STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	08/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State 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	F 0000		

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.

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	Medicaid: 113 Other: 4 Total: 126 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/10/22.			
F 0550 SS=C Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.			

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	§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation and interview, the facility failed to ensure each resident's dignity was maintained related to the use of disposable plates and utensils for 6 of 6 meals observed. This had the potential to affect the 126 residents residing in the facility and receiving food from the kitchen. Findings include: 1. During the initial kitchen sanitation tour, on 7/31/22 at 8:51 a.m., Dietary Cook 1 was observed serving breakfast. On each tray was a styrofoam plate and bowl as well as a plastic spoon and knife. Interview with the Cook at that time, indicated they were serving on styrofoam because there were not enough plates for everyone. 2. On 7/31/22 at 12:17 p.m., the lunch trays were delivered to the North Unit. The meal was served on styrofoam plates and each resident received a plastic spoon and knife. At 12:54 p.m., the lunch trays were delivered to the Memory Care Unit. The meal was served on styrofoam plates and each resident received a plastic spoon and knife.	F 0550	**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 those residents identified:**	09/04/2022

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	3. On 8/1/22 at 9:36 a.m., residents in the Memory Care Unit were served their breakfast. Again, the breakfast meal was served on a styrofoam plate and the hot and/or cold cereal was served in a styrofoam bowl. Plastic spoons and knives were provided. 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., the lunch trays were delivered. For both meals, the food was served on styrofoam plates and bowls. A plastic spoon and knife was provided. 5. On 8/3/22 at 9:07 a.m., residents in the Memory Care Unit were served their breakfast. Again, the breakfast meal was served on a styrofoam plate and the hot and/or cold cereal was served in a styrofoam bowl. Plastic spoons and knives were provided. Interview with the Dietary Food Manager on 8/3/22 at 10:33 a.m., indicated the facility was short on plates due to plates kept getting broken, she confirmed there were no plastic forks. She indicated plates and utensils were being delivered tomorrow. 3.1-3(t)		Administrator purchased glass plates, forks, and bowls to ensure all resident's meals are served on dinnerware. **2) How the facility identified other residents:** All residents could be affected by this deficient practice. An audit inventory was completed for plates, bowls, and forks. Dietary Manager reviewed all residents order to identify residents that have a standing order for Styrofoam. If resident identified the Dietary Manager and DON will review to ensure resident's dignity is not compromised. **3) Measures put into place/ System changes:** Education was provided to the Dietary Department to explain the importance of ensuring each resident's dignity is maintained by 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	

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			residents are receiving proper dinnerware. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/04/2022**	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where			

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	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 failed to ensure an allegation of alleged physical abuse was reported immediately within 2 hours after the allegation was made to the Administrator for 1 of 3 allegations of abuse reviewed. (Resident H) Finding includes: During a confidential interview on 8/5/22, Resident H had been identified as being "slapped" by a staff member and the incident wasn't reported right away. The record for Resident H was reviewed on 8/3/22 at 12:49 p.m. Diagnoses included, but were not limited to, cognitive communication deficit and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 7/14/22, indicated the resident had severe cognitive impairment. Nurses' Notes, dated 7/2/22 at 2:12 p.m., indicated the resident's Responsible Party was called concerning an incident that was reported to the writer and an investigation was in progress.	F 0609	**Aperion- Tolleston Park** **Annual/Recertification Survey** **Compliance 09/04/2022** *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.* **The facility requests paper compliance for this citation.** **F609 Reporting Alleged Violation** **3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**	09/04/2022

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	Nurses' Notes, dated 7/2/22 at 3:11 p.m., indicated the resident presented with minimal swelling to the right hand and wrist, no bruising was noted and her skin was intact. Facial grimacing was noted with active range of motion (AROM), family in facility and requesting an x-ray. The Physician was notified and orders were received for a STAT (immediate) x-ray to the right hand and wrist. The facility investigation indicated the Administrator was notified of the allegation on 7/2/22 at 12:40 p.m. LPN 2 was suspended pending investigation, the local police department was notified, and abuse education was initiated for all staff. CNA 1 had a corrective action form, dated 7/2/22, indicating she failed to report an allegation of alleged abuse. She indicated she didn't witness the incident but heard one of her peers discussing it. The CNA indicated she didn't report the incident because she didn't believe it occurred. The CNA received a written warning. CNA 2 had a corrective action form, dated 7/2/22, indicating she failed to report an allegation of alleged abuse in a timely manner. The CNA had no explanation as to why she didn't report the allegation. The CNA was suspended pending investigation and eventually terminated. Interview with the Director of Nursing (DON) on 8/5/22 at 11:55 a.m., indicated the incident happened on the night shift on 7/1/22. The nurse was identified as being rough with the resident, she held her wrists down because the resident was being combative. The resident was not slapped. The CNA did not let the DON know until the next day and when she found out, she immediately called the Administrator and the		SSD, DON, or designee will conduct audits of progress notes, daily, on scheduled days of work, ongoing, in an effort to identify any episodes/occurrences that could be considered abuse. If any situations are identified, staff will be interviewed to ensure proper, timely reporting to the abuse coordinator has been done. Any identified concerns will be immediately addressed with the responsible individual(s), including but not limited to, provision of re-education, as necessary. **4) How the corrective actions will be monitored:** The Administrator /designee will conduct random Abuse audits with 5 residents per week for 4 weeks. 3 resident for 8 weeks and 2 residents 12 weeks to ensure staff compliance with Abuse Policy. Any reported issues will be handled per the Abuse Policy. Audits will continue until 6 months of compliance is achieved. In an effort to identify any signs of abuse of any kind, the facility Administrator, or designee, will be responsible to monitor staff to resident interactions. These observations will take place at least 5 times weekly, randomly, across all shifts, including weekends and holidays for 4 weeks. Any identified/observed	

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	investigation was started. The allegation of abuse was substantiated and the LPN was terminated. This Federal tag relates to Complaint IN00387286. 3.1-13(g)(1)		concerns will be immediately addressed with the responsible individual(s), with investigations implemented, as necessary. Thereafter, these observations will take place at least 3 times weekly, randomly, across all shifts, including weekends and holidays for 8 weeks, and then at least twice weekly, randomly, across all shifts, including weekends and holidays for 12 weeks. Any identified/observed concerns will be immediately addressed with the responsible individual(s), with investigations implemented, as necessary. Any concerns will be immediately addressed with the responsible individual(s), with investigations implemented, as necessary. **5) Date of compliance: 09/04/2022**	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents were provided assistance with activities of daily living (ADL's) related to assistance with eating, nail care, shaving, and showers for 10 of 12 residents reviewed for ADL's. (Residents H, 61, 78, 112, 116, 8, 74, 125, G and 41) Findings include:	F 0677	**Aperion Care- Tolleston Park Compliance 09/04/22** **F 677 ADL Care Provided for Dependent Residents** **The facility requests paper compliance for this citation.**	09/04/2022

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	1. On 7/31/22 at 9:53 a.m., Resident H was in her room seated in her wheelchair. The resident's eyes were closed and she was holding the styrofoam plate that contained her breakfast. The plate was leaning forward and it was under the over bed table. Shortly thereafter, the resident dropped the plate on the floor. Staff removed the plate from the floor. Staff did not wake the resident up to see if she wanted more food. The record for Resident H was reviewed on 8/3/22 at 12:49 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing) and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 7/14/22, indicated the resident had severe cognitive impairment. She required supervision with eating with set up help only. The resident also received a therapeutic diet. The Care Plan, dated 1/29/22, indicated the resident had a ADL self-care performance deficit and she needed staff assistance with bed mobility, transfers, toileting, and eating related to dementia. Interventions included, but were not limited to, provide set up and staff assistance as needed for eating, has a divided plate. Interview with the Director of Nursing on 8/4/22 at 9:00 a.m., indicated the resident should have been provided assistance and asked if she wanted something else to eat. 2. On 7/31/22 at 9:17 a.m., Resident 61 was served his breakfast in the Memory Care dining room. At 9:20 a.m., the resident was eating his meal with his fingers. At 9:25 a.m., the resident ate his entire meal with his fingers. No redirection was provided		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. Resident H received assistance with meals at the time of survey, and ongoing. 2. Resident #61 received assistance with meals at the time of survey, and ongoing. 3. Resident #78 received assistance with meals at the time of survey, and ongoing. 4. Resident #112 received nail care at the time of survey. 5. Resident #116 received nail care at the time of survey. 6. Resident #8 was shaved at the time of survey. 7. Resident #74 received assistance with meals at the time of survey, and ongoing. 8. Resident #125 was assisted with the removal of facial hair at the time of survey.	

