARK 2350 TAFT ST GRAY, IN 48404 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCE (CACH DEFICIENCY MIST III PRECIDED IN FILL TAG D PREVENTS (X5) COMPLETION PREVENTS (X5) COMPLETION PREVENTS TAG in the wound. The resident was laying on a regular mattress and had no pressure relieving devices such as plitows or blackets on those areas. in the wound. The resident was laying on a regular mattress on those areas. other residents: Residents with altered skin integrity, or those at high type the potential to be affected by this practice. The medical records of the identified resident have been reviewed to ensure treatment orders are present and appropriate intervent the bandages had come off. (X3) Completions The record for Resident G was reviewed on 8/3/22 at 10:25 a.m. The resident was admitted to the facility on 7/23/22. Diagnoses included, but were not limited to, stroke, type 2 diakets, attial fibrillation, chronic kidney disease, aphasia, and facial weakness. (MDS) was in progress. The Admission Minimum Data Set (MDS) was in progress. The Admission Minimum Data Set (MDS) was in progress. (DON/designee will conduct a random audit of at least 5 residents per week, for 8 weeks, with alteretations in skin integrity to validate, and cocy, N. The approaches were to administer treatments as ordered and monitor dressing (right upper back, right our thigh, and cocy) to ensure it was intact and adhring, report lose dressing to nurse inmediately, and provide a pressure reducing/relieving mattress. (LAL mattress) DON/designee will conduct a random audit of at least 5 residents per week, for 8 weeks, with altered according to physician's Orders, dated 7/23/22, indicated foreat are reducing relievients for measur | | | 1 | STREET | ADDRESS, CITY, STATE, ZIP COD | |
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| shoulder, and coccyx. The approaches were to administer treatments as ordered and monitor dressing (right upper back, right outer thigh, and coccyx) to ensure it was intact and adhering, report lose dressing to nurse Immediately, and provide a pressure reducing/relieving mattress. (LAL mattress)treatment administration per orders and ensuring replacement of any dressings/bandages that may have come loose or fallen off.The Nursing Admission Assessment, dated 7/23/22, indicated right outer thigh skin tear red measured 18 centimeters (cm) by 8 cm, right upper back skin tear red measured 5 cm by 2 cm.DON/designee will conduct a random audit of at least 5 residents per week, for 6 weeks, with alterations in skin integrity to validate that treatments have been administered according to physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | | | | - | |
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| dressing (right upper back, right outer thigh, and coccyx) to ensure it was intact and adhering, report lose dressing to nurse Immediately, and provide a pressure reducing/relieving mattress.of any dressings/bandges that may have come loose or fallen off.(LAL mattress)DON/designee will conduct a random audit of at least 5 residents per week, for 6 weeks, with alterations in skin integrity to 7/23/22, indicated right outer thigh skin tear red measured 18 centimeters (cm) by 8 cm, right upper back skin tear pink, measured 5 cm by 7 cm, and coccyx skin tear red measured 5 cm by 2 cm.DN/designee will conduct a random audit of at least 5 residents per week, for 6 weeks, with alterations in skin integrity to validate that treatments have been administered according to physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | | | | | nont |
| coccyx) to ensure it was intact and adhering, report lose dressing to nurse Immediately, and provide a pressure reducing/relieving mattress. (LAL mattress)may have come loose or fallen off.DON/designee will conduct a random audit of at least 5 residents per week, for 6 weeks, with alterations in skin integrity to 7/23/22, indicated right outer thigh skin tear red measured 18 centimeters (cm) by 8 cm, right upper back skin tear pink, measured 8 cm by 7 cm, and coccyx skin tear red measured 5 cm by 2 cm.may have come loose or fallen off.Physician's Orders, dated 7/23/22, indicated cleanse areas to right upper back, coccyx, andmay have come loose or fallen off. | | | | | | |
| report lose dressing to nurse Immediately, and provide a pressure reducing/relieving mattress. (LAL mattress) The Nursing Admission Assessment, dated 7/23/22, indicated right outer thigh skin tear red measured 18 centimeters (cm) by 8 cm, right upper back skin tear pink, measured 8 cm by 7 cm, and coccyx skin tear red measured 5 cm by 2 cm. Physician's Orders, dated 7/23/22, indicated cleanse areas to right upper back, coccyx, and | | | | | | |
| provide a pressure reducing/relieving mattress. (LAL mattress)DON/designee will conduct a random audit of at least 5 residents per week, for 6 weeks, with alterations in skin integrity to validate that treatments have been administered according to physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | | - | | may have come loose of falle | |
| ILAL mattress)random audit of at least 5(LAL mattress)residents per week, for 6 weeks, residents per week, for 6 weeks, with alterations in skin integrity to validate that treatments have been administered according to physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | - | | | DON/designee will conduct a | |
| The Nursing Admission Assessment, datedresidents per week, for 6 weeks, with alterations in skin integrity to validate that treatments have been administered according to physician order, and current interventions to prevent new or worsening alterations in skinPhysician's Orders, dated 7/23/22, indicated cleanse areas to right upper back, coccyx, andresidents per week, for 6 weeks, with alterations in skin integrity to validate that treatments have been administered according to physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | · · | requeing/reneving matterss. | | _ | |
| The Nursing Admission Assessment, datedwith alterations in skin integrity to7/23/22, indicated right outer thigh skin tear redvalidate that treatments have beenmeasured 18 centimeters (cm) by 8 cm, right upperadministered according toback skin tear pink, measured 8 cm by 7 cm, andphysician order, and currentcoccyx skin tear red measured 5 cm by 2 cm.interventions to prevent new orPhysician's Orders, dated 7/23/22, indicatedintegrity are in place. Thereafter, acleanse areas to right upper back, coccyx, andrandom audit of at least 3 | | (Entermanicos) | | | | ake |
| 7/23/22, indicated right outer thigh skin tear red measured 18 centimeters (cm) by 8 cm, right upper back skin tear pink, measured 8 cm by 7 cm, and coccyx skin tear red measured 5 cm by 2 cm.validate that treatments have been administered according to physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | The Nursing Admi | ssion Assessment dated | | | |
| measured 18 centimeters (cm) by 8 cm, right upper back skin tear pink, measured 8 cm by 7 cm, and coccyx skin tear red measured 5 cm by 2 cm.administered according to physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | - | | | C C | • |
| back skin tear pink, measured 8 cm by 7 cm, and coccyx skin tear red measured 5 cm by 2 cm.physician order, and current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | | | | | |
| coccyx skin tear red measured 5 cm by 2 cm.interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | | | | - | |
| Physician's Orders, dated 7/23/22, indicated cleanse areas to right upper back, coccyx, andworsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 | | - | - | | | or |
| Physician's Orders, dated 7/23/22, indicated cleanse areas to right upper back, coccyx, andintegrity are in place. Thereafter, a random audit of at least 3 | | coccyx skill tear le | a measured 5 cm by 2 cm. | | | |
| cleanse areas to right upper back, coccyx, and random audit of at least 3 | | Physician's Orders | dated 7/23/22 indicated | | C C | fter a |
| | | - | | | | nor, a |
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| | | inght outer tingh, w | | | | |

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

Event ID: SKSY11 Facility ID: 008505

If continuation sheet

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PRINTED: 09/14/2022 FORM APPROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155580 B. WING 08/05/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Calmoseptine and cover with dry dressing daily. will be conducted to ensure continued compliance. Any The Treatment Administration Record (TAR) for identified concerns will be 7/2022, indicated the above treatment was not promptly addressed with the signed out as being completed for any of the open responsible individual(s). areas on 7/24/22. Physician's Orders, dated 7/26/22, indicated to 4) How the corrective actions cleanse coccyx with normal saline, apply duoderm will be monitored: to area and cover with dry dressing every day The results of these audits will shift on Monday, Wednesday, and Friday. be reviewed in Quality Physician's Orders, dated 7/26/22, indicated to Assurance Meeting monthly x6 cleanse area to right upper arm and right outer months or until an average of thigh with normal saline, apply Xeroform dressing 90% compliance or greater is and cover with dry dressing every day shift on achieved x3 consecutive Monday, Wednesday and Friday. months. The QA Committee will identify any trends or The Wound Report, dated 8/2/22, indicated the patterns and make following: recommendations to revise the - coccyx: 5 cm by 2 cm with 5% slough and 95% plan of correction as indicated. bright red tissue. The pressure ulcer was a Stage 3. 5) Date of compliance: - right shoulder: 5 cm by 8 cm with 100% necrotic 09/04/2022 soft tissue. The pressure ulcer was unstageable. - right trochanter hip: 18 cm by 8 cm with 100% necrotic soft tissue. The pressure ulcer was unstageable. Interview with LPN 1 on 8/1/22 at 11:38 a.m., indicated the resident was admitted with pressure ulcers and had been there over a week. The mattress he had on his bed was the standard mattress for all the beds. Interview with the Administrator on 8/1/22 at 11:38 a.m., indicated she was ordering a low air loss pressure relieving mattress and was putting the SKSY11 Facility ID: 008505

