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	11/21/2024

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 the Investigation of Complaint IN00446462. Complaint IN00446462 - Federal/State deficiencies related to the allegations are cited at F684. Survey date: November 21, 2024 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 125 Total: 125 Census Payor Type: Medicare: 8 Medicaid: 110 Other: 7 Total: 125 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/26/24.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to complete adequate fall follow up related to missing neurological assessments for 1 of 3 residents reviewed for falls. (Resident B) Finding includes:	F 0684	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B no longer resides at the facility. II. How other residents having the potential to be affected by the	12/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Frank Bensema	Administrator	12/08/2024

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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	The record for Resident B was reviewed on 11/21/24 at 9:26 a.m. Diagnoses included, but were not limited to, malignant neoplasm (abnormal growth) of the head, face, and neck, malignant neoplasm of the tongue, dysphagia (difficulty swallowing) and tracheostomy status. The Admission Minimum Data Set (MDS) assessment, dated 10/5/24, indicated the resident was cognitively intact. The resident was receiving tracheostomy care. A Care Plan, reviewed on 10/3/24, indicated the resident was a fall risk related to cancer and medications. Interventions included, but were not limited to, follow facility fall protocols and evaluate and treat as ordered or as needed. Resident B had an unwitnessed fall on 10/20/24. The Neurological 24 Hour Assessment was initiated on 10/20/24 at 12:25 p.m. The assessments were recorded as completed on the following dates and times: - On 10/20/2024 at 12:25 p.m., 5:12 p.m. and 10:30 p.m. - On 10/21/2024 at 10:05 a.m. There were no other neurological assessments documented in the resident's record for 10/21/24. During an interview on 11/21/24 at 1:19 p.m., the Director of Nursing indicated the nurses should have completed and documented Resident B's neurological assessments every four hours on 10/20 and 10/21/24. The facility policy titled, "Neurological Assessment" was provided by the DON as current on 11/21/24 at 12:39 p.m. The policy indicated neurological checks would be completed		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; DON/designee to educate licensed nurses on the policy "Neurological Assessment" to include completing neurological checks per policy. 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 will audit residents with neuro checks to ensure they were completed per policy. Audits will be completed on 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, then 1 resident a week x 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 x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	at the time of the physician order, potential head injury, or change in condition and every four hours for 24 hours. This citation relates to Complaint IN00446462. 3.1-50(a)(2)			