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	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. On 8/3/22 at 9:12 a.m., the resident was observed eating his pancakes with his fingers. He then proceeded to pick up his bowl of grits and he finished eating them with his fingers. No redirection was provided by staff in the area. The record for Resident 61 was reviewed on 8/3/22 at 9:49 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, mild protein calorie malnutrition, dysphagia (difficulty swallowing), and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 5/20/22, indicated the resident had severe cognitive impairment. He required supervision with eating with one person physical assist. 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. A Physician's Order, dated 2/23/22, indicated the resident received a mechanical soft texture diet. 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.		9. Resident G was provided with the necessary ADL care at the time of survey. **2) How the facility identified other residents:** 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. **3) Measures put into place/ System changes:** Nursing staff was in-serviced on ADL Care Provided for Dependent Residents, including but not limited to, ensuring assistance is provided to residents for eating, nail care, and bathing, as well as all other ADLs. **The DON/Designee** will complete Dignity Rounds at least 5 times weekly at varied times for 4 weeks to ensure residents are provided with assistance in eating, nail care, and bathing. Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, DON/Designee will complete Dignity Rounds at least 5 times per month at varied times for 2	

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	3. On 7/31/22 at 9::20 a.m., Resident 78 was observed eating her breakfast with her fingers and drinking her cereal from her bowl. No redirection was provided by staff in the area. On 8/2/22 at 9:10 a.m., the resident was observed eating her waffle with her fingers. Again, no redirection was provided. On 8/3/22 at 9:05 a.m., the resident was eating her pancakes with her fingers. She then proceeded to eat some of her grits out of her bowl with her fingers. No redirection was provided. The record for Resident 78 was reviewed on 8/2/22 at 11:43 a.m. Diagnoses included, but were not limited to, adult failure to thrive, protein calorie malnutrition, and Alzheimer's disease with late onset. The Admission Minimum Data Set (MDS) assessment, dated 6/3/22, indicated the resident had severe cognitive impairment. She required supervision with 2 person physical assistance for eating and received a therapeutic diet. A Care Plan, dated 6/2/22, indicated the resident had a ADL self-care performance deficit related to bed mobility, transfers, toileting and transfers due to Alzheimer's. Interventions included, but were not limited to, provide finger foods when the resident had difficulty using utensils. 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. 4. On 7/31/22 at 1:33 p.m., Resident 112 was observed to have long fingernails on both hands. Interview with the resident at that time, indicated		months. Any identified concerns will be promptly addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/04/22**	

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	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.			

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	155580	A. BUILDING 00 B. WING	08/05/2022

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The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident had severe cognitive impairment. The resident needed extensive assistance with 1 person physical assist for personal hygiene.

The Care Plan, dated 1/8/22, indicated the resident had an ADL self-care performance deficit and needed staff assistance with bed mobility, transfers, toileting and eating related to impaired mobility, depression, and dementia. Interventions included, but were not limited to, the resident needed extensive to total assist with bathing and showering.

The resident had a bed bath on 7/27, 7/28, and 8/1/22. He refused on 7/25/22. There was no documentation if nail care had been completed.

Interview with the Director of Nursing on 8/4/22 at 9:00 a.m., indicated the resident would be assisted to clean his nails.6. On 7/31/22 at 11:14 a.m., Resident 8 was observed in the hallway outside of his room. The resident had a large amount of facial hair on his face and chin.

Interview with the resident at that time, indicated he needs assistance with shaving and he had not been shaved in long time.

The record for Resident 8 was reviewed on 8/3/22 at 12:45 p.m. Diagnoses included, but were not limited to, type 2 diabetes, schizoaffective disorder, intellectual disabilities, and major depressive disorder.

The Quarterly Minimum Data Set (MDS) assessment, dated 7/15/22 indicated the resident was moderately impaired for cognition and needed

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assistance with personal hygiene.

A Care Plan, dated 3/7/22, indicated the resident would be non-compliant with showers or baths as he refused at times.

There was no Care Plan indicating the resident refused personal hygiene such as periodically being shaved, nor was there any documentation the resident had refused to be shaved.

Interview with the Director of Nursing on 8/4/22 at 8:45 a.m., indicated the resident should have been shaved during care.

7. On 7/31/22 at 12:58 p.m., Resident 74 was observed lying in bed at a 30 degree angle. At that time, there was an over bed tray table in front of him with his lunch meal. The resident was served chicken wings, vegetables, and mashed potatoes. His silverware which consisted of 2 plastic spoons and a plastic knife was wrapped up in the napkin. The resident was observed eating the mashed potatoes with his fingers. There was no staff in the room to redirect.

On 8/2/22 at 9:00 a.m., the resident was observed in bed with an over bed table in front of him. He was holding a spoon in his right hand and staring at the breakfast food in front of him. He had not eaten any of the meal. He was served scrambled eggs, pureed meat, hot cereal, and 2 waffles. The waffles were not cut up and were still whole with no butter or syrup on them. There was also no fork on his tray. At 9:20 a.m., the resident still had not eaten anything on the tray. The Director of Nursing (DON) walked by the room and saw the resident was not eating from the hallway. She entered his room and started to feed the resident. The resident ate his food after being fed by staff.

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	On 8/2/22 at 12:54 p.m., the resident was observed lying in bed with his lunch meal on an over bed table in front of him. His eyes were closed and he was holding a spoon in his hand, however, he was not eating anything. He was served mashed potatoes and gravy, a vegetable and ground meat and a dessert. No staff were observed to help him. At 1:05 p.m., the Director of Rehab entered his room and repositioned the resident to sit up and eat his lunch. At 1:09 p.m., she came back into the room with water and a straw, and cued the resident to eat his lunch and encouraged him to open his eyes. She left the room at 1:10 p.m. At 1:38 p.m., the resident remained with eyes closed and had not eaten any of his food. No staff were observed to go and in assist the resident with eating. The record for Resident 74 was reviewed on 8/2/22 at 9:45 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, dysphagia, acute respiratory failure, protein calorie malnutrition, dependence on renal dialysis and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 5/31/22, indicated the resident was severely cognitively impaired. The resident was an extensive assist with 1 person physical assist for bed mobility, transfers, dressing and eating. A family member was interviewed and indicated it was very important for the resident to listen to music, be around pets, go outside, and participate in his favorite activities. A Care Plan, updated 6/10/22, indicated the resident had an ADL self care deficit and needed assistance with eating.			

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	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.			

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The Care Plan, updated 6/10/22, indicated the resident had an ADL self care deficit related to impaired mobility and weakness.

There was no Care Plan the resident refused personal hygiene. There was no documentation the resident received assistance with the trimming and/or shaving of her facial hair.