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

Event ID:

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09/14/2022

PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | IT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | Cor 08/ | ite survey mpleted 105/2022 |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------|------------|-----------------------------------|
| | PROVIDER OR SUPPLI | | 2350 T/ | address, city, state, zip AFT ST IN 46404 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | | he air loss mattress should have week as the resident was pressure ulcers. | | | | |
| | 3:00 p.m., indicat the pressure ulcer 7/24/22. The ban covering the open | Director of Nursing on 8/3/22 at ed there was no documentation treatments were completed on dages should have been areas and the CNAs were to f they had come off. | | | | |
| | Assessment and M Non-Pressure" po Nursing on 8/5/22 which were applie wounds, and lesio initials of the licer procedure. Dress | evised 6/8/18 "Skin Condition Monitoring Pressure and licy, provided by the Director of at 1:45 p.m., indicated dressings ed to pressure ulcers, skin tears, ns shall include the date and ased nurse who performed the ngs were to be checked daily anliness, and signs and ction. | | | | |
| | _ | elates to Complaint IN00384672. | | | | |
| F 0687 SS=D Bldg. 00 | treatment and ca good foot health (i) Provide foot c accordance with practice, inc complications fro condition(s) and (ii) If necessary, appointments wi | | | | | |

| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE C A. BUILDING B. WING | onstruction (x 00 | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|-------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|
| | PROVIDER OR SUPPLIE | | STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404 | | | |
| | | | | | | |
| (X4) ID PREFIX | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION | |
| TAG | appointments. | R LSC IDENTIFYING INFORMATION | TAG | | DATE | |
| | Based on observation interview, the facility | ion, record review, and ity failed to ensure dependent foot care and had routine visits | F 0687 | Aperion- Tolleston Park | 09/04/2022 | |
| | - | lated to long and thick toenails ts reviewed for ADL's. | | Annual/Recertification | | |
| | (Resident 33) | | | Compliance 09/04/2022 | | |
| | Finding includes: | | | F 687 Foot Care | | |
| | a.m., Resident 33 v At that time he wa | bservation on 8/1/22 at 9:35 was observed lying in his bed. s not wearing any shoes or His toenails were approximately | | This Plan of Correction is the center's credible allegation of compliance. | | |
| | - | thick and discolored. The ils were long and dirty as well. | | Preparation and/or execution of this plan of correction does not constitute admission or agreeme | | |
| | | resident at that time, indicated nd had not had his toenails cut | | by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of | 9 | |
| | | ident 33 was reviewed on 8/2/22 esident was admitted on 4/9/21. | | correction is prepared and/or executed solely because it is | | |
| | Diagnoses include 2 diabetes, high bl | d, but were not limited to, type bood pressure, peripheral nd mild cognitive impairment. | | required by the provisions of federal and state law. | | |
| | | imum Data Set (MDS) | | 1) Immediate actions taken for those residents identified: | | |
| | was moderately co making. The resid | 5/9/22, indicated the resident gnitively impaired for decision ent needed extensive assist ical assist for personal | | Resident 33 was scheduled to s a Podiatrist on 8/5/2022. Reside 33 went to this appointment and no follow up required. | nt | |
| | resident had an AI needed staff assista | | | 2) How the facility identified other residents: The facility completed and audit identify residents that need to see | e | |
| | A consent for podi the resident on 4/4 | atry services was signed by /21. | | the Podiatrist. All residents have the potential to be affected by th | | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPLE C A. BUILDING B. WING | construction 00 | COMI | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|
| | PROVIDER OR SUPPLIE | | 2350 T | ADDRESS, CITY, STATE, ZIP FAFT ST , IN 46404 | COD | | |
| (X4) ID PREFIX TAG | SUMMARY (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | DRRECTION SHOULD BE E APPROPRIATE | (X5) COMPLETIO DATE | |
| | The resident had n admission. Interview with the 3:00 p.m., indicate in, but the facility and they were supp month. The reside podiatrist. 3.1-47(a)(7) | not seen the podiatrist since Director of Nursing on 8/3/22 at ad they had a podiatrist coming switched to another podiatrist posed to be coming later this ent had not been seen by a | | same deficient practic 3) Measures put into System changes: Social Service will erresidents are see and resident voice discom- be referred to a Podia the community. Nurs- the appointment withing business hours after a voiced. After facility wide aud Service/designee will for 4 weeks then mon- thereafter to ensure the foot care is carried out appropriately. New Podiatry compar- providing services to a 9/6/2022. 4) How the corrective will be monitored: The results of these arreviewed in Quality A Meeting monthly for 6 until an average of 90 compliance or greater x3 consecutive month Committee will identifion or patterns and make recommendations to a plan of correction as in 5) Date of compliance | a place/ nsure that nually. If a fort, they will atrist within ing will make n 24 a concern is it, the Social audit weekly thy hat resident's it ny will start the facility on e actions audits will be ssurance b months or 0% r is achieved ns. The QA y any trends revise the indicated. | | |
| [:] 0688 SS=D Bldg. 00 | 483.25(c)(1)-(3) Increase/Prevent §483.25(c) Mobil | t Decrease in ROM/Mobility ity. | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT IDENTIFICATION NUMBER A. BUILDING 00 155580 B. WING | | 00 | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|
| | PROVIDER OR SUPPLI | | 2350 T | address, city, state, zip cod AFT ST IN 46404 | | |
| (X4) ID PREFIX TAG | (EACH DEFICII | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE | |
| | resident who en range of motion reduction in rang resident's clinica that a reduction unavoidable; an §483.25(c)(2) A motion receives services to incre- prevent further of §483.25(c)(3) A receives approp assistance to ma with the maximu- unless a reducti- demonstrably ur Based on observa interview, the fac in place as ordere for limited range Finding includes: On 7/31/22 at 10: observed in his w devices noted to H On 8/2/22 at 10:0 in his wheelchair to his left hand. On 8/3/22 at 9:12 in his wheelchair to his left hand. | resident with limited range of appropriate treatment and case range of motion and/or to decrease in range of motion. resident with limited mobility riate services, equipment, and aintain or improve mobility im practicable independence on in mobility is havoidable. tion, record review, and ility failed to ensure a splint was d for 1 of 2 residents reviewed of motion. (Resident 102) | F 0688 | Aperion Care Tolleston Park Compliance 09/04/2022 F688 ROM The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of | ent | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE to his left hand. correction is prepared and/or executed solely because it is The record for Resident 102 was reviewed on required by the provisions of 8/2/22 at 1:26 p.m. Diagnoses included, but were federal and state law. not limited to, stroke, hemiplegia (loss of control of muscles) affecting left non-dominant side, high 1) Immediate actions taken for blood pressure, and aphasia (loss of ability to those residents identified: understand or express speech). Resident 102's splint was placed at the time of survey. The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/22, indicated the resident 2) How the facility identified was cognitively intact for daily decision making. other residents: All residents who have A Physician's Order, dated 1/20/22, indicated left contractures, or at risk for hand splint, on during the day and off at night. contractures have the potential to be affected by this practice. An A Care Plan, initiated on 1/20/22, indicated the audit was conducted to identify resident had a potential for impairment to skin these residents, care plans were integrity related to left hand splint, impaired reviewed and updated, as mobility, and episodes of incontinence. necessary. Interventions included, but were not limited to, monitor response to preventative treatment as ordered. 3) Measures put into place/ System changes: Interview with the 200 Unit Manager on 8/4/22 at Nursing staff will be re-educated 11:57 a.m., indicated she was unable to find the relative to Increase/Prevent splint in the resident's room. The 200 Unit Decrease in ROM/Mobility. Manager retrieved a new resting hand splint for including but not limited to the resident's left hand. ensuring use of splints per physician order. 3.1-42(a)(2) DON/Unit Managers/Designee will conduct random visual observation audits of at least 5 residents per week, for 4 weeks, with ordered splints to ensure placement as per orders/recommendations. Thereafter, these audits will be conducted on at least 2 residents per week for 8 weeks to ensure continued compliance. SKSY11

