STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/20/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 0000	REGELATORTOR	CESC IDENTIFIED IN ORMETION	1710		DATE			
Bldg. 00	Licensure Survey. The Investigation of Control	Recertification and State This visit included the mplaints IN00436414, 437481, IN00440036, IN00440148,	F 0000					
	Complaint IN00436414 - Federal/state deficiencies related to the allegations are cited at F921.  Complaint IN00437098 - No deficiencies related to the allegations are cited.							
	Complaint IN00437 the allegations are c	7481 - No deficiencies related to cited.						
	Complaint IN00440 the allegations are c	0036 - No deficiencies related to cited.						
	Complaint IN00440 the allegations are c	0148 - No deficiencies related to cited.						
	Complaint IN00442 the allegations are c	2228 - No deficiencies related to cited.						
	Survey dates: Septe 2024.	ember 16, 17, 18, 19, and 20,						
	Facility number: 008505 Provider number: 155580 AIM number: 200064830							
	Census Bed Type: SNF/NF: 123 Total: 123							
	Census Payor Type Medicare: 9	:						

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

TITLE (X6) DATE

Frank Bensema Administrator 10/16/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155580	A. BU B. WI		00	COMPLETED 09/20/2024	
		133360	B. WI			09/20/	2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
F 0583 SS=D Bldg. 00	Medicaid: 108 Other: 6 Total: 123  These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.  Quality review completed on 9/26/24.  483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records  Based on observation, record review, and interview, the facility failed to ensure a resident's privacy was maintained related to staff not knocking on the door prior to entering the resident's room for 2 of 2 residents reviewed for privacy. (Residents 2 and 9)  Findings include:  1. During an interview on 9/16/24 at 2:44 p.m., Resident 2 indicated staff do not always knock on her door prior to entering her room.  On 9/16/24 at 2:55 p.m., CNA 3 opened the door to the resident's room without knocking. The CNA proceeded to close the door and exit the resident's room.		F 05	TAG	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does no constitute admission or agreed	of t ment	
					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.		
	opened the door and member did not kno opening it.  The record for Resid at 9:56 a.m. Diagno limited to, bipolar, t	p.m., a staff member, partially d then closed it. The staff ock on the door prior to dent 2 was reviewed on 9/19/24 oses included, but were not type 2 diabetes, major, and schizophrenia.			Tag number: F583 Personal Privacy I. What corrective action(s) wi accomplished for those reside found to have been affected b deficient practice; Residents and 9 had no adverse reaction related to the alleged deficient practice. II. How other residents having	ill be nts y the 2 ons	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155580	B. W	ING		09/20/	2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		2350 TA			
   APFRI∩I	N CARE TOLLESTO	ON PARK			IN 46404		
	· · · · · · · · · · · · · · · · · · ·	O11 / UUX		5,4141,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		mum Data Set (MDS)			potential to be affected by the		
	l '	5/15/24, indicated the resident			same deficient practice will be		
		paired for daily decision			identified and what corrective		
	making.				action(s) will be taken; All		
					residents have the potential to		
	_	v on 9/18/24 at 4:10 p.m., the			affected by the alleged deficie	nt	
	Director of Nursing indicated staff should have				practice. CNA 3 and		
		or before entering the resident's			Housekeeper 1 were educate		
	room.				on resident rights to include		
					knocking on doors prior to		
					entering a residents room.		
		riew on 9/16/24 at 3:00 p.m.,					
		d staff do not always knock on			III. What measures will be put		
	her door prior to en	tering her room.			place and what systemic chan	~	
					will be made to ensure that the		
		p.m., Housekeeper 1 entered the			deficient practice does not rec		
		eplace the trash bag. She did			DON/designee to educate all		
	not knock on the do	oor prior to entering the room.			staff on resident rights to		
					include knocking on doors		
		dent 9 was reviewed on 9/17/24			prior to entering a resident		
		oses included, but were not			room.		
	limited to, major de	epressive disorder and anxiety.			IV. How the corrective action(s		
	m 0 1 1 1 1 1 1	D + G + (14DG)			will be monitored to ensure the		
		mum Data Set (MDS)			deficient practice will not recui		
		7/15/24, indicated the resident			i.e., what quality assurance		
		paired for daily decision			program will be put into place;		
	making.				DON/designee will conduct		
	Duning a gar intern	or 0/19/24 at 4.10 41 -			audits to ensure staff are		
	_	v on 9/18/24 at 4:10 p.m., the			knocking on residents door	.	
	1	g indicated staff should have			prior to entering. Audits will	DE	
		or before entering the resident's			completed as follows 10		
	room.				resident rooms a week x 4		
	2 1 2(-)(5)				weeks, then 5 resident rooms	s a	
	3.1-3(p)(5)				week x 4 weeks, then 1		
					resident room a week x 4		
					months.		
					The results of these audits will		
					reviewed in Quality Assurance		
					Meeting monthly for 6 months	or	
			1		until an average of 90%		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) I			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W	ING		09/20/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t		2350 T			
APERION	N CARE TOLLESTO	JNI PARK			IN 46404		
AI LINOI	V CARL TOLLEST	JIVI AIKK		GAITT,	IIN 40404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					compliance or greater is achie		
					x4 consecutive weeks. The Q	A	
					Committee will identify any		
					trends or patterns and make		
					recommendations to revise the		
					plan of correction as indicate	ed.	
F 0640	400 00/5/(4) (4)						
	483.20(f)(1)-(4)	tation Desident					
SS=A Bldg. 00	Encoding/Transmi	illing Kesident					
ыад. 00	Assessments	view and interview, the facility	F 0.	(10	The facility we arrests we are		10/14/2024
		ly complete and export the	F 0	540	The facility requests paper		10/14/2024
		n Data Set (MDS) assessment			compliance for this citation.		
	_	ne discharge date for 1 of 28			This Plan of Correction is the		
		OS assessments were			center's credible allegation of		
	reviewed. (Residen				compliance.		
	reviewed. (Residen	ii 33)			Preparation and/or execution	of	
	Finding includes:				this plan of correction does no		
	i manig merades.				constitute admission or agree		
	The Record for Res	ident 53 was reviewed on			by the provider of the truth of t		
		. The resident was admitted to			facts alleged or conclusions se		
		0/23 and discharged with the			forth in the statement of	<b>.</b>	
	return anticipated of				deficiencies. The plan of		
					correction is prepared and/or		
	The Discharge Retu	urn Anticipated MDS			executed solely because it is		
	_	/12/24, indicated it was			required by the provisions of		
	completed and acce				federal and state law.		
	•	•			Tag number: F640		
	During an interview	on 9/20/24 at 10:00 a.m., the			Encoding/Transmitting		
	_	tant indicated the assessment			Assessments		
	was completed and	submitted late.			I. What corrective action(s) wil	ll be	
					accomplished for those reside		
	The Centers for Me	dicare and Medicaid Services			found to have been affected b		
	"Long Term Care F	acility Resident Assessment			deficient practice; Resident 53	3	
	Instrument 3.0 User	s's Manual," dated October			discharged from the facility.		
	2024, indicated, "A	ssessment Transmission:			II. How other residents having	the	
	Comprehensive ass	essments must be transmitted			potential to be affected by the		
	electronically within	n 14 days of the Care Plan			same deficient practice will be		
	Completion Date (V	/0200C2 + 14 days). All other			identified and what corrective		
	MDS assessments r	nust be submitted within 14			action(s) will be taken; Any		

