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	01/24/2025

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00449958. Complaint IN00449958 - Federal/state deficiencies related to the allegations are cited at F686. Unrelated deficiency is cited. Survey dates: January 22, 23, and 24, 2025 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 129 Total: 129 Census Payor Type: Medicare: 6 Medicaid: 111 Other: 12 Total: 129 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/27/25.	F 0000		
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer 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 completed as ordered by the	F 0686	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C Treatment was initiated on	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla Dawson	DON	02/05/2025

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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	Physician for 1 of 3 residents reviewed for pressure ulcers. (Resident C) Finding includes: During an observation on 1/23/25 at 11:08 a.m., the Director of Nursing (DON) completed Resident C's pressure ulcer treatments with the assistance of Unit Manager 1. The DON indicated the pressure ulcer treatment on the coccyx was a duoderm (hydrocolloid dressing) and was to be changed every three days. She indicated the treatment had been completed on 1/22/25. The dressing on the coccyx at the time of the observation was a border gauze dressing with the date of 1/22/25 on the dressing. Resident C's record was reviewed on 1/23/25 at 11:02 a.m. The diagnoses included, but were not limited to, vascular dementia. A Physician's Order, dated 12/15/24, indicated a duoderm dressing was to be applied to the coccyx every three days. The order was discontinued on 1/22/25. A Significant Change Minimum Data Set assessment, dated 12/16/24, indicated a severely impaired cognitive status and unhealed pressure ulcers were present on admission. A Wound Physician's Order, Wound Evaluation and Management Summary, dated 1/17/25, indicated an order for the duoderm dressing every three days to be discontinued and a calcium alginate (dressing to absorb drainage) and border gauze dressing was to be applied daily. A Care Plan, dated 12/20/24, indicated a stage two (partial thickness loss of the dermis) pressure		1/23/2025 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any Resident with a wound treatment has the potential to be affected by the alleged deficient practice. DON completed full house audit to ensure orders were initiated timely. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. DON/ Designee educated Unit Managers on reviewing physician notes after residents assessed by physician to ensure orders are implemented timely. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/Designee to review wound physician notes weekly to ensure orders are implemented timely. Audits to be completed 3x weekly for 6 weeks then 2x weekly for 6 weeks then weekly for 3 months. 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 x4 consecutive weeks. The QA Committee will identify any trends or patterns and make	

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	ulcer was present on the the coccyx. The interventions indicated the treatment to the area would be completed as ordered by the Physician. The Treatment Administration Record, dated 1/2025, indicated the duoderm dressing had been applied to the coccyx on 1/20/25 and the order for the calcium alginate dressing was to be started on 1/23/25. A Physician's Order, dated 1/22/25, indicated the pressure ulcer on the coccyx was to be cleansed with wound cleaner, patted dry, and a calcium alginate and dry dressing was to be applied daily. The start date for the treatment was 1/23/25. During an interview on 1/23/25 at 12 p.m., the DON indicated she was unaware orders for the coccyx pressure ulcer treatment had been changed. During an interview on 1/23/15 at 1:09 p.m., the DON indicated the Wound Physician had written a change in treatment orders for the coccyx pressure ulcer in his summary notes on 1/17/25 and the orders had not been transcribed in the resident's record until 1/22/25. During an interview on 1/23/25 at 1:18 p.m., the DON indicated the new treatment for the coccyx pressure ulcer had been completed on 1/22/25. This citation relates to Complaint IN00449958. 3.1-40(a)		recommendations to revise the plan of correction as indicated.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record	F 0880	I. What corrective action(s) will be	02/14/2025

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	review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff member (Housekeeper 1) when cleaning a room where a COVID-19 positive resident resided (Resident F) and was in COVID-19 Transmission-Based Precautions, for one random observation for infection control. Finding includes: During an observation on 1/22/25 at 12:00 p.m., Resident F was lying in his bed in his room. There was a red sign on the door that indicated the resident's room was a Red Zone, which meant the resident was COVID-19 positive. The Red Zone sign indicated the resident should be asked to put a mask on when the staff were in the room and gloves, gown, face shield and a N95 mask were to be worn when in the room. Housekeeper 1 was observed in the room and mopping the floor. Housekeeper 1 had a surgical mask on and was not wearing a face shield. Housekeeper 1 was interviewed at the time and indicated she was unsure if she should have a N95 mask and face shield on. She indicated the resident was asleep so she had not asked him to put a mask on. Resident F's record was reviewed on 1/24/25 at 10:46 a.m. The diagnoses included, but were not limited to, stroke and COVID-19. A Care Plan, dated 1/13/25, indicated he was COVID-19 positive. The interventions included isolation with droplet precautions. A Nurse's Progress Note, dated 1/13/25 at 12:54 p.m., indicated the resident required droplet precautions related to a confirmed diagnosis of COVID-19.		accomplished for those residents found to have been affected by the deficient practice; Resident F had no adverse outcomes related to alleged deficient practice. Housekeeper number 1 was educated on appropriate PPE to be worn. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff to be educated on appropriate PPE to be worn in Covid room. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/Designee to complete random audits to ensure appropriate use of PPE. 5 employees per week for 4 weeks, 4 employees per week for 4 weeks, then 1 employee weekly for 4 months 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	

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	A facility COVID-19 policy, dated 7/24/23 and received from the Corporate Nurse Consultant as current, indicated the PPE for use in the Red and Yellow Zones consisted of a N95 mask, gown, gloves, and eye protection (face shield). 3.1-18(b)		x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	