Event ID:

Facility ID: 008505

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09/14/2022

PRINTED:

| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155580 | A. BUILDING B. WING | 00 | | |
| | PROVIDER OR SUPPLIE | | 2350 | T ADDRESS, CITY, STATE, ZIP | COD | |
| APERIO | N CARE TOLLEST | ON PARK | GAR | Y, IN 46404 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY) | RRECTION SHOULD BE APPROPRIATE | (X5) COMPLETION DATE |
| = 0697 SS=D Bldg. 00 | 483.25(k) Pain Managemer §483.25(k) Pain I The facility must management is p require such serv professional stan comprehensive p and the residents Based on record re failed to ensure a r received scheduled for 1 of 3 residents Finding includes: Interview with Res indicated he had be | nt Management. ensure that pain provided to residents who prices, consistent with dards of practice, the erson-centered care plan, ' goals and preferences. view and interview, the facility esident with complaints of pain I medication to relieve the pain reviewed for pain. (Resident F) sident F on 7/31/22 at 9:59 a.m., the out of his pain medication his leg was hurting all night, so | F 0697 | Findings will be docur the Angel Rounds shareviewed at the daily of DON is responsible for compliance. 4) How the corrective will be monitored: The results of these a reviewed in Quality As Meeting monthly for 6 until 100% compliance achieved. The QA Co- identify any trends or make recommendation the plan of correction 5) Date of compliance 09/04/2022 Aperion- Tolleston P Annual/Recertification Compliance 09/04/200 F697 Pain Management The facility requests compliance for this of This Plan of Correction | eet and meetings. or e actions udits will be ssurance is months or e is ommittee will patterns and ns to revise as indicated. ce: ark on 22 ent paper citation. on is the | 09/04/202 |

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE C A. BUILDING | ONSTRUCTION (X3 00 |) DATE SURVEY COMPLETED | | |
|---------|-------------------------------------------------|-----------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------|----------------------------|--|--|
| | | 155580 | B. WING | | 08/05/2022 | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP COD | | | |
| APERIO | N CARE TOLLEST | ON PARK | 2350 TAFT ST GARY, IN 46404 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION | | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | TAG | compliance. | DATE | | |
| | The record for Res | ident F was reviewed on 8/2/22 | | | | | |
| | at 12:58 p.m. Diag | gnoses included, but were not | | Preparation and/or execution of | | | |
| | limited to, seizures | s, coronary artery disease, high | | this plan of correction does not | | | |
| | blood pressure, renal insufficiency, peripheral | | | constitute admission or agreemen | nt | | |
| | vascular disease, a | nxiety disorder, and chronic | | by the provider of the truth of the | | | |
| | lung disease. | | | facts alleged or conclusions set | | | |
| | | | | forth in the statement of | | | |
| | The Annual Minin | num Data Set (MDS) | | deficiencies. The plan of | | | |
| | assessment, dated | 5/20/22, indicated the resident | | correction is prepared and/or | | | |
| | was cognitively in | tact for daily decision making. | | executed solely because it is | | | |
| | The resident was an extensive as | n extensive assistance for bed | | required by the provisions of | | | |
| | mobility, transfers | , and toileting. The resident was | | federal and state law. | | | |
| | not on a scheduled | pain medication regimen, | | | | | |
| | received as needed | l (prn) pain medications, did not | | 1) Immediate actions taken for | | | |
| | receive any non-m | edication interventions for pain, | | those residents identified: | | | |
| | and had almost con | nstant pain in the last 5 days | | | | | |
| | making it hard to s | leep and limited day-to-day | | New script was sent per Nurse | | | |
| | activities. | | | Practitioner for resident F | | | |
| | The Care Plan, dat | ed 7/16/21, indicated the | | 2) How the facility identified | | | |
| | resident had poten | tial for pain related to coronary | | other residents: | | | |
| | artery disease and | fracture. Interventions | | | | | |
| | included, but were | not limited to, administer | | All residents receiving pain | | | |
| | analgesia as per or | ders. | | medications have the potential to | | | |
| | | | | be affected by this alleged | | | |
| | | er, dated 6/25/22, indicated | | deficient practice. | | | |
| | | ication) 7.5-325 milligrams (mg) | | | | | |
| | three times a day f | or chronic pain. | | An audit was completed on all | | | |
| | | | | residents with pain medication to | | | |
| | | ast 2022 Medication | | ensure assessments and plan of | | | |
| | | cord (MAR) indicated the | | care were up to date. | | | |
| | - | was not marked as administered | | | | | |
| | on the following d | | | 3) Measures put into place/ | | | |
| | - 7/6/22 at 10:0 | - | | System changes: | | | |
| | - 7/14/22 at 10 | | | | | | |
| | - 7/19/22 at 2:0 | - | | Staff education was provided on | | | |
| | | 00 a.m. and 10:00 p.m. | | Pain Management, including but | | | |
| | | 00 a.m. and 10:00 p.m. | | not limited to, medication | | | |
| | - 8/1/22 at 6:00 |) a.m. and 2:00 p.m. | | administration and the importance | e | | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/05/2022 | | |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|--|
| NAME OF | PROVIDER OR SUPPLIE | ER | STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST | | | | |
| APERIO | N CARE TOLLEST | ON PARK | | IN 46404 | | | |
| (X4) ID PREFIX | | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | ION (X5) D BE COMPLETION OPRIATE | | |
| TAG | REGULATORY C - 8/2/22 at 6:00 | DR LSC IDENTIFYING INFORMATION) a.m. | TAG | of monitoring, assessing, | DATE | | |
| | | ated 7/31/22 at 2:11 p.m., ent needed a new prescription ets. | | documenting, and providir medication according to physician's order and resid plan of care. | | | |
| | 3:30 p.m., indicate system was not we submitted a new p Norco, but the pha new prescription to Interview with the 1:53 p.m., indicate | Director of Nursing on 8/3/22 at ad she was unable to provide any | | Director of Nursing, or des daily, on scheduled days of will review documentation ensure pain assessments completed and pain medio was administered and documented. This review completed 5 times weekly weeks, then 2 times week | of work, to were cation will be for 4 | | |
| | further information This Federal tag ro 3.1-37(a) | n. elates to Complaint IN00384824. | | weeks. 4) How the corrective act will be monitored: | tions | | |
| | | | | The results of these audi be reviewed in Quality Assurance Meeting mont months or until an avera 90% compliance or great achieved x3 consecutive months. The QA Commi will identify any trends o patterns and make recommendations to revi plan of correction as ind | thly x6 ge of ter is ttee r ise the | | |
| | | | | 5) Date of compliance: 09/04/2022 | | | |
| 0757 SS=D Bldg. 00 | 483.45(d)(1)-(6) Drug Regimen is Drugs | Free from Unnecessary | | | | | |

09/14/2022 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155580 B. WING 08/05/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility F 0757 Aperion- Tolleston Park 09/04/2022 failed to ensure blood pressure medication was Compliance 09/04/22 held per parameters and duplicate drug therapy was not ordered for 2 of 5 residents reviewed for F 757 Drug Regimen Free from unnecessary medications. (Residents 118 and C) **Unnecessary Medications** Findings include: The facility requests paper compliance for this citation. 1. The record for Resident 118 was reviewed on 8/4/22 at 3:23 p.m. Diagnoses included, but were This Plan of Correction is the not limited to, heart failure and hypotension (low center's credible allegation of blood pressure). compliance. The Admission Minimum Data Set (MDS) Preparation and/or execution of assessment, dated 7/6/22, indicated the resident this plan of correction does not was moderately impaired for daily decision constitute admission or agreement making. by the provider of the truth of the Event ID: SKSY11 Facility ID: 008505 If continuation sheet Page 40 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| EITHERS I OF | willbreitte a willbre | ALD SERVICES | | | | 0.01 | B 110. 0700 007 |
|--------------|-----------------------|---------------------------------|-------------|------------|-------------------------------------------------------------------------|----------|-----------------|
| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | X3) DATE | SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155580 | B. W | ING | | 08/05/ | /2022 |
| | PROVIDER OR SUPPLIEF | | | 2350 T/ | address, city, state, zip cod AFT ST IN 46404 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | - | DATE |
| | | | | | facts alleged or conclusions se | t | |
| | A Physician's Order | r, dated 6/30/22, indicated the | | | forth in the statement of | | |
| | resident was to rece | eive Midodrine HCl (a | | | deficiencies. The plan of | | |
| | medication to treat | low blood pressure) 5 | | | correction is prepared and/or | | |
| | milligrams (mg) the | ee times a day. The medication | | | executed solely because it is | | |
| | was to be held for a | systolic (top number) blood | | | required by the provisions of | | |
| | pressure of 100. Th | ne order was discontinued on | | | federal and state law. | | |
| | 7/26/22. | | | | | | |
| | | | | | 1) Immediate actions taken fo | r | |
| | A Physician's Orde | r, dated 7/26/22, indicated the | | | those residents identified: | | |
| | resident was to rece | vive Midodrine HCl Tablet 5 | | | | | |
| | mg | | | | 1. Resident #118's medicat | tion | |
| | | 110 (1) | | | | | |