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Event ID:

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Facility ID: 008505

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

PRINTED: 10/28/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155580		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 00 B. WING			X3) DATE SURVEY COMPLETED 09/20/2024			
NAME OF F	PROVIDER OR SUPPLIEF	-		REET ADDRESS, CITY, STATE, 2 350 TAFT ST	ZIP COD			
APERIO	N CARE TOLLESTO	ON PARK	GARY, IN 46404					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LLSC DEPARTMENT DESPRIATION	II PRE	FIX PROVIDER'S PLAN OF CEACH CORRECTIVE ACTION OF CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION		
TAG		empletion Date (Z0500B + 14		resident dischargi facility has the por affected by the allideficient practice. audit was completed residents discharge 60 days to ensure discharge assessicompleted.  III. What measures place and what syswill be made to ensufficient practice of MDS consultant to deficient practice with certain to deficient practice with the program will be put MDS/designee to discharge assessicompleted timely. Be completed 3x v months.  The results of these reviewed in Quality Meeting monthly for until an average of compliance or great x4 consecutive were Committee will ider or patterns and material recommendations to plan of correction as plan	ing from the tential to be eged A full house ted on ged in the last they had a ment  is will be put into stemic changes sure that the loes not recur; or educate assistant on large sily. It is a consument to ensure the vill not recur surance to into place; audit large alignment was a ment was a me	DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W			09/20/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				2350 T			
APERION	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0677	483.24(a)(2)						
SS=D	ADL Care Provide	d for Dependent Residents					
Bldg. 00							
	Based on observation	on, record review, and	F 00	577	The facility requests paper		10/14/2024
	interview, the facility failed to ensure activities of				compliance for this citation.		
	daily living (ADLs)	were completed for dependent			This Plan of Correction is the		
	residents related to	dirty and long fingernails and			center's credible allegation of		
	the removal of facia	al hair for 3 of 10 residents			compliance.		
	reviewed for ADLs.	. (Residents 35, 58, and 236)					
					Preparation and/or execution	of	
	Findings include:				this plan of correction does no	ot	
					constitute admission or agreei	ment	
	1. During random observations on 9/16/24 at 9:32				by the provider of the truth of t	the	
	a.m., 11:44 a.m., an	d 2:38 p.m., on 9/17/24 at 9:00			facts alleged or conclusions se	et	
	a.m., 1:38 p.m., and	l on 9/18/24 at 9:09 a.m., 11:15			forth in the statement of		
	a.m., and 1:57 p.m.,	, Resident 35 was observed with			deficiencies. The plan of		
	dirty fingernails on	her left hand and long and			correction is prepared and/or		
	dirty fingernails on	her right hand.			executed solely because it is		
					required by the provisions of		
	On 9/19/24 at 8:15	a.m., the Assistant Director of			federal and state law.		
	Nursing (ADON) 2	was asked to observe the			Tag number: F 677 ADL Care	е	
	resident's fingernail	s. At that time, ADON 2			I. What corrective action(s) wil	ll be	
	indicated her nails v	were long and dirty.			accomplished for those reside	ents	
					found to have been affected b	y the	
	The record for Resi	dent 35 was reviewed on			deficient practice; Resident 35	5	
	9/17/24 at 2:05 p.m	. Diagnoses included, but were			had their nails cleaned and		
	not limited to, strok	e, aphasia (a language disorder			trimmed on 9/20/24. Reside	nt	
	that makes it difficu	alt to understand or express			58 was shaven on 9/20/24.		
	language), diabetes,	, hemiplegia (paralysis on one			Resident 236 had their facial		
	side of the body), he	eart disease, and high blood			hair shaven on 9/20/24.		
	pressure.				II. How other residents having	the	
					potential to be affected by the		
	The 6/16/24 Quarte	rly Minimum Data Set (MDS)			same deficient practice will be		
	assessment indicate	d the resident was not			identified and what corrective		
	cognitively intact for	or daily decision making. The			action(s) will be taken; All		
		ional limitation of range of			residents have the potential to	be	
	motion impairment to one side for both the upper				affected by the alleged deficie		
	and lower extremities, was dependent on staff for				practice. A full house audit w		
	bathing and needed substantial to maximal				completed on nail care and		
	assistance with pers				shaving. Any discrepancies		