Interview with the Director of Nursing on 8/4/22 at 8:40 a.m., indicated the resident's facial hair should have been removed during care.

9. On 8/1/22 at 10:20 a.m., Resident G was observed lying in bed. He was holding the oxygen tubing up to his nose as it was not behind his ears. He was crooked in bed and was laying on the blanket. The resident had long dirty fingernails and a large amount of facial hair on his face and chin.

Interview with the resident at that time, indicated he had not had a shower since he had been there, however, the staff had cleaned him up "real good." He indicated his hair had not been washed for a very long time, nor had he been shaved in awhile.

On 8/3/22 at 9:02 a.m., the resident was observed in bed and eating breakfast. He indicated he needed a napkin so the Director of Nursing (DON), who was standing outside the door, brought him a napkin. At that time, the DON asked the resident if she could shave him and trim his nails. The DON was asked about washing his hair, as he had not had that washed in a very long time. The resident agreed to everything and did not refuse.

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	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 diabetes, atrial fibrillation, chronic kidney disease, aphasia, and facial weakness. The Admission Minimum Data Set (MDS) was in progress. The Care Plan, dated 7/23/22, indicated the resident had an ADL self-care performance deficit related to weakness and a stroke. The resident received a bed bath on 7/25, 7/28, and 8/1/22. The resident did not have his hair washed on any of those bath days. There is no documentation the resident had his nails trimmed or he was shaved. Interview with the DON on 8/3/22 at 9:57 a.m., indicated she shaved, trimmed his nails and washed his hair. The resident should have his hair washed, nails trimmed and shaved with the bed baths. 10. Interview with Resident 41 on 7/31/22 at 12:06 p.m., indicated he needed a shower and specifically requested staff to attend to his dirty and dry feet. The record for Resident 41 was reviewed on 8/2/22 at 9:00 a.m. Diagnoses included, but were not limited to, chronic lung disease, heart failure, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/10/22, indicated the resident was moderately impaired for daily decision making and required extensive assistance for bed mobility and total dependence on staff for transfers and			

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	bathing. The Care Plan, revised on 1/9/22, indicated the resident had an activities of daily living (ADL) self care performance deficit due to generalized weakness, chronic lung disease, and heart failure. Interventions included, but were not limited to, the resident was totally dependent on one staff to provide baths or showers. The Care Plan, revised on 3/7/22, indicated the resident was resistive to care with showers or baths. Interventions included, but were not limited to, the resident would be compliant and receive showers or bed baths twice a week. The ADL bathing tasks indicated the resident received showers on Wednesday and Saturday each week. The tasks were marked as completed on 7/2/22, 7/6/22, 7/13/22, and 7/20/22. The record lacked documentation of showers received or refused on 7/9/22 and 7/16/22. Interview with the Director of Nursing on 8/4/22 at 10:59 a.m., indicated the resident frequently refused showers, but the record lacked documentation of any refusals on 7/9/22 and 7/16/22. 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)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care			

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	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 interview, the facility failed to ensure a resident was invited and taken to activities for 1 of 2 residents reviewed for activities. (Resident 74) Finding includes: On 7/31/22 at 12:58 p.m., Resident 74 was observed lying in bed at a 30 degree angle. At that time, there was an over bed tray table in front of him with his lunch meal. The lights were turned off and the curtains were pulled. There was no television or radio on in the room. At 2:20 p.m., the resident remained in bed with no television or radio turned on. On 8/1/22 at 9:30 a.m., the resident was leaving for dialysis. On 8/2/22 at 9:00 a.m., 9:20 a.m., 12:54 p.m., 1:05 p.m., and 1:38 p.m. the resident was observed in bed dressed in a hospital gown. The resident's television was turned on. At 2:17 p.m., the staff had gotten the resident out of bed and he was sitting in a wheelchair in front of the nurses' station. No staff took the resident down to the activity room or assisted him to participate. The record for Resident 74 was reviewed on 8/2/22 at 9:45 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, dysphagia,	F 0679	**Aperion- Tolleston Park Annual/ Recertification Survey Compliance 09/04/22** **F679 Activities Meets Interest/Needs** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 74 was invited to attend activities, and care plans was	09/04/2022

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	acute respiratory failure, protein calorie malnutrition, dependence on renal dialysis and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 5/31/22, indicated the resident was severely cognitively impaired. The resident was an extensive assist with 1 person physical assist for bed mobility, transfers, dressing and eating. A family member was interviewed and indicated it was very important for the resident to listen to music, be around pets, go outside, and participate in his favorite activities. The Care Plan, revised on 5/25/22, indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations. The approaches were to invite the resident to scheduled activities and ensure the activities the resident was attending were compatible with physical and mental capabilities and known interests and preferences. A 5/26/22 Activity Assessment, indicated the resident's current interests were television, pets, crafts and exercise. The Activity Participation logs for July and August 2022 indicated the resident did not participate in any activities. The July and August Activity Calendar indicated on Sundays, Tuesdays and Thursdays throughout the calendar there were exercises, arts and crafts, and sensory groups. Interview with the Activity Director on 8/4/22 at 1:30 p.m., indicated she had no documentation the resident participated in activities for the months of		updated. Resident 74 will be offered to listen to music, channels to watch that meet specific interests, such as animal channel, and going outside. **2) How the facility identified other residents:** All residents could be affected by this deficient practice. An audit of 100% of residents was completed on 8/22/22 to ensure all residents are invited and receiving activities. Staff will complete assessments and update care plans as needed for each resident to ensure they are offered activities that meet their needs and interests. **3) Measures put into place/ System changes:** Activity staff will be re-educated on the importance of providing daily activities, as well as documenting activity preferences, assessments and care planning. In addition, Activity Staff will provide resident activities seven days a week, including but not limited to, group activities, sensory, as well as individual activities. A guide will be created each month outlining the foundation for these activities and times they are aimed to start. **4) How the corrective actions will be monitored:**	

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	7/2022 and 8/2022. The resident was dependent on staff for activity participation and was not receiving 1 to 1 visits. 3.1-33(a)		The Activity Director or other designee will be responsible to complete the audit tool to monitor for compliance with following resident preferences and participation with activities. The tool will be completed weekly, on an ongoing basis to ensure continued compliance. Any concerns identified will be corrected upon discovery and findings documented on tracking log. All findings will be reviewed monthly in the facility Quality Assurance Process Improvement (QAPI) meeting to ensure ongoing compliance for a minimum 6 months and until the facility maintains 90% compliance for two months. **5) Date of compliance: 09/04/22**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising and arterial ulcers were assessed and monitored. The facility also failed to ensure treatments were completed and signed out as	F 0684	**Aperion- Tolleston Park** **Annual/Recertification**	09/04/2022

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	ordered for 2 of 2 residents reviewed for skin conditions (non-pressure related). (Residents 116 and G) Findings include: 1. On 8/1/22 at 11:00 a.m., a fading reddish/purple discoloration was observed on Resident 116's lower left shin. On 8/3/22 at 1:01 p.m., the fading discoloration remained to the resident's left lower shin. 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. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident had severe cognitive impairment. The resident needed limited assistance with 1 person physical assist for bed mobility and transfers. A Physician's Order, dated 4/18/22, indicated the resident received Aspirin 81 milligrams (mg) chewable daily. The Weekly Skin Observation sheet, dated 7/28/22, indicated the resident's skin was intact and there was no documentation of bruising. Interview with the 200 Unit Manager on 8/4/22 at 3:00 p.m., indicated she would assess the resident's left lower leg, she was aware of the resident having a skin tear but not aware of any bruising. Nurses Notes' dated, 8/4/22 at 3:16 p.m., indicated the resident was noted to have a small area of		**Compliance 09/04/2022** **F684 Quality of Care** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The Physician was notified of bruise for resident 116 and assessment was completed. Resident G had wound assessments and treatments completed, as ordered. **2) How the facility identified other residents:** Full house skin sweep completed to identify any other skin concerns. This Plan of Correction	