mg three times a day, hold for systolic pressure over 100. The July 2022 Medication Administration Record (MAR), indicated the medication was given when the resident's systolic blood pressure was greater

than 100 on the following dates and times: 8:00 a.m.: 7/3-7/5, 7/14-7/23, and 7/28-7/30/22. 12:00 p.m.: 7/3-7/5, 7/9, 7/11, 7/13-7/22, 7/24, and 7/28-7/31/22. 6:00 p.m.: 7/3-7/5, 7/7, 7/9-7/25, 7/27, 7/28, 7/30, and 7/31/22. The August 2022 MAR, indicated the medication was given when the resident's systolic blood pressure was greater than 100 on the following dates and times: 8:00 a.m.: 8/3/22.

6:00 p.m.: 8/2 and 8/3/22. Interview with the Director of Nursing on 8/4/22 at 9:05 a.m., indicated the resident's Midodrine should have been held per parameters. 2. The closed record for Resident C was reviewed on 8/3/22 at 3:26 p.m. The resident was admitted on 6/20/22 and discharged on 7/15/22. Diagnoses included, but were not limited to,

order, and parameters for withholding/administering, was reviewed with assigned nurses at the time of survey. 2. Resident C no longer resides at the facility; therefore, no further corrective action could be taken for this resident. 2) How the facility identified other residents: Audits have been conducted to identify any residents having medication orders with specified parameters for withholding/administering the prescribed medication, and to identify any duplicate drug therapy on resident's eMARs. This plan of correction applies to any residents identified in these audits.

3) Measures put into place/ System changes:

Licensed nurses and QMAs have been re-educated relative to Drug

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12:00 p.m.: 8/2/22.

SKSY11 Event ID:

Facility ID: 008505

If continuation sheet

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PRINTED: 09/14/2022 FORM APPROVED

OMB NO. 0938-039

| TERS FO | R MEDICARE & MEDIC | CAID SERVICES | | | 0 | OMB NO. 0938-039 | | |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|--|
| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPL A. BUILDING B. WING | e construction g <u>00</u> | СОМ | (X3) DATE SURVEY COMPLETED 08/05/2022 | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | EET ADDRESS, CITY, STATE, ZIP CO 0 TAFT ST | DD | | | |
| APERIO | N CARE TOLLEST | ON PARK | | RY, IN 46404 | | | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORF | RECTION | (X5) | | |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | PREFL | K (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A | OULD BE | COMPLETION | | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | | | DATE | | |
| 0804 S=E Idg. 00 | The Admission Mi assessment, dated of was moderately im Physician's Orders, Omeprazole 20 mil release, give 1 caps Physician's Orders, Omeprazole 20 mg The 6/2022 Medica (MAR), indicated the night and 20 mg da administered 6/20- signed out as being therefore it was dug Interview with the 1:30 p.m., indicated Omeprazole was sit two times every da 3.1-48(a)(1) 3.1-48(a)(3) | ation Administration Record the Omeprazole 20 mg daily at aily was signed as being 6/27/22. Both orders were g administered together, plicate drug therapy. Director of Nursing on 8/4/22 at d she was unaware the gned out as being administered y rather than daily. | | Regimen is Free from Unnecessary Drugs, innot limited to ensuring for medications are either of administered according parameters, and ensuring residents do not have of drug therapy. The DON/designee will eMARs of at least 10 rediaily, on scheduled day for 4 weeks, then week weeks thereafter to ensomedication orders are for relative to withholding/administering medications according parameters, and relative ensuring no duplicate of is administered. How the corrective will be monitored: The results of the auditing reviewed in the Quality monthly for 6 months of compliance is achieved committee will identify a or pattern and recommitor to revise the plan of con- indicated 5) Date of compliance 09/04/2022 | that withheld or to ordered ing that duplicate audit esidents /s of work, ly for 8 sure that followed ng to ordered e to lrug therapy actions will be Meeting r until 90% I. The QA any trends endations rrection as | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/14/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING CTEVET ADDRESS, CITY, CTATE, ZD, COD | | | (X3) DATE SURVEY COMPLETED 08/05/2022 | | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------|--|
| | NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK | | | STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION provides- | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI TAG DEFICIENCY) | | : | (X5) COMPLETION DATE | |
| | conserve nutritiv appearance; §483.60(d)(2) For palatable, attract appetizing tempo Based on observa failed to ensure for temperature for 5 (Residents 66, 12) Findings include: Interview with Ref a.m., indicated the warm for each me room. Interview with Ref a.m., indicated the were the first unit resident would eat Interview with Ref indicated the food would eat in her ref Interview with Ref p.m., indicated the resident would eat Interview with Ref indicated the food eat in her room. On 8/3/22 at 12:00 | tion and interview, the facility ood was served at a palatable of 5 residents reviewed for food. 3, B, 128, and 25) sident 66 on 7/31/22 at 10:55 e food was not consistently eal. The resident would eat in her sident 123 on 7/31/22 at 11:31 e food was often cold and they to get served each meal. The t in her room. sident B on 7/31/22 at 2:53 p.m., was always cold. The resident oom. | FO | 804 | Aperion- Tolleston Park Annual/Recertification Compliance 09/04/2022 F804 Nutritive Value/Appear, Palatable/Prefer Temp The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreem by the provider of the truth of th facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: | ent e | 09/04/202 | |

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155580 | (X2) MULTIPLE C A. BUILDING B. WING | <u>00</u> | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| | PROVIDER OR SUPPLIE | | 2350 T | ADDRESS, CITY, STATE, ZIP COD AFT ST , IN 46404 | | |
| (X4) ID PREFIX TAG | SUMMARY (EACH DEFICIE REGULATORY C participated in pass room. The meal tr lid. The final tray temperatures from time: The cream of chic Fahrenheit. The st degrees Fahrenhei Interview with the time, indicated the | A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION sing out the meal trays to each ays were covered with a dome was delivered at 12:30 p.m. and the test tray were taken at that ken over rice was 110 degrees eamed brussel sprouts was 130 t. Dietary Food Manager at that e cream of chicken over rice and prouts should have been | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) on the importance of serving at a palatable temperature for residents. Dietary Manager has review, checklists to ensure that food temperatures are being prop recorded prior to serving, an all temperature controlled, at cooking equipment is in prop working condition. Dietary Manager has checked the following trays of the affected residents (66, 123, B, 128, a 25) are in acceptable temper range. How the facility identified other residents: All residents have the potent be affected by this deficient practice. Measures put into place/ System changes: Dietary Manager and/ or des will conduct audits 5 times a week. This will occur at mea service times to ensure steat table, transport carts and refrigeration units are operat acceptable temperatures to maintain food temp. Test tray assessment will be conducted ensure palatability, temperat and appearance are maintait acceptable levels until the pot the resident receives meal. | food or all ed the d erly d that nd oer d nd rature d tial to d tial to ing at y ed to ure ned at | (X5) COMPLETIC DATE |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | MULTIPLE C BUILDING | onstruction 00 | · / | E SURVEY PLETED |
|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------|
| | or condection | 155580 | B. WING | | <u></u> | | 5/2022 |
| NAME OF | PROVIDER OR SUPPLIE | R | - | | ADDRESS, CITY, STATE, ZIP | COD | |
| APERIO | N CARE TOLLEST | ON PARK | | | AFT ST , IN 46404 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CO | | (X5) |
| PREFIX TAG | | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE E APPROPRIATE | COMPLETION DATE |
| | | | | | 4) How the correctiv will be monitored: | e actions | |
| | | | | | Dietary Manager or d interview three reside daily asking about for temperatures during x 3 months. | ents randomly od | |
| | | | | | The results of these be reviewed in Quali Assurance Meeting months or until an a 90% compliance or g achieved x3 consect months. The QA Co will identify any tren patterns and make recommendations to plan of correction as | ity monthly x6 verage of greater is utive mmittee ids or | |
| ⁼ 0809 SS=E Bldg. 00 | §483.60(f) Freque §483.60(f)(1) Eac the facility must p daily, at regular ti mealtimes in the accordance with requests, and pla §483.60(f)(2)The hours between a and breakfast the a nourishing snac to 16 hours may | ch resident must receive and provide at least three meals mes comparable to normal community or in resident needs, preferences, | | | 5) Date of complian 09/04/2022 | ce: | |