Z43O11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLI	ETED
		155580	B. W	ING _		09/20/	2024
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		2350 TA			
∆DEDI∩	N CARE TOLLESTO	ON PARK			IN 46404		
AI ENIU		ON I AIM		GART,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					were immediately corrected.		
		sed on 8/5/22, indicated the			III. What measures will be put	into	
		L self-care performance deficit			place and what systemic char	nges	
		An approach indicated the			will be made to ensure that th	e	
		re staff assistance with			deficient practice does not red	cur;	
	personal hygiene.				DON/designee to educate		
					nursing staff on ADL		
	The task section of the EMR (electronic medical				care/showering to include na	ail	
	record), completed by the CNA, indicated there				care and shaving.		
	was no documentation the resident's fingernails				IV. How the corrective action(	s)	
	had been cleaned or trimmed.				will be monitored to ensure th		
					deficient practice will not recu	r	
	During an interview on 8/19/24 at 8:15 a.m., ADON				i.e., what quality assurance		
	2 indicated the resident's fingernails were in need				program will be put into place	;	
	of being trimmed a	nd cleaned.			DON/designee will conduct a		
					audit on nail care and shavir	ng	
					to ensure it is completed.		
	_	observations on 9/16/24 at			Audits will be completed on	10	
		m., and 3:40 p.m., on 9/17/24 at			residents a week x 8 weeks,	5	
		., and 3:00 p.m., and on 9/18/24			residents a week x 8 weeks		
		:00 p.m., Resident 58 was			then 1 resident a week 2		
		facial hair under her chin and			months.		
	on her neck.				The results of these audits wil		
					reviewed in Quality Assurance		
		p.m., the resident was observed			Meeting monthly for 6 months	or	
	_	air in her room. At that time,			until an average of 90%		
		o come to the resident's room			compliance or greater is achie		
		l hair. The CNA indicated she			x4 consecutive weeks. The C	QA	
		resident 2 days prior,			Committee will identify any		
	· ·	have missed the facial hair			trends or patterns and make		
		neck. She indicated the facial			recommendations to revise		
	hair was very long.				plan of correction as indicat	ed.	
		ident 58 was reviewed on					
	_	The resident was admitted to					
	the facility on 7/19/24. Diagnoses included, but						
	were not limited to, type 2 diabetes, stroke,						
		sis to one side of the body),					
		e, urinary tract infection (UTI),					
	obstructive uropath	y (occurred when urine				l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155580	B. Wl			09/20/	/2024
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
ΔPERI∩N	N CARE TOLLESTO	ON PARK		2350 TA	AFT ST IN 46404		
	<u> </u>				II TUTUT		ı
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1110		h the urinary tract), dementia,		1110			BITE
	anxiety, and depres						
		nimum Data Set (MDS)					
	assessment, dated 7/22/24, indicated the resident was cognitively impaired for daily decision making						
		sion with personal hygiene.					
	1	1 30					
	The 9/8/24 5-day Medicare MDS assessment,						
		nt was cognitively impaired for					
	1 -	ng and now she needed					
	substantial assistance with personal hygiene.  A Care Plan, dated 7/25/24, indicated the resident						
		re performance deficit related					
	to a stroke.						
	The task section of	the EMR, completed by the					
		had a shower on 8/22, 9/5,					
		No shaving was documented.					
	1	y on 9/19/24 at 8:10 a.m., the					
		of Nursing (ADON) 2 indicated have had the facial hair					
	removed during car						
		bservations on 9/16/24 at 10:08					
	_	46 p.m., and 3:43 p.m., on 9/17/24					
		.m., and 1:40 p.m., and on 9/18/24 0:50 a.m., Resident 236 was					
		derate amount of facial hair on					
	his face and chin ar						
	l '	p.m., the resident was observed					
		chair in his room. The					
	resident's son was of in the room.	observed sitting on the couch					
	m me room.						
	During an interview	on 9/18/24 at 2:25 p.m., the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155580	B. WING		09/20/2024
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST , IN 46404	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	resident's daughter is be clean shaven and him a shave.  The record for Resi 9/17/24 1:48 p.m. T facility on 9/11/24. not limited to, pneu hearing loss, joint p  The Admission Mir assessment was still  The Care Plan, date resident had an AD mobility and weakn  The task section of CNA, indicated Res 9/12/24 and a show documented.  During an interview Assistant Director of	nimum Data Set (MDS) I in progress.  d 9/12/24, indicated, the L self-care deficit related to	TAG	DEFICIENCY)	DATE
F 0684 SS=D Bldg. 00	483.25 Quality of Care				
. J	interview, the facili non-pressure ulcer to ordered for 3 of 4 re conditions and faile consult as ordered f	on, record review, and ty failed to ensure treatments were completed as esidents reviewed for skin d to obtain a psychiatric for 1 of 5 residents reviewed dications. (Residents 94 and	F 0684	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation compliance.	е

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Event ID:

Z43O11

Facility ID: 008505

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155580	B. W	ING		09/20/2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	PROVIDER OR SUPPLIEF	₹		2350 T		
ΔPERI∩N	N CARE TOLLESTO	ON PARK			IN 46404	
AI LINOI	· OAKE TOLLEST	OI 1 / JIM		OAITI,		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)	DATE
					Preparation and/or execution	
	Findings include:				this plan of correction does	not
					constitute admission or	
		n observation on 9/16/24 at			agreement by the provider o	f
	10:26 a.m., Resident 94 was observed sitting on a couch in the dining/day room. The resident's left				the truth of the facts alleged	or
					conclusions set forth in the	
	lower leg was observed to be scaly, with scabbed				statement of deficiencies. T	
		eas. There were no bandages			plan of correction is prepare	
	on her left lower leg	g.			and/or executed solely beca	
					it is required by the provisio	ns
		dent 94 was reviewed on			of federal and state law.	
		. Diagnoses included, buy were				
		zophrenia, morbid obesity,				
		d pressure, major depressive			Tag number: F684 Quality of	
		steoarthritis, and bipolar			Care	
	disorder.				I. What corrective action(s) will	
					accomplished for those reside	
		erly Minimum Data Set (MDS)			found to have been affected b	-
		ed the resident was not			deficient practice; Resident 94	4
	cognitively intact for	or daily decision making.			had no adverse reactions to	
					related to the alleged deficie	
		d on 3/25/24, indicated the			practice. Resident 107 had n	0
	resident was resistiv	ve to care and refused wound			adverse outcomes related to	
	care.				the alleged deficient practice	
		4.64.			and will be seen by psych	
	· ·	d on 7/1/24, indicated the			services on 9/20.	
		us/stasis ulcer to the left lower			II. How other residents having	
		s were to perform the treatment			potential to be affected by the	
	as ordered.				same deficient practice will be	
		1 . 17/0/04 . 1:			identified and what corrective	
	1 -	dated 7/2/24, indicated			action(s) will be taken; Any	
	1 -	ernal cream 0.1 % apply to the			resident receiving treatments	
		ally on day shift every			psych meds have the potentia	
	1	ay, and Friday, and wrap with			be affected by the alleged def	
	kerlix.				practice. A full house audit w	ras
					completed to ensure any	
		ninistration Records (TAR),			resident with an order for a	
	_	present, indicated the treatment			psych evaluation has one	
		signed out as being completed			completed or scheduled.	
	on the following da	ys:	1		Moving forward the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W	ING		09/20/	2024
		1		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		2350 TA			
APFRI∩I	N CARE TOLLESTO	ON PARK			IN 46404		
AI LINIOI	OAKE TOLLLOT	JIVI AIRK		OAITI,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- 4/2024: blank on 4				DON/designee will ensure all	l	
	- 5/2024: blank on				treatment are completed as		
		6/14, 6/21 and 6/28/24			ordered		
		7/1, 7/15, 7/17, 7/19, 7/22, 7/24,			III. What measures will be put		
	and 7/26/24				place and what systemic chan	-	
	- 8/2024: blank on 8	8/7 and 8/19/24			will be made to ensure that the		
	0/20/24 + 0.20				deficient practice does not rec	:ur;	
	During an interview on 9/20/24 at 9:20 a.m.,				DON/designee will educate		
	Assistant Director of Nursing (ADON) 2 indicated				nursing staff on completing	and	
		e left lower extremity were not			initialing treatments are		
	signed out as being	completed for the resident.			ordered. SS will be educated		
					on ensuring any resident wit		
					an order for a psych evaluati	ion	
		esident 107 was reviewed on			has one completed.		
		n. Diagnoses included, but			IV. How the corrective action(	•	
		Parkinson's disease, high			will be monitored to ensure the		
		chotic disorder, major			deficient practice will not recui	r	
		, dementia without behaviors,			i.e., what quality assurance		
		. The resident transferred to			program will be put into place;		
	_	4 from another skilled nursing			DON/designee will audit the		
	home.				MAR/TAR to ensure treatmen		
					are completed and initialed a	as	
		mum Data Set (MDS)			ordered. DON/designee will		
	l '	7/5/24, indicated the resident			audit new admissions to ens	ure	
		intact for daily decision			everyone with an order for a		
	~	nt had mood problems such as			psych evaluation has one		
	_	ng tired, poor appetite and			scheduled or completed as		
		ng on things. The resident			ordered. Audits will be		
		chotic, anti-anxiety, and			completed on 10 residents	_	
	antidepressant med	ications.			treatments a week x 8 weeks		
		1 . 14/1/04 : 1: 1			residents treatments a week	X	
		dated 4/1/24, indicated			4 weeks, then 1 resident		
		-anxiety medication) 0.5 mg			treatment a week x 3 months	<b>5.</b>	
	1	ing shifts and a psychiatric			Audits will be completed on		
	evaluation to treat a	as indicated.			new admissions/readmission	ns	
	Dissolution 1 O 1	1-4-10/19/24 :1:1			to ensure psych evals are		
	l -	dated 9/18/24, indicated			completed/scheduled as		
		psychotic medication) 20			ordered. Audits will be		
		ablet at night time. Trazadone			completed on all new		
	(an antidepressant r	nedication) 50 mg at bedtime,			admission during daily clinic	cal	