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	bruising to the left lower leg. No complaints of pain or discomfort expressed. A Physician's Order, dated 8/4/22, indicated to monitor the bruising to the left lower leg until resolved, every shift. 2. On 8/1/22 at 10:20 a.m., Resident G was observed lying in bed. He was holding the oxygen tubing up to his nose as it was not behind his ears. He was crooked in bed and was laying on the blanket. The resident indicated that he could not see very well and had been in this position since after breakfast. Interview with the resident at that time, indicated he had open pressure sores on his back, shoulder and thigh. The resident was asked to raise both feet up so his heels could be observed. The right heel was observed with a black deep tissue injury. There was no bandage nor was there any pressure relieving devices on his feet. LPN 1 was asked to come to the room for a skin assessment. The resident was repositioned onto his right side and there was a skin tear observed to his lower back with no bandage. Interview with LPN 1 at that time, indicated he did not look at or assess the resident's skin tears or heels yesterday (7/31/22), and was not told by any CNA the bandages had come off, nor was he told in report the bandages had come off. The resident did not have a treatment order for the right heel as that was a new wound. 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 diabetes, atrial fibrillation, chronic kidney disease, aphasia, and facial weakness.		applies to all those identified with skin conditions. **3) Measures put into place/ System changes:** Licensed Nursing Staff will be re-educated on Quality of Care including but not limited to assessment and monitoring of skin conditions and ensuring treatments are completed and documented. Director of Nursing or designee will conduct random visual observation rounds at least three times weekly times 4 weeks, then weekly times 4 weeks to ensure treatments are in place as ordered. DON, or designee, will audit all skin assessments 3x week times 4 weeks then weekly times 4 weeks. **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **09/04/22**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	08/05/2022

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	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			

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	- right heel deep tissue injury 100% necrotic hard tissue, that measured 2.5 cm by 3.5 cm. A venous/arterial doppler scan was performed on 8/2/22, which indicated the resident was diagnosed with hemodynamically significant stenosis in the right leg. Interview with the Director of Nursing on 8/3/22 at 3:00 p.m., indicated there was no documentation the skin tear treatments were completed on 7/24/22. The right heel deep tissue injury was an acquired wound and had not been treated prior to 8/1/22. The right heel was an arterial ulcer. The current and revised 6/8/18 "Skin Condition Assessment and Monitoring Pressure and Non-Pressure" policy, provided by the Director of Nursing on 8/5/22 at 1:45 p.m., indicated dressings which were applied to pressure ulcers, skin tears, wounds, and lesions shall include the date of the licensed nurse who performed the procedure. Dressings will be checked daily for placement, cleanliness, and signs and symptoms of infection. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or			

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	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 failed to ensure residents with impaired vision received the necessary services related to following up with referrals to an Ophthalmologist for 1 of 1 residents reviewed for vision. (Resident 71) Finding includes: Interview with Resident 71 on 7/31/22 at 1:44 p.m., indicated he had a cataract and he would like to see the eye doctor. The record for Resident 71 was reviewed on 8/2/22 at 10:40 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 5/26/22, indicated the resident was moderately impaired for daily decision making. His vision was listed as adequate with no corrective lenses. There was no current Care Plan related to vision services. The resident signed a consent for vision services on 4/3/19. A Physician's Order, dated 12/17/21, indicated the resident was to have an Eye Consult. There was no documentation indicating the resident had been by the Ophthalmologist (eye doctor).	F 0685	**Aperion- Tolleston Park Annual/Recertification Compliance 09/04/2022** **F 685 Treatment/Devices to Maintain Hearing/Vision** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 71 is scheduled to see an Ophthalmologist on September 22 at 3:45pm. **2) How the facility identified other residents:** The facility completed and audit to identify residents that need to see the eye Doctor or require a follow up appointment. All residents have the potential to be affected by the same deficient practice.¿¿	09/04/2022

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	Interview with the Director of Nursing on 8/4/22 at 1:15 p.m., indicated the resident had not seen the eye doctor for his cataract. 3.1-39(a)(1)		**3) Measures put into place/ System changes:** Social Service will ensure that residents are see annually. If a resident is referred to an eye specialist Nursing will make the appointment within 24 business hours. After facility wide audit, the Social Service/designee will audit weekly for 4 weeks then monthly thereafter to ensure that orders are carried out appropriately. **4) How the corrective actions will be monitored:** The results of the audit will be reviewed in the Quality Meeting monthly for 6 months or until 100% compliance is achieved. The QA committee will identify any trends or pattern and recommendations to revise the plan of correction as indicated **5) Date of compliance: 09/04/2022**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were			

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	unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to treatments not done as ordered and missing bandages on open sores for 1 of 3 residents reviewed for pressure ulcers. (Resident G) Finding includes: On 8/1/22 at 10:20 a.m., Resident G was observed lying in bed. He was holding the oxygen tubing up to his nose as it was not behind his ears. He was crooked in bed and was laying on the blanket. The resident indicated that he could not see very well and had been in this position since after breakfast. Interview with the resident at that time, indicated he had open pressure sores on his back, shoulder and thigh. He was asked to pull down his gown around his shoulder. There was a large open area on his right shoulder with no bandage covering the ulcer. The open wound was black in color with no drainage. The resident was asked to lift his gown by his thigh as well. There was a large black and open area observed to his right hip that also had no bandage. LPN 1 was asked to come to the room for a skin assessment. The resident was repositioned onto his right side and his brief was removed. There was a large sacral pressure ulcer observed with yellow slough (necrotic tissue). The pressure sore had no bandage covering it and there was bowel movement noted	F 0686	**Aperion Care Tolleston Park Annual/ Recertification Compliance 09/04/2022** **F 686 Treatment/Svcs to Prevention/Heal Pressure Ulcer** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident G had appropriate treatments administered and preventative skin interventions implemented at the time of survey. **2) How the facility identified**	09/04/2022

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	in the wound. The resident was laying on a regular mattress and had no pressure relieving devices such as pillows or blankets on those areas. Interview with LPN 1 at that time, indicated he did not look at or assess the pressure ulcers yesterday (7/31/22), and was not told by any CNA the bandages had come off, nor was he told in report the bandages had come off. 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 diabetes, atrial fibrillation, chronic kidney disease, aphasia, and facial weakness. The Admission Minimum Data Set (MDS) was in progress. The Care Plan, dated 8/1/22, indicated the resident had a pressure ulcer to the right hip, right 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) 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 right outer thigh, with normal saline, apply		**other residents:** 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 alteration in skin integrity are documented. **3) Measures put into place/ System changes:** Nursing staff have been re-educated relative to Treatment/Svcs to Prevent/Heal Pressure Ulcer, including but not limited to ensuring residents with pressure ulcers receive the necessary treatment and services to promote healing, including treatment administration per orders and ensuring replacement of any dressings/bandages that 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 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 residents per week, for 6 weeks	

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	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 for any of the open areas on 7/24/22. Physician's Orders, dated 7/26/22, indicated to cleanse coccyx with normal saline, apply duoderm to area and cover with dry dressing every day shift on Monday, Wednesday, and Friday. Physician's Orders, dated 7/26/22, indicated to cleanse area to right upper arm and right outer thigh with normal saline, apply Xeroform dressing and cover with dry dressing every day shift on Monday, Wednesday and Friday. The Wound Report, dated 8/2/22, indicated the following: - coccyx: 5 cm by 2 cm with 5% slough and 95% bright red tissue. The pressure ulcer was a Stage 3. - right shoulder: 5 cm by 8 cm with 100% necrotic 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		will be conducted to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/04/2022**	