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155580 B. WING 08/05/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. 09/04/2022 Based on observation, record review, and F 0809 interview, the facility failed to ensure the breakfast Aperion- Tolleston Park and lunch meals were served on time for 3 of 4 units observed. (The North, South, and Memory POC Annual/Recertification Care Units) Compliance 09/04/2022 Findings include: 1. On 7/31/22 at 8:35 a.m., a second tray cart was F809 Frequency of Meals delivered to the North Unit. The facility requests paper At 9:17 a.m., breakfast trays were delivered to the compliance for this citation. Memory Care Unit. This Plan of Correction is the At 12:17 PM, lunch trays were delivered to the center's credible allegation of North Unit. compliance. At 12:48 p.m., the first lunch cart was delivered to Preparation and/or execution of the South Unit and the second cart was delivered this plan of correction does not at 12:50 p.m. constitute admission or agreement by the provider of the truth of the At 12:54 p.m., the lunch trays were delivered to facts alleged or conclusions set the Memory Care Unit. forth in the statement of deficiencies. The plan of 2. On 8/2/22 at 8:55 a.m., the first breakfast cart correction is prepared and/or arrived on the South Unit. At 8:59 a.m., the executed solely because it is breakfast trays were delivered to the Memory Care required by the provisions of federal and state law. Unit. At 1:00 p.m., the first lunch cart arrived on the 1) Immediate actions taken for South Unit. At 1:04 p.m., the lunch trays were those residents identified: Event ID: SKSY11 Facility ID: 008505 If continuation sheet Page 46 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete

| TERS FO | R MEDICARE & MEDI | CAID SERVICES | | | 0 | 1B NO. 0938-039 |
|---------|----------------------|-----------------------------------|------------------|-----------------------------------------------------------------|----------------------|-----------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | | r í | SURVEY |
| ND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED 08/05/2022 | |
| | | 155580 | B. WING | | | |
| AME OF | PROVIDER OR SUPPLIE | R | STREET | _ | | |
| | | | | AFT ST | | |
| PERIO | N CARE TOLLEST | ON PARK | GARY, | IN 46404 | | |
| (4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTIO |)N | (X5) |
| REFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO | BE | COMPLETIO |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE |
| | delivered to Memo | bry Care. | | | | |
| | | | | Kitchen staff was re in- ser | | |
| | The Meal Times w | vere scheduled as follows: | | on the importance of servin | g food | |
| | | | | at the provided mealtimes. | | |
| | | 3:10 a.m., PCU 8:20 a.m., and | | | | |
| | South 8:30 a.m. | 10 m m DCU 12:15 | | 2) How the facility identified | ed | |
| | | 10 p.m., PCU 12:15 p.m., and | | other residents: | atial to | |
| | South 12:25 p.m. | 5 p.m., PCU 5:30 p.m., and South | | All residents have the poten | | |
| | 5:45 p.m. | 5 p.m., FCO 5.50 p.m., and South | | be affected by this deficien practice. | L | |
| | 5.45 p.m. | | | practice. | | |
| | 3. On 8/3/22 at 9: | 07 a.m., the breakfast trays were | | 3) Measures put into place | <u>e</u> / | |
| | delivered to the M | • | | System changes: | | |
| | | | | Dietary Manager and/ or de | esianee | |
| | During the initial l | titchen sanitation tour, on | | will conduct audits 5 times | • | |
| | - | n., Dietary Cook 1 indicated | | to ensure meals are served | lon | |
| | breakfast was serv | ed at 8:10 a.m. and lunch at | | time. | | |
| | 12:10 p.m. She in | dicated no one was eating in the | | | | |
| | main dining room | and the North Unit was served | | 4) How the corrective acti | ons | |
| | first, then South, a | nd then Memory Care. | | will be monitored: | | |
| | Interview with the | Administrator on 8/5/22 at 10:00 | | Dietary Manager or design | ao will | |
| | | meals should have been | | observe the tray line 5 time | | |
| | delivered in a more | | | week. Interview three resid | | |
| | | 5 | | randomly daily asking was | | |
| | This Federal tag re | lates to Complaint IN00387286. | | food on time during various | | |
| | | - | | x 3 months. | | |
| | 3.1-21(c) | | | | | |
| | | | | The results of these audit | s will | |
| | | | | be reviewed in Quality | | |
| | | | | Assurance Meeting month | - | |
| | | | | months or until an averag | | |
| | | | | 90% compliance or greate | r is | |
| | | | | achieved x3 consecutive | | |
| | | | | months. The QA Commit | ee | |
| | | | | will identify any trends or | | |
| | | | | patterns and make | a 4la - | |
| | | | | recommendations to revis | | |
| | | | | plan of correction as indic | aleu. | |
| | | | 1 | | | 1 |

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | | | (X3) DAT | | |
|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------|-----------------------------------------------------------------------------------------------------------------|----------|----------------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155580 | A. BUILDING (B. WING | | | | mpleted /05/2022 | |
| | PROVIDER OR SUPPLIE | | 23 | 350 TAF | | | | |
| APERIO | N CARE TOLLEST | ON PARK | G | ARY, IN | 46404 | | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREI TA | FIX | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| | | | | |) Date of compliance: 9/04/2022 | | | |
| ^F 0812 SS=F Bldg. 00 | | re/Prepare/Serve-Sanitary safety requirements. | | | | | | |
| | §483.60(i)(1) - Pr approved or cons federal, state or I (i) This may inclu directly from loca applicable State regulations. (ii) This provision facilities from usi gardens, subject applicable safe g practices. (iii) This provision | ocure food from sources sidered satisfactory by ocal authorities. de food items obtained I producers, subject to | | | | | | |
| | §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to store and serve food under sanitary conditions related to food not labeled and dated and touching food items with a gloved hand. This had the potential to affect the 126 residents who received their meals from the kitchen. (The Main Kitchen) | | F 0812 | | Aperion- Tolleston Park Annual/Recertificati Compliance 09/04/2022 | on | 09/04/2022 | |
| | Finding includes: | | | - | 812 Food/Procurement/ store/Prepare/Serve-Sanit | ary | | |
| | | g the initial kitchen tour, on 1. with the Dietary Food | | Т | he facility requests pape | r | | |

| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---------|-----------------------|---------------------------------|----------------------------|---------|------------------------------------------------------------------------|------------------|----------|
| | OF CORRECTION | IDENTIFICATION NUMBER | ì í | JILDING | 00 | COMPL | |
| | | 155580 | B. WI | | <u></u> | 08/05 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF | PROVIDER OR SUPPLIEF | | | | AFT ST | | |
| APERIO | N CARE TOLLEST | ON PARK | | GARY, | IN 46404 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETI |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | Manager (DFM), in | dicated the following: | | | compliance for this citation. | | |
| | a. A stainless steel | container in the reach in | | | This Plan of Correction is the | | |
| | | n orange substance that was | | | center's credible allegation of | | |
| | - | . There was also a stainless | | | compliance. | | |
| | steel container of an | plesauce that was not dated | | | | | |
| | - | ners of sliced peaches that | | | Preparation and/or execution | of | |
| | were not dated. | | | | this plan of correction does no | | |
| | | | | | constitute admission or agree | ment | |
| | Interview with the I | DFM at that time, indicated the | | | by the provider of the truth of | the | |
| | items should have b | een dated. | | | facts alleged or conclusions s | et | |
| | | | | | forth in the statement of | | |
| | b. At 8:53 a.m., the | breakfast service was still | | | deficiencies. The plan of | | |
| | | the tray line. Dietary Cook 1 | | | correction is prepared and/or | | |
| | | eft hand and no glove on her | | | executed solely because it is | | |
| | - | ok was observed picking up | | | required by the provisions of | | |
| | - | st and sausage patties with | | | federal and state law. | | |
| | | well as handling styrofoam | | | | | |
| | plates and bowls. | | | | 1) Immediate actions taken f | or | |
| | T | | | | those residents identified: | | |
| | | Administrator on 8/4/22 at 3:00 | | | The unlebeled feed was disca | سما م ما | |
| | tongs to handle the | Cook should have been using | | | The unlabeled food was disca | | |
| | tongs to natione the | 1000. | | | The Dietary Manager complete an audit on all food in the kitc | | |
| | 3.1-21(i)(3) | | | | to ensure it was labeled and | len | |
| | 5.1-21(1)(5) | | | | dated. Kitchen staff was re in- | | |
| | | | | | serviced on the importance of | | |
| | | | | | labeling and dating all food. A | | |
| | | | | | cooks were in-serviced and | | |
| | | | | | informed to serve food with | | |
| | | | | | utensils. | | |
| | | | | | 2) How the facility identified | | |
| | | | | | other residents: | | |
| | | | | | All residents have the potentia | al to | |
| | | | | | be affected by this deficient | | |
| | | | | | practice. | | |
| | | | | | 3) Measures put into place/ | | |
| | | | | | System changes: | | |