PRINTED: 10/28/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	ETED
		155580	B. WING			09/20/	/2024
NAME OF A			S	TREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R	2	350 T	AFT ST		
APERIO	N CARE TOLLEST	ON PARK	G	SARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
	· ·	depressant medication) 50 mg			meetings x 3 months.		
	at night time.				The results of these audits will		
					reviewed in Quality Assurance		
		er (NP) Progress Note, dated			Meeting monthly for 6 months	or	
		the resident had the diagnosis			until an average of 90%		
of psychotic disorder with delusions and was on Olanzapine 20 mg with psychiatric services following him.				compliance or greater is achie			
				x4 consecutive weeks. The Q	A		
				Committee will identify any tre	nds		
					or patterns and make		
	_	w on 9/19/24 at 1:50 p.m.,			recommendations to revise the	9	
		of Nursing (ADON) 2 indicated			plan of correction as indicated		
	the resident was ad						
	he first arrived. Aft						
		to the PCU unit. She had					
		t was being seen by the					
	outside behavior co	ompany for his medications.					
	There was no docu	mentation or consents					
	obtained for the res	sident to seek outside behavior					
	management.						
	During an interview	w on 9/20/24 at 1:45 p.m., the					
	_	ndicated the psychiatric					
	consult was not obt	tained in a timely manner.					
	3.1-37(a)						
E 0600	400.05(-)(4).(0)						
F 0688 SS=D	483.25(c)(1)-(3)						
Bldg. 00	Increase/Prevent	Decrease in ROM/Mobility					
Blug. 00	Rosed on observati	on, record review, and	E 0600	,	The facility requests name		10/14/2024
		ity failed to ensure a palm	F 0688	)	The facility requests paper compliance for this citation.		10/14/2024
		-			This Plan of Correction is the		
	^	protector was donned as ordered by the physician for 1 of 1 residents reviewed for range of motion.					
	(Resident 35)	reviewed for range of illution.			center's credible allegation of		
	(Kesidelli 55)				compliance.		
	Finding includes:	Finding includes:			Preparation and/or execution of	of	
					this plan of correction does no		

During a random observation on 9/16/24 at 9:32

a.m., Resident 35 was observed sitting in a geri

constitute admission or agreement

by the provider of the truth of the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/20/2024 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE chair, dressed in street clothes and finishing facts alleged or conclusions set breakfast. At that time, her right hand was forth in the statement of clenched like a fist and there was no deficiencies. The plan of anti-contracture device in her hand. correction is prepared and/or executed solely because it is On 9/16/24 at 11:44 a.m., the resident now was required by the provisions of observed with a palm protector in her right hand federal and state law. Tag number: F688 The record for Resident 35 was reviewed on Increase/Prevent/Decrease in 9/17/24 at 2:05 p.m. Diagnoses included, but were **ROM** not limited to, stroke, aphasia (a language disorder I. What corrective action(s) will be that makes it difficult to understand or express accomplished for those residents language), diabetes, hemiplegia (paralysis on one found to have been affected by the side of the body), heart disease, and high blood deficient practice; Resident 35's pressure. order for the palm protecter was placed on the MAR on The 6/16/24 Quarterly Minimum Data Set (MDS) 9/19/24 to ensure it is in place assessment, indicated the resident was not as ordered. cognitively intact for daily decision making. The II. How other residents having the resident had a functional limitation of range of potential to be affected by the motion impairment to one side for both the upper same deficient practice will be and lower extremities and was dependent on staff identified and what corrective for bathing and needed substantial to maximal action(s) will be taken; All assistance with personal hygiene. residents who have a device to prevent a decrease in ROM have The Care Plan, dated 9/23/22, indicated the the potential to be affected by the resident had hemiplegia due to a stroke with alleged deficient practice. A full weakness to the right side. The approaches were house audit was completed to to provide a palm proctor to the right palm as per ensure anyone with a device to order. prevent a decrease in ROM has an order on the MAR to ensure it is Physician's Orders, dated 10/19/23, indicated the being placed as ordered. resident may have a palm protector or rolled wash III. What measures will be put into cloth to the right hand. place and what systemic changes will be made to ensure that the The Medication and Treatment Administration deficient practice does not recur; Records for 6/2024,7/2024, 8/2024 and 9/2024 DON/designee to educate lacked documentation to indicate if the palm nursing staff on following an protector was donned or doffed. There was no order to place any device to

documentation of any refusals.

prevent a decrease in ROM.

