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	02/02/2022

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 Investigation of Complaints IN00368730, IN00369639, IN00370813, IN00371729 and IN00371969. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00368730 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00369639 - Substantiated. Federal/State deficiencies related to the allegations are cited at F800, F880 and F921. Complaint IN00370813 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00371729 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00371969 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Survey dates: January 31, February 1 and 2, 2022. Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 135 Total: 135 Census Payor Type: Medicare: 26 Medicaid: 94 Other: 15 Total: 135	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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/10/22.			
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, record review and interview, the facility failed to ensure a diabetic resident received the correct Physician ordered diet for 1 of 3 residents reviewed for nutrition. (Resident J) Finding includes: On 2/1/22 at 8:45 a.m., Resident J was observed in bed eating his breakfast. There were grits, eggs, pancakes, coffee, sugar packets and jelly on his tray. His tray ticket indicated he was on a regular diet, with double portions. On 2/1/22 at 12:28 p.m., the resident's lunch tray was observed. There were ham, mashed potatoes and gravy, broccoli, pink lemonade and vanilla pudding. The tray ticket indicated a regular diet. The resident's record was reviewed on 2/1/22 at 11:21 a.m. The resident was admitted on 9/20/21. Diagnoses included, but were limited to, Diabetes Mellitus.	F 0800	**Aperion- Tolleston Park** **Survey 02/02/22** **Exit 02/02/2022** **Compliance 02/20/2022** **F800 Provided Diet meets needs** *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*	02/20/2022

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	A Physician's order, dated 12/27/21, indicated the diet was changed to NAS (no added salt) and NCS (no concentrated sweets). Interview with the Director of Nursing on 2/1/22 at 3:35 p.m., indicated the new diet order had been entered correctly, but was not printing on the tray tickets correctly, so he was still receiving a regular diet. She indicated it would be corrected. This Federal tag relates to complaint IN00369639. 3.1-46		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** * Resident J's Meal ticket was compared to the MD's order and correct. **2) How the facility identified other residents:** All residents having special therapeutic diets have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** An audit was conducted on all residents to ensure that the tray cards match the physician's orders. **4) How the corrective actions will be monitored:** Dietary manager/DON, or designee, will conduct random audits on at least 5 tray cards weekly, and with any new admissions, for 4 weeks to ensure residents are receiving the proper diet. **The results of these audits will**	

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			be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.F **5) Date of compliance: 02/20/2022**	
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 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			

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	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 (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.			

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	§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 observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly during staff COVID-19 testing, and improperly stored wash basins, urinals, laundry and briefs for random observations of infection control on 3 of 6 units observed. (Contracted Staff 1, Behavioral Care Unit, 200 hall and 300 hall) Findings include: 1. On 1/31/22 at 2:40 p.m., routine COVID-19 testing for staff members was observed in the Main Dining room. Contracted Staff 1 (CS 1) was wearing an N-95 respirator mask and glasses, no protective eyewear or gown. CS 1 sanitized her hands, applied gloves and performed a nasal swab on a staff member. She then removed the gloves, performed hand hygiene, applied new gloves and performed a nasal swab on the next staff member. Interview with CS 1 at that time, indicated she was not aware she had to wear a gown and eye protection when testing staff members. Interview with the Director of Nursing on 1/31/22 at 3:05 p.m., indicated the contracted company CS	F 0880	**Aperion- Tolleston Park** **Complaint Survey 02/02/2022** **Compliance 02/20/22** **F880 Infection control** *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:** Contracted Staff 1 (CS1) was immediately re-in serviced on	02/20/2022

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	1 worked for should have instructed her on proper PPE to be used during testing. An untitled document from the contracted company was provided by the Administrator on 2/1/22 at 10:20 a.m. indicated, "The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following...Eye Protection. Put on eye protection (i.e. goggles or a face shield that covers front and sides of the face) upon entry to the patient room or care area...Gowns. Put on a clean isolation gown upon entry in to patient room or area...." 2. The Behavioral Care Unit (BCU) was observed on 1/31/22 at 9:37 a.m. There were two large piles of laundry on the floor in the hallway, next to a large open bag of garbage and an overflowing garbage can with no lid. A staff member approached and began bagging the laundry. On 1/31/22 at 2:25 p.m., at the same location on the BCU, the large bag of garbage and overflowing garbage can were still there. In the Dining Room of the BCU, there were two large bags of laundry in the middle of the floor. Interview with CNA 1 on 1/31/22 at 2:30 p.m., indicated she had been working since 7:00 a.m., and had not seen anyone from housekeeping that normally picked up the laundry and garbage. 3. During the Environmental tour on 1/31/22 at 9:15 a.m. with the Environmental Director, the following was observed: 200 Unit a. There was an uncovered plastic wash basin on the bathroom floor in Room 216. Two residents resided in the room.		facility and Company policy for infection control and testing. CNA1 was in serviced on infection control policies for the facility and provided with the housekeeping supervisors number to ensure that the alleged deficient practice does not recur. **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:** Facility IDT team completed a root cause analysis and Infection Control Self-Assessment with the Corporate Infection Control Preventionist. Reviewed findings and developed action plan and education materials based on findings. Staff will be re-educated regarding spread of infections as is relates to infection control policies and Facility ICN will complete staff and resident testing. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will (See Action Plan for the recommended monitoring)	