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPLE C A. BUILDING B. WING | construction 00 | COMI | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|---------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|
| NAME OF | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP (| COD | | |
| APERIO | N CARE TOLLEST | ON PARK | | , IN 46404 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | RRECTION SHOULD BE APPROPRIATE | (X5) COMPLETION DATE | |
| | | | | All dietary staff were in labeling and dating all refrigerator and freeze facility policy. Dietary observe the tray line 5 week to ensure cooks the proper utensils wh 4) How the corrective will be monitored: Dietary manager/desig conduct observation a kitchen 5 times per we various times to ensur sanitation, food is labe and infection control is maintained. The results of these a be reviewed in Qualit Assurance Meeting m months or until an av 90% compliance or g achieved x3 consecu months. The QA Cor will identify any trend patterns and make recommendations to plan of correction as 5) Date of compliance | I food put in er on per Manager will 5 times a a are using hen serving. e actions gnees will audits in the eek at re proper elled /dated, s audits will ty monthly x6 verage of greater is utive mmittee ds or previse the indicated. | | |
| ⁵ 0880 SS=E Bldg. 00 | | ion & Control | | | | | |

PRINTED: 09/14/2022 FORM APPROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and Event ID: SKSY11 Facility ID: 008505 Page 51 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on random observations, record review, F 0880 F 880 Infection Prevention and 09/04/2022 and interview, the facility failed to ensure Control infection control guidelines were in place and The facility requests paper implemented, including those to prevent and/or compliance for this citation. contain COVID-19 related to handwashing before This Plan of Correction is the meals on 1 of 4 units, the use of personal center's credible allegation of protective equipment (PPE) in isolation rooms, the compliance. lack of COVID-19 monitoring, and not sanitizing multi-use equipment in between residents. (The Preparation and/or execution of Memory Care Unit, Residents G, 32, and 67) this plan of correction does not constitute admission or agreement Findings include: by the provider of the truth of the facts alleged or conclusions set Event ID: SKSY11 Facility ID: 008505 Page 52 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

09/14/2022

PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155580 B. WING 08/05/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1. On 7/31/22 at 9:17 a.m., the breakfast trays were forth in the statement of being served in the Memory Care dining room. deficiencies. The plan of The residents were not offered hand sanitizer correction is prepared and/or before their meals. executed solely because it is required by the provisions of At 12:54 p.m., the residents were not offered hand federal and state law. sanitizer prior to their lunch meal. 1) Immediate actions taken for On 8/2/22 at 9:02 a.m., the breakfast trays were those residents identified: being served in the Memory Care dining room. 1. Memory care staff was Again, the residents were not offered hand re-educated at the time of survey. sanitizer before their meal. No residents were adversely affected by this practice. At 1:04 p.m., the residents were not offered hand 2. Housekeeper #1 was sanitizer prior to their lunch meal. addressed at the time of survey. Resident G was not adversely On 8/3/22 at 9:07 a.m., the breakfast trays were affected by this practice. delivered to the Memory Care Unit. The residents 3. Daily monitoring of were not offered hand sanitizer before their meals. temperature and oxygen saturation were added to Resident Interview with the Director of Nursing on 8/4/22 at G's plan of care. Resident G was 9:00 a.m., indicated the residents' hands should not adversely affected by this have been cleaned before each meal. 2. During a practice. random observation on 8/2/22 at 9:45 a.m., 4 RN #1 was addressed at the Housekeeper 1 entered Resident G's room carrying time of survey relative to proper a garbage can and only wearing a surgical face sanitation of multi-use resident mask. At that time, a sign on the resident's door equipment. No residents were indicated "Droplet/Contact Isolation. Proper adversely affected by this practice. Personal Protective Equipment (PPE): an isolation gown, protective eye wear, a N95 face mask and 2) How the facility identified gloves to both hands before entering." The other residents: resident was observed seated in a geri chair and All residents have the potential to the housekeeper walked within 2 feet of him to be affected. Thus, this plan of place a garbage can by the bathroom door. He correction applies to all residents walked out of the room and did not perform hand of the facility. The facility infection hygiene. control self-assessment will be reviewed to ensure accuracy and Interview with Housekeeper 1 at that time, will be revised, as necessary. indicated he was not aware the resident was in isolation and did not see the signage on the door. 3) Measures put into

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Event ID:

SKSY11

Facility ID: 008505

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MUL A. BUII | | 00 | (X3) DATE SURVEY COMPLETED | |
|---------------|-------------------------------------|----------------------------------------------------------------|---------------------|--------------|-----------------------------------------------------------------------------------------|-------------------------------|--------------------|
| | | 155580 | B. WING | | | 08/05/2022 | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP COD | | |
| APERIO | N CARE TOLLEST | ON PARK | | | IN 46404 | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | • | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION | | REFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | E | COMPLETION DATE |
| | | | | | place/system changes: | | |
| | - | tepped away from the room | | | Root Cause Analyses (RCA) w | ere | |
| | - | isolation gown from the 3 tiered | | | conducted. As a result of the | | |
| | - | nned the gown, and walked to | | | RCAs, facility staff will be | | |
| | | room who was also in | | | re-educated relative to proper F | | |
| | - | lation. He removed his surgical | | | use in isolation rooms. Nursing | 9 | |
| | | ned a clean N95 face mask and | | | staff will be educated by | | |
| | | om carrying another garbage | | | DON/designee on hand hygien | е | |
| | | on protective eye wear or gloves | | | for residents, sanitizing of | | |
| | | e entering the room. He left the | | | multi-use resident equipment, a | | |
| | - | perform hand hygiene and | | | monitoring of residents for s/s of | of | |
| | pushed a transport | ation cart down the hallway. | | | Covid-19 | | |
| | Interview with the | Director of Nursing on 8/4/22 at | | | 4) How the corrective actions | | |
| | 9:30 a.m., indicate | d the housekeeper should have | | | will be monitored: | | |
| | worn the correct P | PE prior to entering those | | | The IP nurse/DON/Designee w | ill | |
| | resident rooms. | | | | complete random visual rounds | 5 | |
| | | | | | daily, on scheduled days of wo | rk, | |
| | An updated and cu | rrent facility policy titled | | | for 6 weeks, and until complian | се | |
| | "Infection Control | -Interim COVID-19", provided | | | is maintained to ensure staff an | е | |
| | by the Administrat | tor on 8/1/22 at 9:00 a.m., | | | practicing appropriate Infection | | |
| | indicated "PPE in | Yellow Zone: all recommended | | | Control Practices, including but | | |
| | COVID-19 PPE sh | hould be worn during direct care | | | not limited to, proper PPE use i | | |
| | | yellow zone quarantine which | | | isolation rooms, hand hygiene f | | |
| | | e protection, N95 respirator, | | | residents, sanitizing of multi-us | | |
| | gloves and gown." | 3. The record for Resident G | | | resident equipment, and | | |
| | was reviewed on 8 | 3/1/22 at 9:30 a.m. The resident | | | monitoring of residents for s/s of | of | |
| | was admitted to th | e facility on 7/23/22. The | | | Covid-19. | | |
| | resident was unvac | ccinated for COVID-19 and was | | | The results of these audits wi | 11 | |
| | put in transmission | n-based precautions (TBP). | | | be reviewed in Quality | | |
| | A Dhyginian's Ord | ar dated 7/25/22 indicated to | | | Assurance Meeting monthly for | or | |
| | | er, dated 7/25/22, indicated to | | | 6 months, or until 100% | | |
| | - | and symptoms of COVID-19 | | | compliance is achieved for 3 | | |
| | every shift. | | | | consecutive months. The QA | | |
| | A Physician's Ord | er, dated 7/26/22, indicated to | | | Committee will review, update | ; , | |
| | - | 's temperature and oxygen | | | and make changes, as | | |
| | saturation daily. | s temperature and oxygen | | | necessary, to this plan of | ial | |
| | saturation daily. | | | | correction to ensure substant | | |
| | The Treatment Ad | | | | compliance for no less than 6 months. The results of these | | |