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	order in as stat. The air loss mattress should have been ordered last week as the resident was admitted with the pressure ulcers. Interview with the Director of Nursing on 8/3/22 at 3:00 p.m., indicated there was no documentation the pressure ulcer treatments were completed on 7/24/22. The bandages should have been covering the open areas and the CNAs were to inform the nurse if they had come off. The current and revised 6/8/18 "Skin Condition Assessment and Monitoring Pressure and Non-Pressure" policy, provided by the Director of Nursing on 8/5/22 at 1:45 p.m., indicated dressings which were applied to pressure ulcers, skin tears, wounds, and lesions shall include the date and initials of the licensed nurse who performed the procedure. Dressings were to be checked daily for placement, cleanliness, and signs and symptoms of infection. This Federal tag relates to Complaint IN00384672. 3.1-40(a)(2)			
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such			

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	appointments. Based on observation, record review, and interview, the facility failed to ensure dependent residents received foot care and had routine visits with a podiatrist related to long and thick toenails for 1 of 12 residents reviewed for ADL's. (Resident 33) Finding includes: During a random observation on 8/1/22 at 9:35 a.m., Resident 33 was observed lying in his bed. At that time he was not wearing any shoes or socks to his feet. His toenails were approximately 2 to 3 inches long, thick and discolored. The resident's fingernails were long and dirty as well. Interview with the resident at that time, indicated he was a diabetic and had not had his toenails cut in a very long time. The record for Resident 33 was reviewed on 8/2/22 at 1:05 p.m. The resident was admitted on 4/9/21. Diagnoses included, but were not limited to, type 2 diabetes, high blood pressure, peripheral vascular disease, and mild cognitive impairment. The Quarterly Minimum Data Set (MDS) assessment, dated 5/9/22, indicated the resident was moderately cognitively impaired for decision making. The resident needed extensive assist with 1 person physical assist for personal hygiene. The Care Plan, updated 5/12/22, indicated the resident had an ADL self performance deficit and needed staff assistance. A consent for podiatry services was signed by the resident on 4/4/21.	F 0687	**Aperion- Tolleston Park** **Annual/Recertification** **Compliance 09/04/2022** **F 687 Foot Care** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 33 was scheduled to see a Podiatrist on 8/5/2022. Resident 33 went to this appointment and no follow up required. **2) How the facility identified other residents:** The facility completed and audit to identify residents that need to see the Podiatrist. All residents have the potential to be affected by the	09/04/2022

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	The resident had not seen the podiatrist since admission. Interview with the Director of Nursing on 8/3/22 at 3:00 p.m., indicated they had a podiatrist coming in, but the facility switched to another podiatrist and they were supposed to be coming later this month. The resident had not been seen by a podiatrist. 3.1-47(a)(7)		same deficient practice.¿¿ **3) Measures put into place/ System changes:** Social Service will ensure that residents are see annually. If a resident voice discomfort, they will be referred to a Podiatrist within the community. Nursing will make the appointment within 24 business hours after a concern is voiced. After facility wide audit, the Social Service/designee will audit weekly for 4 weeks then monthly thereafter to ensure that resident's foot care is carried out appropriately. New Podiatry company will start providing services to the facility on 9/6/2022. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/04/2022**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility.			

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	§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a splint was in place as ordered for 1 of 2 residents reviewed for limited range of motion. (Resident 102) Finding includes: On 7/31/22 at 10:02 a.m., Resident 102 was observed in his wheelchair with no splinting devices noted to his left hand. On 8/2/22 at 10:00 a.m., the resident was observed in his wheelchair with no splinting devices noted to his left hand. On 8/3/22 at 9:12 a.m., the resident was observed in his wheelchair with no splinting devices noted to his left hand. On 8/4/22 at 11:52 a.m., the resident was observed in his wheelchair with no splinting devices noted	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*	09/04/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to his left hand. The record for Resident 102 was reviewed on 8/2/22 at 1:26 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (loss of control of muscles) affecting left non-dominant side, high blood pressure, and aphasia (loss of ability to understand or express speech). The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 1/20/22, indicated left hand splint, on during the day and off at night. A Care Plan, initiated on 1/20/22, indicated the resident had a potential for impairment to skin integrity related to left hand splint, impaired mobility, and episodes of incontinence. Interventions included, but were not limited to, monitor response to preventative treatment as ordered. Interview with the 200 Unit Manager on 8/4/22 at 11:57 a.m., indicated she was unable to find the splint in the resident's room. The 200 Unit Manager retrieved a new resting hand splint for the resident's left hand. 3.1-42(a)(2)		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 102's splint was placed at the time of survey. **2) How the facility identified other residents:** All residents who have contractures, or at risk for contractures have the potential to be affected by this practice. An audit was conducted to identify these residents, care plans were reviewed and updated, as necessary. **3) Measures put into place/ System changes:** Nursing staff will be re-educated relative to Increase/Prevent Decrease in ROM/Mobility, including but not limited to ensuring use of splints per physician order. 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.	

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	155580	A. BUILDING 00 B. WING	08/05/2022

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			Findings will be documented on the Angel Rounds sheet and reviewed at the daily meetings. DON is responsible for compliance. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/04/2022**	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident with complaints of pain received scheduled medication to relieve the pain for 1 of 3 residents reviewed for pain. (Resident F) Finding includes: Interview with Resident F on 7/31/22 at 9:59 a.m., indicated he had been out of his pain medication since 7/30/22 and his leg was hurting all night, so he was unable to get any rest.	F 0697	**Aperion- Tolleston Park Annual/Recertification Compliance 09/04/2022** **F697 Pain Management** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of*	09/04/2022

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	The record for Resident F was reviewed on 8/2/22 at 12:58 p.m. Diagnoses included, but were not limited to, seizures, coronary artery disease, high blood pressure, renal insufficiency, peripheral vascular disease, anxiety disorder, and chronic lung disease. The Annual Minimum Data Set (MDS) assessment, dated 5/20/22, indicated the resident was cognitively intact for daily decision making. The resident was an extensive assistance for bed mobility, transfers, and toileting. The resident was not on a scheduled pain medication regimen, received as needed (prn) pain medications, did not receive any non-medication interventions for pain, and had almost constant pain in the last 5 days making it hard to sleep and limited day-to-day activities. The Care Plan, dated 7/16/21, indicated the resident had potential for pain related to coronary artery disease and fracture. Interventions included, but were not limited to, administer analgesia as per orders. A Physician's Order, dated 6/25/22, indicated Norco (a pain medication) 7.5-325 milligrams (mg) three times a day for chronic pain. The July and August 2022 Medication Administration Record (MAR) indicated the Norco 7.5-325 mg was not marked as administered on the following dates and times: - 7/6/22 at 10:00 p.m. - 7/14/22 at 10:00 p.m. - 7/19/22 at 2:00 p.m. - 7/30/22 at 6:00 a.m. and 10:00 p.m. - 7/31/22 at 6:00 a.m. and 10:00 p.m. - 8/1/22 at 6:00 a.m. and 2:00 p.m.		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** New script was sent per Nurse Practitioner for resident F **2) How the facility identified other residents:** All residents receiving pain medications have the potential to be affected by this alleged deficient practice. An audit was completed on all residents with pain medication to ensure assessments and plan of care were up to date. **3) Measures put into place/ System changes:** Staff education was provided on Pain Management, including but not limited to, medication administration and the importance	