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLET	
		155580	B. W	ING		09/20/20	U24
	ROVIDER OR SUPPLIER			2350 T	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	record), where the C "Nursing: Splint/Br to wear palm protect at all times you may palm protector is be 9/1-9/16/24 the palr N/A (not applicable documentation the r palm protector.  During an interview Assistant Director of	on 9/19/24 at 1:50 p.m., of Nursing 2 indicated there on to monitor if the palm			IV. How the corrective action (swill 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 any resident with a device to ensure it is in place as order or any refusal is documented Audits will be completed 5x week x 8 weeks, then 3x a week x 8 weeks, then weekly 2 months.  The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achie x4 consecutive weeks. The Quality Assurance or patterns and make recommendations to revise the plan of correction as indicated	edd.aa I be or eved	
F 0690 SS=D Bldg. 00	Based on observation interview, the facility (urinary) catheter by the floor for 1 of 1 m	on, record review, and ty failed to ensure Foley ags and tubing were kept off of resident reviewed for urinary	F 0	690	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of the compliance.	e	10/14/2024
	a.m., Resident 58 w	oservation on 9/16/24 at 9:30 as observed in bed. Her ag was on the floor at the side			Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged	not f	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPI	
ANDILAN	OF CORRECTION	155580	B. W		00	09/20	
		10000	2			00/20	72021
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE TOLLEST	ON PARK			AFT ST IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CAMPANIA DE LA CONTRACTIONA		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IATE	DATE
	During an interviev	v at that time, CNA 1 indicated			conclusions set forth in the	)	
	the catheter bag sho	ould not be on the floor.			statement of deficiencies.	The	
					plan of correction is prepar	ed	
	During random obs	servations on 9/18/24 at 9:12			and/or executed solely beca	ause	
	a.m. and 10:04 a.m	., the resident was up and			it is required by the provision	ons	
	dressed and observe	ed sitting in her wheelchair. At			of federal and state law.		
	those times the cath	neter bag and tubing was					
	observed on the flo	or under the wheelchair.					
					Tag number: F690		
		9 a.m., the Director of			Bowel/Bladder, catheter, U1	П	
		red the resident's room and			I. What corrective action(s) w		
		ady for therapy. The resident			accomplished for those resid		
		so the director pushed her out			found to have been affected	-	
		herapy room. At that time, the			deficient practice; Resident s	58	
		bing remained on the floor			had not adverse outcomes		
		down the hallway. At 11:10			related to the alleged deficient	ent	
		as finished with therapy and			practice.		
	_	wn the hallway back to her			II. How other residents having	-	
		eter bag and tubing still			potential to be affected by the		
	observed on the flo	or.			same deficient practice will b		
					identified and what corrective	)	
	_	ion on 9/18/24 at 2:00 p.m., the			action(s) will be taken; All		
		ved sitting in her wheelchair			residents have the potentia	l to	
		that time, the catheter bag and			be affected by the alleged		
	tubing remained on	the floor under the wheelchair.			deficient practice.		
	Daning 1	:			III. What measures will be pu		
	_	ion on 9/18/24 at 2:45 p.m., the			place and what systemic cha	•	
	_	bing were still on the floor			will be made to ensure that the		
		wheelchair. CNA 2 was asked			deficient practice does not re	cur;	
	•	oom to observe the catheter			DON/designee to educate		
	bag and tubing.				nursing staff on the policy		
	During an interview	v at that time, CNA 2 indicated			"Urinary Catheter Care" to		
	_	wheelchair dip down too low			include keeping a foley bag and tubing off the floor.		
		ne catheter bag was on the			IV. How the corrective action	(e)	
	-	vare the catheter bag and			will be monitored to ensure the	` '	
	tubing should not b				deficient practice will not recu		
	adding should not 0	on the moon.			i.e., what quality assurance	AI.	
	The record for Resi	ident 58 was reviewed on			program will be put into place	۶.	
		a. The resident was admitted to			DON/designee will audit fold		
	5/10/2   at 2.35 p.m	. The resident was admitted to	1		Donwaesignee win addit 1010	∪ y	I

Z43O11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155580	B. W	ING		09/20/	2024
				GED DEET.	ADDRESS STEW STATE STR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO				2350 TA			
APERIO	N CARE TOLLEST	ON PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
		/24. Diagnoses included, but			catheters/tubing to ensure th	nev	
	-	, type 2 diabetes, stroke,			are kept off the floor. Audits	•	
		sis to one side of the body),			will be completed on 5		
		e, urinary tract infection (UTI),			residents a week x 8 weeks,		
		y (occurred when urine			then 3 resident's a week x 4		
	_	th the urinary tract), dementia,			months.		
	_				The results of these audits wil	l he	
anxiety, and depressive disorder				reviewed in Quality Assurance			
	The Admission Mi	nimum Data Set (MDS)			Meeting monthly for 6 months		
		7/22/24, indicated the resident			until an average of 90%	OI	
		paired for daily decision making			compliance or greater is achie	wod	
		sion with personal hygiene.			x4 consecutive weeks. The Q		
	and needed supervi	sion with personal hygiene.			Committee will identify any tre		
	The 0/8/24 5 day M	Medicare MDS assessment			1	ilus	
		58 was cognitively impaired for			or patterns and make recommendations to revise the	_	
		ing. She needed substantial					
	-	-			plan of correction as indicated		
	_	sonal hygiene and had a Foley					
	catheter.						
	A Como Dlam marrian	ed on 8/6/24, indicated the					
	resident had a Fole	y cameter.					
	Diaminia de Ondana	dated 9/4/24, indicated Foley					
	1	•					
		with a 10 cubic centimeters					
	(CC) balloon.						
	Dhyginian Onder	loted 0/4/24 and diti					
		lated 9/4/24 and discontinued					
		ed Ciprofloxacin HCl (an					
	1	00 milligrams (mg), give 1 tablet					
		y and evening shift for an UTI					
		nem (an antibiotic) Intravenous					
		ed 2 grams, give 100 milliliters					
		three times a day for UTI for 9					
	days.						
		v on 9/18/24 at 4:00 p.m., the					
		g indicated the catheter bag and					
	tubing should not b	e on the floor.					
	The current and rev	rised 2/14/19, "Urinary Catheter					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/20/2024
	PROVIDER OR SUPPLIER		2350 T	ADDRESS, CITY, STATE, ZIP COD FAFT ST , IN 46404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0693 SS=D Bldg. 00	Care" policy provid Nursing 2 on 9/19/2 drainage bags and to prevent either from 3.1-41(a)(2)  483.25(g)(4)(5) Tube Feeding Mgl.  Based on observation interview, the facility feeding was infusing treatment orders were tube (a tube inserted abdomen directly interested in the residents reviewed to 10 and 107)  Findings include:  1. On 9/19/24 at 8:30 observed in his room pump was turned of feeding hanging from 10 of 10	ed by Assistant Director of 24 at 2:30 p.m., indicated urinary ubing shall be positioned to touching the floor directly.  mt/Restore Eating Skills  on, record review, and ty failed to ensure a tube g at the correct time and ere obtained for a gastrostomy d through the wall of the to the stomach) site for 2 of 2 for tube feeding. (Residents  35 a.m., Resident 10 was m in bed. His tube feeding if and there was no tube m the pole.  a.m., the resident was seated in the was being transported to m. The resident was not be feeding at that time.  dent 10 was reviewed on . Diagnoses included, but were thagia (difficulty swallowing), struction, and dementia with y Minimum Data Set (MDS) /24/24, indicated the resident	F 0693	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 agreed 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.  ="""; =""">  """   =""">  Tag number: F693 Tube Feeding  I. What corrective action(s) will accomplished for those resident found to have been affected by deficient practice; Resident 10 had no adverse outcomes related to the alleged deficient practice. Resident 107 had an	10/14/2024  of tonent he et  it be nots y the one of th
	was cognitively imp	paired for daily decision making		order placed to cleanse g-tub	e