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Event ID: SKSY11 Facility ID: 008505

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY, IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE dated 7/2022, indicated the resident had not been audits will be reviewed in monitored for signs and symptoms of COVID-19 **Quality Assurance Meeting** until 7/25/22, two days after admission. He had monthly for 6 months. not had his temperature or oxygen saturation assessed until 7/26/22, 3 days after admission. **Completion Date:** 09/04/2022 Interview with the Infection Preventionist and the Director of Nursing on 8/1/22 at 1:25 p.m., indicated sometimes the Physician's Orders got left in the queue and were not displayed for the nurses to complete. They were unable to provide any further documentation. The Indiana Department of Health Long-term Care COVID-19 Clinical Guidance, dated 2/8/22, indicated, " ... Assessment of residents. Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximetry ..." 4. On 8/3/22 at 9:13 a.m., RN 1 was observed preparing the medications for Resident 32. She picked up a wrist blood pressure cuff from the top of the medication cart and entered the resident's room. RN 1 then placed the blood pressure cuff on the resident's left wrist and assessed her blood pressure. After she administered the resident's medications, she took the blood pressure cuff out of the room and set it back on the medication cart. She did not clean or disinfect the blood pressure cuff. She then started preparing Resident 67's medications. She picked up the wrist blood pressure cuff from the top of the medication cart and entered the resident's room. She placed the blood pressure cuff on the resident's right wrist and assessed her blood pressure. After she administered the resident's medications, she took the blood pressure cuff out of the room and set it back on the medication cart. She did not clean or disinfect the blood pressure cuff. Event ID: SKSY11 Facility ID: 008505 Page 55 of 63 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

09/14/2022

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

| AND PLAN | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | (X3) DATE SURVEY COMPLETED 08/05/2022 |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| | PROVIDER OR SUPPLIE | | 2350 | tt address, city, state, zip cod TAFT ST Y, IN 46404 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | / STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| = 0919 SS=E Bldg. 00 | indicated she had a cuff in between re- clean the cuff with pad, but she had n A facility policy re Director of Nursin Sanitizing-Wheeld Equipment," indic used for more than between each resid 3.1-18(b) 483.90(g)(2) Resident Call Sy §483.90(g) Resid The facility must allow residents to through a commu- relays the call dir a centralized stat §483.90(g)(2) To Based on observat failed to ensure re- Behavioral Unit ha at the bedside for 42) This had the p residents who resid Finding includes: During a random of a.m., there was no | ecceived as current from the ig, titled "Cleaning & shairs and Other Medical ated, "5. Devices/equipment in one resident shall be cleaned dent" stem dent Call System be adequately equipped to to call for staff assistance unication system which rectly to a staff member or to | F 0919 | Aperion- Tolleston Park Annual/ Recertification Surve Compliance 09/04/22 F919 Resident Call System The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. | y 09/04/202 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------|-------------------------------------------------------------------------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 155580 | B. WING | | 08/05/2022 | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | AFT ST | | |
| APERIO | N CARE TOLLEST | ON PARK | GARY, | IN 46404 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIE) | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | COMPLETI | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | | | | this plan of correction does no | t l | |
| | | Administrator on 8/2/22 at 3:15 | | constitute admission or agreer | | |
| | - | had left the facility 6 months | | by the provider of the truth of t | he | |
| | prior to the openin | g of the behavioral unit, and | | facts alleged or conclusions se | t | |
| | when she came bac | ck to be the Administrator, she | | forth in the statement of | | |
| | questioned why the | ere were no call lights on the | | deficiencies. The plan of | | |
| | unit. The residents | s who reside on the unit can | | correction is prepared and/or | | |
| | walk without assis | tance and can take care of | | executed solely because it is | | |
| | themselves with m | inimal assist. | | required by the provisions of | | |
| | | | | federal and state law. | | |
| | There were 9 resid | ent rooms on the Behavioral | | | | |
| | | e rooms have no call light at the | | 1) Immediate actions take | n | |
| | | All of the rooms have a call | | for those residents identified | | |
| | light in the bathroom. There were 13 residents who resided on the unit, and 9 of those residents resided in a room with no call light at the bedside. | | | Resident 42 call light wa | | |
| | | | | reattached to the wall and place | | |
| | | | | in resident's reach. | eu | |
| resided in a ro | | with no can light at the bedside. | | | | |
| | T | A 1 · · · · · · · · · · · · · · · · · · | | All rooms on the Behavioral | | |
| | | Administrator on 8/5/22 at 9:30 | | Health Unit have call light to | | |
| | | facility was aware there were no | | ensure residents can summon | | |
| | - | dside in 7 of those rooms, and the a plan for the residents to | | for help at the bedside. | | |
| | summons for help. | - | | 2) How the facility identified | d | |
| | | | | other residents: | | |
| | 3.1-19(u)(1) | | | All dependent residents | | |
| | ()() | | | have the potential to be affected | | |
| | | | | by this deficient practice. | | |
| | | | | | | |
| | | | | 3) Measures put into place | e/ | |
| | | | | System changes: | | |
| | | | | All resident in the facility will ha | | |
| | | | | a call light to call for assistance | e | |
| | | | | when needed. | | |
| | | | | | | |
| | | | | 4) How the corrective | | |
| | | | | actions will be monitored: | | |
| | | | | DON/Designee will do 5 rando | m | |
| | | | | call light audits a week x 4 wee | | |
| | | | | then 3 random call light audits | | |
| | | | | week for 2 weeks then 1 rando | | |
| | | | | | | |