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	- 8/2/22 at 6:00 a.m. A Nurses' Note, dated 7/31/22 at 2:11 p.m., indicated the resident needed a new prescription for the Norco tablets. Interview with the Nurse Practitioner on 8/1/22 at 3:30 p.m., indicated the electronic prescription system was not working correctly. She had submitted a new prescription to refill the order of Norco, but the pharmacy was not able to view the new prescription to fill it. Interview with the Director of Nursing on 8/3/22 at 1:53 p.m., indicated she was unable to provide any further information. This Federal tag relates to Complaint IN00384824. 3.1-37(a)		of monitoring, assessing, documenting, and providing pain medication according to physician's order and resident plan of care. Director of Nursing, or designee, daily, on scheduled days of work, will review documentation to ensure pain assessments were completed and pain medication was administered and documented. This review will be completed 5 times weekly for 4 weeks, then 2 times weekly for 4 weeks. **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/04/2022**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs			

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	§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 failed to ensure blood pressure medication was held per parameters and duplicate drug therapy was not ordered for 2 of 5 residents reviewed for unnecessary medications. (Residents 118 and C) Findings include: 1. The record for Resident 118 was reviewed on 8/4/22 at 3:23 p.m. Diagnoses included, but were not limited to, heart failure and hypotension (low blood pressure). The Admission Minimum Data Set (MDS) assessment, dated 7/6/22, indicated the resident was moderately impaired for daily decision making.	F 0757	**Aperion- Tolleston Park Compliance 09/04/22** **F 757 Drug Regimen Free from Unnecessary Medications** **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*	09/04/2022

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	A Physician's Order, dated 6/30/22, indicated the resident was to receive Midodrine HCl (a medication to treat low blood pressure) 5 milligrams (mg) three times a day. The medication was to be held for a systolic (top number) blood pressure of 100. The order was discontinued on 7/26/22. A Physician's Order, dated 7/26/22, indicated the resident was to receive Midodrine HCl Tablet 5 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. 12:00 p.m.: 8/2/22. 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,		*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:** 1. Resident #118's medication 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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	gastroesophageal reflux disease (gerd). The Admission Minimum Data Set (MDS) assessment, dated 6/27/22, indicated the resident was moderately impaired for cognition. Physician's Orders, dated 6/20/22, indicated Omeprazole 20 milligrams (mg) capsule delayed release, give 1 capsule by mouth every night shift. Physician's Orders, dated 6/21/22, indicated Omeprazole 20 mg daily. The 6/2022 Medication Administration Record (MAR), indicated the Omeprazole 20 mg daily at night and 20 mg daily was signed as being administered 6/20-6/27/22. Both orders were signed out as being administered together, therefore it was duplicate drug therapy. Interview with the Director of Nursing on 8/4/22 at 1:30 p.m., indicated she was unaware the Omeprazole was signed out as being administered two times every day rather than daily. 3.1-48(a)(1) 3.1-48(a)(3)		Regimen is Free from Unnecessary Drugs, including but not limited to ensuring that medications are either withheld or administered according to ordered parameters, and ensuring that residents do not have duplicate drug therapy. The DON/designee will audit eMARs of at least 10 residents daily, on scheduled days of work, for 4 weeks, then weekly for 8 weeks thereafter to ensure that medication orders are followed relative to withholding/administering medications according to ordered parameters, and relative to ensuring no duplicate drug therapy is administered. **4) How the corrective actions will be monitored:** The results of the audit will be reviewed in the Quality Meeting monthly for 6 months or until 90% compliance is achieved. The QA committee will identify any trends or pattern and recommendations to revise the plan of correction as indicated **5) Date of compliance: 09/04/2022**	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility			

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	provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food was served at a palatable temperature for 5 of 5 residents reviewed for food. (Residents 66, 123, B, 128, and 25) Findings include: Interview with Resident 66 on 7/31/22 at 10:55 a.m., indicated the food was not consistently warm for each meal. The resident would eat in her room. Interview with Resident 123 on 7/31/22 at 11:31 a.m., indicated the food was often cold and they were the first unit to get served each meal. The resident would eat in her room. Interview with Resident B on 7/31/22 at 2:53 p.m., indicated the food was always cold. The resident would eat in her room. Interview with Resident 128 on 7/31/22 at 3:51 p.m., indicated the food was usually cold. The resident would eat in her room. Interview with Resident 25 on 8/1/22 at 11:52 a.m., indicated the food was cold. The resident would eat in her room. On 8/3/22 at 12:09 p.m., the tray cart was delivered to the North Unit and five staff members	F 0804	**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 agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Kitchen staff was re in- serviced	09/04/2022

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	participated in passing out the meal trays to each room. The meal trays were covered with a dome lid. The final tray was delivered at 12:30 p.m. and temperatures from the test tray were taken at that time: The cream of chicken over rice was 110 degrees Fahrenheit. The steamed brussel sprouts was 130 degrees Fahrenheit. Interview with the Dietary Food Manager at that time, indicated the cream of chicken over rice and steamed brussel sprouts should have been warmer for the lunch meal. 3.1-21(a)(2)		on the importance of serving food at a palatable temperature for all residents. Dietary Manager has reviewed the checklists to ensure that food temperatures are being properly recorded prior to serving, and that all temperature controlled, and cooking equipment is in proper working condition. Dietary Manager has checked the following trays of the affected residents (66, 123, B, 128, and 25) are in acceptable temperature range. **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Dietary Manager and/ or designee will conduct audits 5 times a week. This will occur at meal service times to ensure steam table, transport carts and refrigeration units are operating at acceptable temperatures to maintain food temp. Test tray assessment will be conducted to ensure palatability, temperature and appearance are maintained at acceptable levels until the point the resident receives meal.	

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			4) How the corrective actions will be monitored: Dietary Manager or designee will interview three residents randomly daily asking about food temperatures during various meals x 3 months. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/04/2022**	
F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the			

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	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. Based on observation, record review, and interview, the facility failed to ensure the breakfast and lunch meals were served on time for 3 of 4 units observed. (The North, South, and Memory Care Units) Findings include: 1. On 7/31/22 at 8:35 a.m., a second tray cart was delivered to the North Unit. At 9:17 a.m., breakfast trays were delivered to the Memory Care Unit. At 12:17 PM, lunch trays were delivered to the North Unit. At 12:48 p.m., the first lunch cart was delivered to the South Unit and the second cart was delivered at 12:50 p.m. At 12:54 p.m., the lunch trays were delivered to the Memory Care Unit. 2. On 8/2/22 at 8:55 a.m., the first breakfast cart arrived on the South Unit. At 8:59 a.m., the breakfast trays were delivered to the Memory Care Unit. At 1:00 p.m., the first lunch cart arrived on the South Unit. At 1:04 p.m., the lunch trays were	F 0809	**Aperion- Tolleston Park** **POC Annual/Recertification** **Compliance 09/04/2022** **F809 Frequency of Meals** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	09/04/2022