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

Event ID:

Z43O11

Facility ID: 008505

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W	NG		09/20/2024	
				CTD FFT A	ADDRESS STEW STATE ZID SOD		
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	LOADE TOLLECT			2350 TA			
APERIO	N CARE TOLLESTO	JN PARK		GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓF	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	and he had a feedin	g tube through which he			site on 9/26/24		
	received 51% or mo	ore of his total calories.			II. How other residents having	the	
					potential to be affected by the		
	A Care Plan, dated	8/1/24, indicated the resident			same deficient practice will be		
	required a peg (pero	cutaneous endoscopic			identified and what corrective		
	gastrostomy tube) tube related to an intestinal				action(s) will be taken; <b>Any</b>		
	obstruction. The resident also received an oral				resident with a g-tube has the	е	
	diet. Interventions included, but were not limited				potential to be affected by the	е	
	to, dependent with tube feeding and water				alleged deficient practice. A		
	flushes, see physician orders for current feeding				full house audit was conduct	ed	
	orders.				to ensure any resident with		
					g-tube has an order to cleans	e	
	-	r, dated 7/27/24, indicated the			the site.		
		eive a tube feeding of Jevity 1.2			III. What measures will be put		
		) an hour, on at 7:00 p.m. and off			place and what systemic chan	•	
	at 9:00 a.m.				will be made to ensure that the		
					deficient practice does not rec	ur;	
	-	v on 9/20/24 at 9:25 a.m., the 200			DON/designee will educate		
	-	ated the resident's tube			nurses on the policy "Tube		
	-	urned off at 9:00 a.m.			Feeding and Care" to include		
	_	vation on 9/18/24 11:05 a.m.			administering the feeding pe	r	
		sked to use the bathroom. At			physicians orders and		
		heeled out of the dining room			obtaining an order to cleanse	<del>)</del>	
	-	ed back to his room. The			site.		
		pervisor (who was also a CNA) acing the resident on the toilet.			IV. How the corrective action(s	•	
	•	was asked to lift up the			will be monitored to ensure the		
		is peg tube (a tube that was			deficient practice will not recur		
		o the stomach for nutrition)			i.e., what quality assurance		
		The peg tube was intact and			program will be put into place;		
		sty drainage around the stoma			DON/designee will audit residents with g-tubes feeding	ae	
		oandage covering the stoma			to ensure they are running at	_	
	site.	sandage covering the stoma			the scheduled times. New	•	
					admissions/readmissions with	th a	
	During an interview	v on 9/18/24 at 11:09 a.m., RN 1			g-tube will be audited to	u	
	-	shed the tube on his shift but			ensure they have an order to		
		d around it. After he had			cleanse g-tube sites . Audits		
		puter, he indicated there were			will be completed 5x week fo	r	
		g tube site to be cleaned.			4 weeks, 3x week for 4 weeks		
	,	<u> </u>			and then weekly x 4 months.		
			1		and then wookly k 4 months.		