| STATEME | NT OF DEFICIENCIES | CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA | (X2) MI | II TIPLE CONS | STRUCTION | | IB NO. 0938-039 E SURVEY |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580 | | IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | | COMP | LETED 5/2022 |
| APERIO (X4) ID | PROVIDER OR SUPPLIE N CARE TOLLEST SUMMARY | | | STREET AD 2350 TAF GARY, IN ID | PROVIDER'S PLAN OF CORRECT | ION | (X5) |
| PREFIX TAG | | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | | reach corrective action shoul cross-referenced to the appro DEFICIENCY call light audit per 1 week compliance is met. The re of these audits will be reviewed in Quality Assu Meeting monthly x6 mon until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Commi will identify any trends o patterns and make recommendations to revi plan of correction as ind | until esults rance ths or ttee r | COMPLETION DATE |
| ⁼ 0921 SS=E Bldg. 00 | §483.90(i) Other The facility must sanitary, and con residents, staff ar Based on observati failed to ensure the clean and in good a tiles, dirty and disc torn chairs for 3 of PCU) Finding includes: During the Environ 2:15 p.m. through Director, the follow North Unit: | on and interview, the facility residents' environment was repair related to cracked floor olored floors, marred walls, and 3 units. (North, South, and mmental Tour on 8/4/22, from 2:35 p.m. with the Housekeeping | F 09 | | Aperion- Tolleston Park Annual/Recertificatio Compliance 09/04/2022 F921 Safe/Functional/Sanitary ortable Environment The facility requests pap compliance for this citati This Plan of Correction is center's credible allegation | /Comf er on. the | 09/04/202 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
|-----------------------------------------------------|---------------------|---------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------|-----------|
| NAME OF | PROVIDER OR SUPPLIE | R | | ET ADDRESS, CITY, STATE, ZIP CO TAFT ST | DD | |
| APERIO | N CARE TOLLEST | ON PARK | | Y, IN 46404 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORR | RECTION | (X5) |
| PREFIX TAG | | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PREFIX TAG | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) | PPROPRIATE | COMPLETIC |
| IAG | | oken off and missing. | IAG | | | DATE |
| | wheelchall was bi | oken om and missing. | | compliance. | | |
| | | The walls above the bed were lents resided in the room. | | Preparation and/or exe this plan of correction d | | |
| | marred. Two resid | ients resided in the room. | | constitute admission or | | |
| | c. Room 109. Th | e light above bed 2 was not | | by the provider of the tr | - | |
| | | It side of the closet door was off | | facts alleged or conclus | | |
| | | d not close. The paint was | | forth in the statement of | | |
| | | aseboard in the bathroom and | | deficiencies. The plan | | |
| | | not the correct size to fit the | | correction is prepared a | | |
| | toilet. Two reside | nts resided in the room. | | executed solely becaus | | |
| | | | | required by the provisio | | |
| | South Unit: | | | federal and state law. | | |
| | a. Room 209-1: 7 | The floor tile was dirty and | | 1) Immediate action | ns taken | |
| | | s a hole in the outside of the | | for those residents ide | entified: | |
| | | e bracket was missing for the | | | | |
| | | , and one of the towel rack | | Room 106-2 wheelchai | r arm was | |
| | | missing. Two residents resided | | replaced. | | |
| | in the room. | | | Room 108 walls above | the bed | |
| | 1 D 210 1 7 | | | were painted. | | |
| | | There were water stains the | | Room 109 the light abo | | |
| | - | le was dirty, and the inside bb was loose. The bedside | | was fixed and the close | | |
| | | and missing trim. One resident | | placed back on track. A | | |
| | resided in the room | | | room109 the paint near | | |
| | resided in the 100h | | | baseboard was touched paint, and the toilet sea | • | |
| | c. Memory Care I | Dining Room: The floors were | | replaced to fit the toilet. | | |
| | | ed and cracked floor tiles. The | | Room 209 the floor tile | | |
| | | e ceiling was peeling. Multiple | | cleaned, the hole in the | | |
| | | were torn or peeling. | | the bathroom door was | | |
| | | * U | | the toilet paper holder a | | |
| | d. Room 214-1: 7 | The privacy curtain for bed 1 was | | holder bracket was repl | | |
| | | ooks. Two residents resided in | | Room 210 the water sta | | |
| | the room. | | | ceiling was repaired. Th | ne floor tile | |
| | | | | was cleaned, and the b | | |
| | e. Room 217-1: 7 | The wall behind the bed was | | doorknob was tightened | | |
| | marred and the flo | or tile was dirty and discolored. | | the bedside table was r | eplaced. | |
| | Two residents resi | ded in the room. | | In the memory care din | ing room, | |
| | | | | the floors were cleaned | and the | 1 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/05/2022 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST APERION CARE TOLLESTON PARK GARY. IN 46404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE f. Room 224-1: The floor tiles were discolored and tile was replaced. The ceiling cracked in the room and bathroom. Two residents dining room was repainted. The resided in the room. chairs were replaced. Room 214-1 privacy curtain hooks PCU: was replaced. Room 217 -1 wall was repainted, a. Room 310: There was a strong urine odor in floor was cleaned, and the tile was the room. The floor around the toilet was black replaced. and discolored. The bathroom walls were marred, Room 224 floor tiles were replaced and the ceiling vent was dusty. Two residents in the room and bathroom. resided in the room and shared the bathroom. Room 310 was deep cleaned and the floor tile around the toilet was b. Room 311-1: The room walls were marred. Two replaced, and bathroom wall residents resided in the room. painted. Also, bathroom ceiling vents were dusted. c. Room 314-2: The bathroom walls were marred, Room 311-1- bedroom wall was and the floor tile was discolored. Two residents painted. resided in the room. Room 314-2-bathroom walls were painted, and the floor tiles were Interview with Housekeeping Director on 8/4/22 at replaced. 2:35 p.m., indicated the above was in need of cleaning or repair. The Maintenance Director had How the facility identified 2) quit recently, so they only had one Maintenance other residents: Assistant working. All residents have the potential to 3.1-19(f) be affected by this deficient practice. Measures put into place/ 3) System changes: Staff was in-serviced on notifying Maintenance Director/Environmental Manage and staff when environment needs to be repaired or cleaned. How the corrective 4) actions will be monitored: SKSY11

Facility ID: 008505

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09/14/2022

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| ENTERS FU | R MEDICARE & MEDI | CAID SERVICES | | | C | OMB NO. 0938-039 | |
|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | | (X3) DATE SURVEY COMPLETED 08/05/2022 | |
| | PROVIDER OR SUPPLIE | | 23 | REET ADDRESS, CITY, STATE, ZIP COI 50 TAFT ST \RY, IN 46404 |) | | |
| (X4) ID PREFIX | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREF | CROSS-REFERENCED TO THE APP | CTION JLD BE PROPRIATE | (X5) COMPLETION | |
| TAG F 0925 SS=B Bldg. 00 | 483.90(i)(4) Maintains Effectir §483.90(i)(4) Ma control programs pests and rodent Based on observat failed to maintain related to flies in a Memory Care Uni B) Finding includes: On 7/31/22 at 9:17 in the MCU. During an intervie 2:51 p.m., indicate room and in the ha constantly. The rest | ve Pest Control Program intain an effective pest so that the facility is free of s. ion and interview, the facility an environment free of pests, resident's room and the t (MCU) dining room. (Resident d there were flies observed w with Resident B on 7/31/22 at d there had been flies in her llway outside of her door sident indicated she had killed er the previous weekend. | F 0925 | G DEPICIENCY The Interdisciplinary tear Angel rounds 5 days a widentify cleanliness of ear and environmental items to be repaired. The result these audits will be revi- in Quality Assurance M monthly x6 months or u average of 90% complia greater is achieved x3 consecutive months. T Committee will identify trends or patterns and u recommendations to replan of correction as in 5) Date of compliance: 09/04/22 Aperion- Tolleston Park Annual/Recertification Compliance 09/04/2022 F925 Maintains an Effect Pest Control Program The facility requests par compliance for this citat This Plan of Correction is center's credible allegatic compliance. | reek to ch room that need ults of iewed eeting until an ance or he QA any make vise the dicated. | 09/04/202 | |

| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580 | (X2) MULTIPLE C A. BUILDING B. WING | COMP | X3) DATE SURVEY COMPLETED 08/05/2022 | |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| | PROVIDER OR SUPPLIE | | 2350 T | ADDRESS, CITY, STATE, ZIP C AFT ST , IN 46404 | COD | |
| (X4) ID PREFIX | SUMMARY (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / | RECTION HOULD BE APPROPRIATE | (X5) COMPLETIC |
| TAG | On 8/2/22 at 9:47 Resident B's room swatting away the On 8/3/22 at 9:05 the MCU dining ro their meal trays. T swatting the flies a about the flies in th Interview with the p.m., indicated sho put any preventati She indicated sho control company f flies. | A LSC IDENTIFYING INFORMATION a.m., there were two flies in . The resident was constantly flies during the interview. a.m., there were flies present in toom, landing on residents or on wo CNA's were observed tway. A resident commented the dining room. Administrator on 8/3/22 at 3:12 was told the facility could not we measures in place for flies. would be contacting the pest for a follow up service for the elates to Complaint IN00384824. | TAG | this plan of correction of constitute admission of by the provider of the affacts alleged or conclut forth in the statement of deficiencies. The plant correction is prepared executed solely becaut required by the provisi federal and state law. 1) Immediate actions those residents ident Maintenance assistant fly traps and installed the every door leading out facility on each unit. Macontrol continues to combi-weekly and as need 2) How the facility iden other residents: All residents have the be affected by this defined practice. 3) Measures put into System changes: Staff in-serviced on normality of the environmentation o | does not or agreement truth of the usions set of o of and/or use it is ions of taken for ified: t purchased them above t of the lonroe Pest ome out led. entified optential to icient place/ otifying al Manager t needs to be actions eam will do a week to needs to be | DATE |

| | ° OF HEALTH AND HUI MEDICARE & MEDIC | | | | | | TED: 09/14/202 RM APPROVED B NO. 0938-039 |
|--------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------------------------------|
| | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 0 B. WING | | | survey eted /2022 |
| | ROVIDER OR SUPPLIEF | | | 2350 T/ | ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | | | | | audits will be reviewed in Quality Assurance Meeting monthly x6 months or until a average of 90% compliance greater is achieved x3 consecutive months. The Q Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicat 5) Date of compliance: 09/04/2022 | or A the | |

SKSY11 Facility ID: 008505

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