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	delivered to Memory Care. The Meal Times were scheduled as follows: Breakfast: North 8:10 a.m., PCU 8:20 a.m., and South 8:30 a.m. Lunch: North 12:10 p.m., PCU 12:15 p.m., and South 12:25 p.m. Dinner: North 5:15 p.m., PCU 5:30 p.m., and South 5:45 p.m. 3. On 8/3/22 at 9:07 a.m., the breakfast trays were delivered to the Memory Care Unit. During the initial kitchen sanitation tour, on 7/31/22 at 8:51 a.m., Dietary Cook 1 indicated breakfast was served at 8:10 a.m. and lunch at 12:10 p.m. She indicated no one was eating in the main dining room and the North Unit was served first, then South, and then Memory Care. Interview with the Administrator on 8/5/22 at 10:00 a.m., indicated the meals should have been delivered in a more timely manner. This Federal tag relates to Complaint IN00387286. 3.1-21(c)		Kitchen staff was re in- serviced on the importance of serving food at the provided mealtimes. **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Dietary Manager and/ or designee will conduct audits 5 times a week to ensure meals are served on time. **4) How the corrective actions will be monitored:** Dietary Manager or designee will observe the tray line 5 times a week. Interview three residents randomly daily asking was their food on time during various meals x 3 months. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			5) Date of compliance: 09/04/2022	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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) Finding includes: Observation during the initial kitchen tour, on 7/31/22 at 8:51 a.m. with the Dietary Food	F 0812	**Aperion- Tolleston Park** **Annual/Recertification** **Compliance 09/04/2022** **F812 Food/Procurement/ Store/Prepare/Serve-Sanitary** **The facility requests paper**	09/04/2022

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	155580	A. BUILDING 00 B. WING	08/05/2022

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	Manager (DFM), indicated the following: a. A stainless steel container in the reach in cooler containing an orange substance that was not labeled or dated. There was also a stainless steel container of applesauce that was not dated and 3 plastic containers of sliced peaches that were not dated. Interview with the DFM at that time, indicated the items should have been dated. b. At 8:53 a.m., the breakfast service was still being completed on the tray line. Dietary Cook 1 had a glove on her left hand and no glove on her right hand. The Cook was observed picking up pieces of french toast and sausage patties with her gloved hand as well as handling styrofoam plates and bowls. Interview with the Administrator on 8/4/22 at 3:00 p.m., indicated the Cook should have been using tongs to handle the food. 3.1-21(i)(3)		**compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The unlabeled food was discarded. The Dietary Manager completed an audit on all food in the kitchen to ensure it was labeled and dated. Kitchen staff was re in-serviced on the importance of labeling and dating all food. All cooks were in-serviced and informed to serve food with utensils. **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:**	

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			All dietary staff were in serviced on labeling and dating all food put in refrigerator and freezer on per facility policy. Dietary Manager will observe the tray line 5 times a week to ensure cooks are using the proper utensils when serving. **4) How the corrective actions will be monitored:** Dietary manager/designees will conduct observation audits in the kitchen 5 times per week at various times to ensure proper sanitation, food is labelled /dated, and infection control is maintained. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **09/04/2022**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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	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			

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	(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, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19 related to handwashing before meals on 1 of 4 units, the use of personal protective equipment (PPE) in isolation rooms, the lack of COVID-19 monitoring, and not sanitizing multi-use equipment in between residents. (The Memory Care Unit, Residents G, 32, and 67) Findings include:	F 0880	**F 880 Infection Prevention and Control** **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*	09/04/2022

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	1. On 7/31/22 at 9:17 a.m., the breakfast trays were being served in the Memory Care dining room. The residents were not offered hand sanitizer before their meals. At 12:54 p.m., the residents were not offered hand sanitizer prior to their lunch meal. On 8/2/22 at 9:02 a.m., the breakfast trays were being served in the Memory Care dining room. Again, the residents were not offered hand sanitizer before their meal. At 1:04 p.m., the residents were not offered hand sanitizer prior to their lunch meal. On 8/3/22 at 9:07 a.m., the breakfast trays were delivered to the Memory Care Unit. The residents were not offered hand sanitizer before their meals. Interview with the Director of Nursing on 8/4/22 at 9:00 a.m., indicated the residents' hands should have been cleaned before each meal. 2. During a random observation on 8/2/22 at 9:45 a.m., Housekeeper 1 entered Resident G's room carrying a garbage can and only wearing a surgical face mask. At that time, a sign on the resident's door indicated "Droplet/Contact Isolation. Proper Personal Protective Equipment (PPE): an isolation gown, protective eye wear, a N95 face mask and gloves to both hands before entering." The resident was observed seated in a geri chair and the housekeeper walked within 2 feet of him to place a garbage can by the bathroom door. He walked out of the room and did not perform hand hygiene. Interview with Housekeeper 1 at that time, indicated he was not aware the resident was in isolation and did not see the signage on the door.		*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:** 1. Memory care staff was re-educated at the time of survey. No residents were adversely affected by this practice. 2. Housekeeper #1 was addressed at the time of survey. Resident G was not adversely affected by this practice. 3. Daily monitoring of temperature and oxygen saturation were added to Resident G's plan of care. Resident G was not adversely affected by this practice. 4. RN #1 was addressed at the time of survey relative to proper sanitation of multi-use resident equipment. No residents were adversely affected by this practice. **2) How the facility identified other residents:** All residents have the potential to be affected. Thus, this plan of correction applies to all residents of the facility. The facility infection control self-assessment will be reviewed to ensure accuracy and will be revised, as necessary. **3) Measures put into**	

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	The housekeeper stepped away from the room after removing an isolation gown from the 3 tiered plastic bin. He donned the gown, and walked to another resident's room who was also in droplet/contact isolation. He removed his surgical face mask and donned a clean N95 face mask and walked into the room carrying another garbage can. He did not don protective eye wear or gloves to his hands before entering the room. He left the room and did not perform hand hygiene and pushed a transportation cart down the hallway. Interview with the Director of Nursing on 8/4/22 at 9:30 a.m., indicated the housekeeper should have worn the correct PPE prior to entering those resident rooms. An updated and current facility policy titled "Infection Control-Interim COVID-19", provided by the Administrator on 8/1/22 at 9:00 a.m., indicated "PPE in Yellow Zone: all recommended COVID-19 PPE should be worn during direct care of residents under yellow zone quarantine which includes use of eye protection, N95 respirator, gloves and gown." 3. The record for Resident G was reviewed on 8/1/22 at 9:30 a.m. The resident was admitted to the facility on 7/23/22. The resident was unvaccinated for COVID-19 and was put in transmission-based precautions (TBP). A Physician's Order, dated 7/25/22, indicated to monitor for signs and symptoms of COVID-19 every shift. A Physician's Order, dated 7/26/22, indicated to assess the resident's temperature and oxygen saturation daily. The Treatment Administration Record (TAR),		**place/system changes:** Root Cause Analyses (RCA) were conducted. As a result of the RCAs, facility staff will be re-educated relative to proper PPE use in isolation rooms. Nursing staff will be educated by DON/designee on hand hygiene for residents, sanitizing of multi-use resident equipment, and monitoring of residents for s/s of Covid-19.. **4) How the corrective actions will be monitored:** The IP nurse/DON/Designee will complete random visual rounds daily, on scheduled days of work, for 6 weeks, and until compliance is maintained to ensure staff are practicing appropriate Infection Control Practices, including but not limited to, proper PPE use in isolation rooms, hand hygiene for residents, sanitizing of multi-use resident equipment, and monitoring of residents for s/s of Covid-19. **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months, or until 100% compliance is achieved for 3 consecutive months. The QA Committee will review, update, and make changes, as necessary, to this plan of correction to ensure substantial compliance for no less than 6 months. The results of these**	

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	dated 7/2022, indicated the resident had not been monitored for signs and symptoms of COVID-19 until 7/25/22, two days after admission. He had not had his temperature or oxygen saturation assessed until 7/26/22, 3 days after admission. 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.		**audits will be reviewed in Quality Assurance Meeting monthly for 6 months.** **Completion Date: 09/04/2022**	