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	b. There was an uncovered plastic wash basin on the bathroom floor in Room 225. Two residents resided in the room. c. There was an uncovered and unlabeled plastic urinal on the bathroom floor in Room 231. One resident resided in the room. 300 Unit a. There was an uncovered and unlabeled plastic urinal on the floor near the bed containing urine in Room 311. Two residents resided in the room. b. There was an uncovered plastic wash basin on the bathroom floor in Room 324. Two residents resided in the room. When interviewed on 2/1/22 at 9:30 a.m., the Environmental Director indicated those items should have been contained, labeled, and off the floor. This Federal tag relates to complaints IN00369639 and IN00371969. 3.1-18(b)		**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: 02/20/2022**	
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 maintain a sanitary, safe, and homelike environment related to dirty floors, dirty garbage cans, soiled sheet, loose door trim and cracked floor tiles in 3 of 6 units observed. (100, 200 and	F 0921	**F-921** **Safe/Functional/Sanitary/Comfortable Environment** **Tolleston Park Aperion Care Survey 02-2-2022**	02/20/2022

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	300 halls) Findings include: 1. During the Environmental tour on 1/31/22 at 9:13 a.m. with the Environmental Director, the following was observed on the 100 hall: a. Room 101 had a fitted sheet that was discolored near the foot of the bed and a brown substance on the sheet. The floors were dirty and there was paper debris on the floor. One resident resided in the room. b. Room 112 had dirty floors. One resident resided in the room. c. Room 119 had dirty floors, paper and plastic debris on the floor around the bed, there was no liner in the garbage can which was dirty and contained garbage. Two residents resided in the room. d. Room 123 had dirty floors, no liner in the garbage can which was dirty and contained garbage. There was a large chunk of wood missing from the headboard on the wall and a loose piece of trim in the doorway. One resident resided in the room. e. Room 124 had dirty floors, an empty beverage bottle and paper debris on floor. Two residents resided in the room. Interview with the Environmental Director on 2/1/22 at 9:15 a.m., indicated he observed the above items and they were in need of cleaning or repair. 2. During the Environmental tour on 1/31/22 at		*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: All the identified concerns below were identified and corrected:** **All the identified concerns below were identified and corrected:** On the units During the Environmental tour on 1/31/22 at 9:13 a.m. with the Environmental Director, the following was observed on the 100 hall: a. Room 101 had a fitted sheet that was discolored near the foot of the bed and a brown substance on the sheet. **The sheet was removed and replaced with a clean sheet.** The floors were dirty and there	

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	9:15 a.m. with the Environmental Director , the following was observed on the 200 hall: a. Room 214 - There were used paper towel products on the floor and the floor was dirty with splatters of unknown substances throughout room. Two residents resided in the room. b. Room 217 - There were paper straw wrappers and food packaging on floor and the floor was dirty. Two residents resided in the room. c. Room 221- There were used paper products and food packages on floor. Two residents resided in the room. d. Room 224- There were broken tiles upon entrance to the room, there was rust around the toilet and floor was dirty. One resident resided in the room. e. Room 230- There were broken tiles upon entrance to the room, food on the floor, floor was dirty, and there was rust around the toilet. Two residents resided in the room. 300 hall: a. Room 310- There was paper product wrappers on the floor and the floor was dirty. Two residents resided in the room. When interviewed on 2/1/22 at 9:30 a.m., the Environmental Director indicated the above areas should have been cleaned and/or repaired. This Federal tag relates to complaint IN00369639. 3.1-19(e)		was paper debris on the floor. One resident resided in the room. b. Room 112 had dirty floors. One resident resided in the room. c. Room 119 had dirty floors, paper, and plastic debris on the floor around the bed, there was no liner in the garbage can which was dirty and contained garbage. **Debris was removed from the floor and the floors cleaned. Garbage can liners replaced.** Two residents resided in the room. d. Room 123 had dirty floors, no liner in the garbage can which was dirty and contained garbage. There was a large chunk of wood missing from the headboard on the wall and a loose piece of trim in the doorway. **Headboard replaced and trim repaired**. One resident resided in the room. e. Room 124 had dirty floors, an empty beverage bottle and paper debris on floor. **Debris removed and floor cleaned.** Two residents resided in the room. 200 hall: a. Room 214 - There were used paper towel products on the floor and the floor was dirty with splatters of unknown substances throughout room. **Debris removed and splatters removed, and floors cleaned.** Two residents resided in the room. b. Room 217 - There were paper straw wrappers and food packaging on floor and the floor was dirty. **Debris removed and Floors Cleaned.** Two	