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU  ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLE  155580 B. WING 09/20/2		ETED			
	PROVIDER OR SUPPLIER		2350 TA	ADDRESS, CITY, STATE, ZIP COD AFT ST IN 46404		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
	(EACH DEFICIENT REGULATORY OF The record for Resi 9/19/24 at 10:55 a.r were not limited to, blood pressure, psydepressive disorder and type 2 diabetes the facility on 1/4/2 home.  The Quarterly Minited assessment, dated 7 was not cognitively making. The resident feeling down, feeling trouble concentration of swallowing probuith no significant and received a media A Care Plan, revise resident required turn swallowing.  Physician's Orders, peg tube with 100 mediations every vomiting, diarrhea, distention, coughing cyanosis, frothy spurestlessness.	cy MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION dent 107 was reviewed on m. Diagnoses included, but Parkinson's disease, high chotic disorder, major generation, dementia without behaviors, and the resident transferred to define the form another skilled nursing mum Data Set (MDS) (75/24, indicated the resident intact for daily decision and the mood problems such as the generation of the following and weighed 160 pounds weight loss. He had a peg tube thanically altered diet.  In do no 7/23/24, indicated the be feeding related to difficulty dated 4/1/24, indicated flush milliliters (ml) of water every dated 6/28/24, indicated for for tube feeding ye shift including nausea, constipation, abdomen ge, congestion, choking,			I be or ved A nds	
	During an interview	on 9/18/24 at 11:20 a.m., the (DON) indicated there was no				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	00	COMPL	ETED
		155580	B. W	ING		09/20/	/2024
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u>.                                    </u>	
NAME OF P	ROVIDER OR SUPPLIE	R		2350 T	AFT ST		
APERION	N CARE TOLLEST	ON PARK		GARY,	IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	order to cleanse are	bund the peg tube.					
	The current 8/3/20	"Tube-Feeding and Care"					
		the DON on 9/18/24 at 11:28					
		na site care: clean skin with					
		antiseptic of choice, begin next					
	-	sing a spiral pattern moving					
		under the skin disk with a					
	·	noroughly and leave open to					
	air, use a dressing of						
	-						
	3.1-44(a)(2)						
F 0695	483.25(i)						
SS=D	Respiratory/Trach	neostomy Care and					
Bldg. 00	Suctioning						
	Based on observati	on, record review, and	F 0	695	The facility requests paper		10/14/2024
		ity failed to ensure oxygen was			compliance for this citation.		
		ow rate for 2 of 2 residents			This Plan of Correction is the		
	reviewed for respir	atory care. (Residents 236 and			center's credible allegation of		
	55)				compliance.		
	Findings include:				Preparation and/or execution	of	
					this plan of correction does no	t	
	-	observations on 9/16/24 at 2:46			constitute admission or agreei	ment	
		, and on 9/17/24 at 9:08 a.m.,			by the provider of the truth of t	the	
		p.m., Resident 236 was observed			facts alleged or conclusions se	et .	
		r nasal cannula at 2 liters per			forth in the statement of		
	minute (lpm) on the	e room concentrator.			deficiencies. The plan of		
					correction is prepared and/or		
		servations on 9/18/24 at 9:13			executed solely because it is		
		nd 2:05 p.m., and on 9/19/24 at			required by the provisions of		
	·	ent was wearing oxygen per			federal and state law.		
		5 liters per minute on the room			="" j=""> j="">		
		1/18/24 at 8:10 a.m., Assistant			/="">   ="" j="">		
		g (ADON) 2 was in the room xygen was set at 2.5 liters.				.h	
	and marcated the of	Aygen was set at 2.3 mers.			Tag number: F695 Resp/Trac	<b>311</b>	
	The record for Res	ident 236 was reviewed on			I. What corrective action(s) wil	ll he	
		The resident was admitted to the			accomplished for those reside		
	7,17,211,70 p.m.	The resident was admitted to the			accomplished for those reside	1113	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155580	B. W	ING _		09/20/2	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹		2350 T			
APFRION	N CARE TOLLESTO	ON PARK			IN 46404		
	· CANCE TOLLEGIC	O11 / UUX		5,4141,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	•	Diagnoses included, but were			found to have been affected b	•	
	-	monia, high blood pressure,			deficient practice; Resident 55	5	
	hearing loss, joint p	oain, and arthritis.			and resident 236 had no		
	The Admission Minimum Data Set (MDS)				adverse reactions related to		
	assessment was still in progress.				the alleged deficient practice		
	assessment was sun	i iii progress.			Their oxygen flow rate was s to the ordered flow rate.	et	
	The Care Dlan data	ed 9/12/24, indicated the	1			the	
		gen therapy. The approaches	1		II. How other residents having potential to be affected by the		
		gen at 3 liters per minute.	1		same deficient practice will be		
	were to set the oxyg	gen at 5 mers per minute.			identified and what corrective		
	Physician's Orders	dated 9/12/24, indicated			action(s) will be taken; Any		
	-	er minute via nasal cannula			resident on oxygen therapy I	has	
	continuously.	or immute via nasar caimara			the potential to be affected b		
					the alleged deficient practice	-	
	During an interview	v on 9/19/24 at 8:10 a.m., ADON			A full house audit was	·	
	-	gen was set at 2.5 liters and it			completed to ensure any		
	should have been at	-			resident on oxygen therapy I	has	
		:18 a.m. and 12:22 p.m., Resident			their concentrator set on the		
		earing oxygen via nasal			correct flow rate. Any		
	cannula. The oxyge	en flow rate was on at 3 liters.			discrepancies will be		
					immediately corrected.		
	The record for Resi	dent 55 was reviewed on			III. What measures will be put	into	
	-	. The diagnoses included, but			place and what systemic chan	iges	
		anoxic (no oxygen to the			will be made to ensure that the		
	, .	e, dysphagia (difficulty			deficient practice does not rec	ur;	
	swallowing), hyper	tension (high blood pressure),			DON/designee will educate		
	` `	vere brain damage), and			nursing staff on ensuring		
	chronic obstructive	pulmonary disease (COPD).			residents oxygen is set at the	е	
		D G (2.575°)			correct flow rate.		
		mum Data Set (MDS)			IV. How the corrective action(s	´ .	
		1/12/24, indicated the resident			will be monitored to ensure the		
		red for daily decision making			deficient practice will not recui	ſ	
	and the resident req	uired oxygen therapy.			i.e., what quality assurance		
	A Claus D1 1 1 1	2/9/24 : 1:4-141			program will be put into place;		
	· ·	2/8/24, indicated the resident			DON/designee will audit		
		erapy. Interventions were to			residents on oxygen to ensu	re	
	_	spiratory distress and to			their flow rate is set at the	h .	
		settings via nasal cannula per			ordered amount. Audits will	pe	
	oxygen orders.		1		completed on 5 residents a		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W	ING	_	09/20/	/2024
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE TOLLESTO	ON PARK		GARY,	IN 46404		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0759	administer oxygen a continuously every  The Medication Ad indicated oxygen wat 2 liters on 9/16/2.  During an interview Assistant Director of	ministration Record (MAR) as signed out as being given 4. y on 9/19/24 at 9:52 a.m., of Nursing (ADON) 1 indicated ing the oxygen and the			week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 months The results of these audits wil reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achie x4 consecutive weeks. The C Committee will identify any tre or patterns and make recommendations to revise th plan of correction as indicated	II be e s or eved QA ends	
SS=D Bldg. 00	Based on observation interview, the facilitierror rate of less that observed during me were observed during medication at a medication error rate of less that observed during medication at a medication error rate of less that it is medicated at medication error rate of less that is medicated at the less t	on, record review, and ty failed to ensure a medication on 5% for 2 of 6 residents dication pass. Two errors and 33 opportunities for errors administration. This resulted in ate of 6.06%. (Residents 3 and vation of medication pass on, LPN 1 prepared the insuling a for Resident 3. She opened the seal with an alcohol meedle, dialed the pen to 10 did to administer the medication LPN did not prime the pen on of the insuling on 9/20/24 at 9:25 a.m., the 200	F 0'	759	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s 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.  Tag number: F759 Free of Milerror rates 5% or more  I. What corrective action(s) with accomplished for those resides	of ot ment the et	10/14/2024

10/28/2024 PRINTED:

	T OF HEALTH AND HU R MEDICARE & MEDIC					M APPROVED 3 NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/20/2024	
NAME OF	PROVIDER OR SUPPLIEF	· {		ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE TOLLESTO	ON PARK		TAFT ST , IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Unit Manager indic	ated the insulin pen should		found to have been affected by	y the	
	have been primed p	orior to giving the insulin.		deficient practice; Residents 3	3	
				and 126 had no adverse		
	The facility policy	titled, "Insulin Pen Procedure"		outcomes related to the		
	was reviewed on 9/	20/24 at 1:54 p.m. The policy		deficient practice.		
	was provided by the	e nurse consultant and		II. How other residents having	the	
	identified as curren	t. The policy indicated the		potential to be affected by the		
	following, "7. Pri	me the insulin pen. Priming		same deficient practice will be		
	means removing air	r bubbles from the needle, and		identified and what corrective		
	ensures that the nee	edle is open and working. The		action(s) will be taken; All		
	pen must be primed	l before each injection. 8. To		residents receiving medication	on	
		en, turn the dosage knob to the		have the potential to be		
	2 units indicator. W	ith the pen pointing upward,		affected by the alleged		
	push the knob all th	ne way. At least one drop of		deficient practice. A full hous	se	
	insulin should appe	ar. You may need to repeat		audit was completed to ensu	re	
	this step until a dro	p appears"		any discontinued medication	1	
				was removed from the		
				medication cart.		
	2. On 9/19/24 at 8:	41 a.m., LPN 2 was observed		III. What measures will be put	into	
	preparing medication	ons for Resident 126. The LPN		place and what systemic chan	ges	
	placed an Aldacton	e (a blood pressure		will be made to ensure that the	Э	
	medication) 25 mill	ligram (mg) tablet into the		deficient practice does not rec	ur;	
	medication cup and	administered the pill to the		DON/designee to educate		
	resident.			nursing staff on the policy		
				"Insulin Pen Procedure" to		
	The record for Resi	dent 126 was reviewed on		include priming the pen prior	r	
		. A Physician's Order, dated		to administering insulin.		
		e resident's Aldactone had		Nursing staff to be educated	on	
	been discontinued.			removing a medication from		
				the med cart when it is		
	During an interview	v on 9/20/24 at 1:54 p.m., the		discontinued and the proper		
	Nurse Consultant in	ndicated the Aldactone should		procedure to follow when		
	not have been given	n if it was discontinued.		performing med pass.		
				IV. How the corrective action(s	s)	
	3.1-48(c)(1)			will be monitored to ensure the	Э	
				deficient practice will not recur	-	