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	Interview with RN 1 on 8/3/22 at 9:25 a.m., indicated she had not cleaned the blood pressure cuff in between residents. She would usually clean the cuff with a bleach wipe or an alcohol pad, but she had not. A facility policy received as current from the Director of Nursing, titled "Cleaning & Sanitizing-Wheelchairs and Other Medical Equipment," indicated, "...5. Devices/equipment used for more than one resident shall be cleaned between each resident..." 3.1-18(b)			
F 0919 SS=E Bldg. 00	483.90(g)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. Based on observation and interview, the facility failed to ensure residents who resided on the Behavioral Unit had a means to summon for help at the bedside for 1 of 1 resident rooms. (Resident 42) This had the potential to affect 9 of 13 residents who resided on the Behavioral Unit. Finding includes: During a random observation on 8/1/22 at 11:34 a.m., there was no call light observed in Resident 42's room. The resident indicated at that time, "if you need help, you just go down the hall and yell for help."	F 0919	**Aperion- Tolleston Park Annual/ Recertification Survey 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.* *Preparation and/or execution of*	09/04/2022

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	Interview with the Administrator on 8/2/22 at 3:15 p.m., indicated she had left the facility 6 months prior to the opening of the behavioral unit, and when she came back to be the Administrator, she questioned why there were no call lights on the unit. The residents who reside on the unit can walk without assistance and can take care of themselves with minimal assist. There were 9 resident rooms on the Behavioral Unit and 7 of those rooms have no call light at the resident's bedside. All of the rooms have a call 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. Interview with the Administrator on 8/5/22 at 9:30 a.m., indicated the facility was aware there were no call lights at the bedside in 7 of those rooms, and would come up with a plan for the residents to summons for help. 3.1-19(u)(1)		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 42 call light was reattached to the wall and placed in resident's reach. All rooms on the Behavioral Health Unit have call light to ensure residents can summon for help at the bedside. **2) How the facility identified other residents:** All dependent residents have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** All resident in the facility will have a call light to call for assistance when needed. **4) How the corrective actions will be monitored:** DON/Designee will do 5 random call light audits a week x 4 weeks, then 3 random call light audits a week for 2 weeks then 1 random	

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			call light audit per 1 week until compliance is met. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/04/2022**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to cracked floor tiles, dirty and discolored floors, marred walls, and torn chairs for 3 of 3 units. (North, South, and PCU) Finding includes: During the Environmental Tour on 8/4/22, from 2:15 p.m. through 2:35 p.m. with the Housekeeping Director, the following was observed: North Unit: a. Room 106-2: The left arm rest of the resident's	F 0921	**Aperion- Tolleston Park** **Annual/Recertification** **Compliance 09/04/2022** **F921** **Safe/Functional/Sanitary/Comfortable Environment** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of*	09/04/2022

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	wheelchair was broken off and missing. b. Room 108-1: The walls above the bed were marred. Two residents resided in the room. c. Room 109: The light above bed 2 was not working. The right side of the closet door was off the track and would not close. The paint was peeling near the baseboard in the bathroom and the toilet seat was not the correct size to fit the toilet. Two residents resided in the room. South Unit: a. Room 209-1: The floor tile was dirty and scuffed. There was a hole in the outside of the bathroom door, one bracket was missing for the toilet paper holder, and one of the towel rack brackets/bars was missing. Two residents resided in the room. b. Room 210-1: There were water stains the ceiling, the floor tile was dirty, and the inside bathroom door knob was loose. The bedside table was chipped and missing trim. One resident resided in the room. c. Memory Care Dining Room: The floors were dirty with discolored and cracked floor tiles. The paint/plaster on the ceiling was peeling. Multiple seats on the chairs were torn or peeling. d. Room 214-1: The privacy curtain for bed 1 was missing multiple hooks. Two residents resided in the room. e. Room 217-1: The wall behind the bed was marred and the floor tile was dirty and discolored. Two residents resided in the room.		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Room 106-2 wheelchair arm was replaced. Room 108 walls above the bed were painted. Room 109 the light above bed 2 was fixed and the closet door was placed back on track. Also, in room109 the paint near the baseboard was touched up with paint, and the toilet seat was replaced to fit the toilet. Room 209 the floor tile was cleaned, the hole in the outside of the bathroom door was repaired, the toilet paper holder and towel holder bracket was replaced. Room 210 the water stains on the ceiling was repaired. The floor tile was cleaned, and the bathroom doorknob was tightened. Also, the bedside table was replaced. In the memory care dining room, the floors were cleaned, and the	

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	f. Room 224-1: The floor tiles were discolored and cracked in the room and bathroom. Two residents resided in the room. PCU: a. Room 310: There was a strong urine odor in the room. The floor around the toilet was black and discolored. The bathroom walls were marred, and the ceiling vent was dusty. Two residents resided in the room and shared the bathroom. b. Room 311-1: The room walls were marred. Two residents resided in the room. c. Room 314-2: The bathroom walls were marred, and the floor tile was discolored. Two residents resided in the room. Interview with Housekeeping Director on 8/4/22 at 2:35 p.m., indicated the above was in need of cleaning or repair. The Maintenance Director had quit recently, so they only had one Maintenance Assistant working. 3.1-19(f)		tile was replaced. The ceiling dining room was repainted. The chairs were replaced. Room 214-1 privacy curtain hooks was replaced. Room 217 -1 wall was repainted, floor was cleaned, and the tile was replaced. Room 224 floor tiles were replaced in the room and bathroom. Room 310 was deep cleaned and the floor tile around the toilet was replaced, and bathroom wall painted. Also, bathroom ceiling vents were dusted. Room 311-1- bedroom wall was painted. Room 314-2-bathroom walls were painted, and the floor tiles were replaced. **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Staff was in-serviced on notifying Maintenance Director/Environmental Manage and staff when environment needs to be repaired or cleaned. **4) How the corrective actions will be monitored:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	08/05/2022

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			The Interdisciplinary team will do Angel rounds 5 days a week to identify cleanliness of each room and environmental items that need to be repaired. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/04/22**	
F 0925 SS=B Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an environment free of pests, related to flies in a resident's room and the Memory Care Unit (MCU) dining room. (Resident B) Finding includes: On 7/31/22 at 9:17 a.m., there were flies observed in the MCU. During an interview with Resident B on 7/31/22 at 2:51 p.m., indicated there had been flies in her room and in the hallway outside of her door constantly. The resident indicated she had killed at least 10 flies over the previous weekend.	F 0925	**Aperion- Tolleston Park** **Annual/Recertification** **Compliance 09/04/2022** **F925 Maintains an Effective Pest Control Program** **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*	09/04/2022

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	On 8/2/22 at 9:47 a.m., there were two flies in Resident B's room. The resident was constantly swatting away the flies during the interview. On 8/3/22 at 9:05 a.m., there were flies present in the MCU dining room, landing on residents or on their meal trays. Two CNA's were observed swatting the flies away. A resident commented about the flies in the dining room. Interview with the Administrator on 8/3/22 at 3:12 p.m., indicated she was told the facility could not put any preventative measures in place for flies. She indicated she would be contacting the pest control company for a follow up service for the flies. This Federal tag relates to Complaint IN00384824. 3.1-19(f)(4)		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Maintenance assistant purchased fly traps and installed them above every door leading out of the facility on each unit**.** Monroe Pest control continues to come out bi-weekly and as needed. **2) How the facility identified other residents:** All residents have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Staff in-serviced on notifying Maintenance Director/Environmental Manager when the environment needs to be repaired or cleaned. **4) How the corrective actions will be monitored:** The Interdisciplinary team will do Angel rounds 5 days a week to identify environmental needs to be repaired. **The results of these**	

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			audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/04/2022**	