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			residents resided in the room. c. Room 221- There were used paper products and food packages on floor. Food packages and paper packages removed. Two residents resided in the room. d. Room 224- There were broken tiles upon entrance to the room, there was rust around the toilet and floor was dirty. **Tiles repaired and Rust removed, and floor cleaned**. One resident resided in the room. e. Room 230- There were broken tiles upon entrance to the room, food on the floor, floor was dirty, and there was rust around the toilet. **Tiles repaired and Rust removed, and floor cleaned** Two residents resided in the room. 300 hall: a. Room 310- There was paper product wrappers on the floor and the floor was dirty. **Paper products removed and the floor cleaned.** **2. All residents are at risk for the same 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**	

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			will be monitored: **The Administrator/designee will monitor corrective actions & sustain compliance; Completing rounds 5 days a week to ensure the facility is a safe comfortable and sanitary environment. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 02/20/2022**	
F 9999 Bldg. 00	3.1-18 INFECTION CONTROL PROGRAM (b) The facility must establish an infection control program under which it does the following: (7) Reports communicable disease to public health authorities. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to establish an Infection Control program which included a system that reported	F 9999	**Aperion- Tolleston Park** **POC Survey 02/02/2022** **Compliance 02/20/2022** **F9999 Infection control Program**	02/20/2022

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	communicable disease to public health authorities related to not reporting COVID-19 positive staff and resident cases to the Indiana Department of Health (IDOH) as required. This had the potential to affect all residents in the facility. Finding includes: Interview with the Infection Preventionist (IP) on 2/1/22 at 1:15 p.m., indicated the facility's most recent COVID-19 outbreak started on 12/16/21. A total of 102 residents and 47 staff members had tested positive since the beginning of the outbreak. Review of the COVID-19 line list provided by the IP on 2/1/22 at 1:15 p.m., indicated 30 residents and 13 staff had tested positive since 1/13/22. The line list indicates a total of 102 residents positive for COVID-19 from 12/23/21-1/24/22 and 47 staff positive for COVID-19 from 12/16/21-1/31/22. Review of the COVID-19 LTC (Long Term Care) Case and Death reports, dated 2/1/2022, indicated eight residents and five staff had tested positive since 1/13/22. There were no reported cases before 1/13/22. Interview with the Director of Nursing (DON) and IP on 2/1/22 at 1:55 p.m., indicated the IP had been reporting all positive cases at the time of receiving results. The IP indicated she was aware of reporting the point of care (POC) test results as well as positive cases. Interview with the IP on 2/2/22 at 3:35 p.m., indicated the cases were being reported to the incorrect location online, which was the reason for the number discrepancy between the facility line list report and the LTC Case and Death reports.		**1) Immediate corrective action(s) for those residents affected by the deficient practice:** All residents and staff may be affected by the alleged deficient practice. **2) Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** The IP reached out to Redcap to ensure that any reporting discrepancies are resolved. **3) Facility measures and systemic changes to ensure the deficient practice does not recur:** The IP will input the testing into the redcap system and the DON or designee will ensure that the reporting system is correct. **4) Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:** **The IP will call the red cap system monthly to ensure that there are no discrepancies. 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**	

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	02/02/2022

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

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	The IDOH document, "LTC Facility COVID-19 Data Submission Guidelines", dated 12/22/20, indicated, ".... Importantly, the state requires that facilities report to the following systems, which are focused on patient-level testing information: - Long-term Care COVID-19 Reporting form (required for all SNF/NF [skilled care] and RCF/AL [Assisted Living]) - COVID-19 Point of Care (POC) Test Reporting form (Certified nursing homes [SNF/NFs] are exempt from this reporting beginning October 28, 2020 and should begin reporting point-of-care testing to NSHN directly; required for all RCF/AL [Assisted Living]) - Death Reporting Line for COVID-19-related deaths ...."		**recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 02/20/2022**	