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i.e., what quality assurance program will be put into place; DON/designee to perform audits on nursing staff

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THE THE TENTE OF THE TENTE THE TENTE	TILL ( BEIL ( TOES		1011.11111
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 0938
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>	COMPLETED

155580 B. WING 09/20/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2350 TAFT ST GARY, IN 46404 APERION CARE TOLLESTON PARK

APERIC	N CARE TOLLESTON PARK	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 0791	483.55(b)(1)-(5)		administering insulin via insulin pen to ensure they are priming pen prior to administration and they are following the correct med pass procedure DON/designee will audit med carts to ensure any discontinued medication has been removed. Audits will be completed 5 times a week x 4 weeks, 3x week x 4 weeks, then weekly 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.		
SS=D Bldg. 00	Routine/Emergency Dental Srvcs in NFs  Based on observation, record review, and interview, the facility failed to ensure a resident had seen the dentist at least yearly for 1 of 2 residents reviewed for dental care. (Resident 88)  Finding includes:  On 9/16/24 at 10:43 a.m., Resident 88 was observed with missing upper and lower teeth. During an interview at that time, the resident indicated he had not seen the dentist since he arrived at the facility in 2022. The resident expressed he wanted dentures and indicated he had been on the dental list for a long time.	F 0791	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	10/16/2024	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII TIDLE CO	ONSTRUCTION	(X3) DATE SURVEY	
		,	(X2) MULTIPLE CONSTRUCTION		î '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED	
155580		155580	B. WING		09/20/2024	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				AFT ST		
APERION CARE TOLLESTON PARK			GARY,	IN 46404		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				provisions of federal and st	ate	
	The record for Resi	dent 88 was reviewed on		law.		
	9/18/24 at 8:45 a.m	. The diagnoses included, but		Tag number: F791 Dental		
	were not limited to,	, hypotension (low blood		Services		
	pressure), anemia (	low iron), adult failure to thrive,		I. What corrective action(s) w	ill be	
		heart failure, kidney disease,		accomplished for those reside	l l	
	and dependence on			found to have been affected be		
		•		deficient practice; Resident 8	<u> </u>	
	The Ouarterly Mini	imum Data Set (MDS)		scheduled to see the dentis		
	I	7/28/24, indicated the resident		10/16/2024.		
		paired for daily decision		II. How other residents having	n the	
	making.	pariou for anny accipien		potential to be affected by the	-	
	making.			same deficient practice will be		
	There was no denta	l care nlan		identified and what corrective		
	There was no denta	ir care plan.		action(s) will be taken; All		
	A Physician's Orde	r, dated 2/5/24, indicated the		residents have the potential	to	
	1	ive dental care as needed.			10	
	resident could recei	ive dental care as needed.		be affected by the alleged		
	During on intervious	v on 9/19/24 at 11:13 a.m., the		deficient practice. A full hou		
	_	ector (SSD) indicated she had		audit was completed to ensu		
		ss reference the previous		any resident who consented		
		which residents had not been		dental care has been seen b	уа	
	I	She indicated Resident 88 had		dentist in the past year.	4 :4	
				III. What measures will be pu		
		dentist since admission		place and what systemic char	_	
		lling with a deviance with his dent had just signed a new		will be made to ensure that the		
		agent had just signed a new application on 8/29/24.		deficient practice does not re		
	senior dentai pian a	ipplication on 8/29/24.		SSD educated on schedulin	<b>-</b>	
	D	0/10/04 + 0.47 + 1		residents who have consent	tea	
	_	v on 9/19/24 at 2:47 p.m., the		to dental care in a timely		
	SSD indicated she was wrong about the resident			manner.	, ,	
	having a deviance with his insurance. She			IV. How the corrective action(	. ,	
	indicated they recognized the resident had not			will be monitored to ensure th		
	seen the dentist since admission and had the			deficient practice will not recu	ır	
	resident sign a new dental agreement on 8/29/24.			i.e., what quality assurance		
		t in the facility on 9/11/24 and		program will be put into place		
	the resident was no	t on the dental list to be seen.		SSD/designee will complete		
				audit all new		
	3.1-24(a)(1)			admission/readmissions to		
			ensure anyone consenting t	:o		

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dental care has an

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DEPARTMENT	OF HEALTH AND	HUMAN SERVICES	
CENTERS FOR	MEDICARE & MI	EDICAID SERVICES	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155580		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/20/2024	
NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
F 0842 SS=D Bldg. 00	Based on record reversal failed to ensure clin complete related to who had pushed and ground for 1 of 1 re (Resident 94)  Finding includes:  The record for Resident 9:45 a.m. not limited to, schiz cellulitis, high blood disorder, anxiety, or disorder.  The 6/15/24 Quarter assessment indicate cognitively intact for A Care Plan, dated	70(i)(1)-(5) - Identifiable Information riew and interview, the facility ical records were accurate and 15 minute checks for a resident other resident down to the sidents reviewed for abuse.  Ident 94 was reviewed on Diagnoses included, buy were ophrenia, morbid obesity, d pressure, major depressive steoarthritis, and bipolar  In Minimum Data Set (MDS) d the resident was not or daily decision making.  7/31/24, indicated the resident be physically aggressive.	F 0842	appointment scheduled in a timely manner. Audits will be conducted 5x week x 4 week then weekly x 5 months.  The results of these audits wi reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achie x4 consecutive weeks. The Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated.  The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of 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.  """> """> """> """> """  Tag number: F842 Resident Records	e (s, ) Il be e e e e e e e e e e e e e e e e e e

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EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039		
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580  NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/20/2024			
NAME OF				ADDRESS, CITY, STATE, ZIP COD				
APERIC	N CARE TOLLEST	ON PARK		, IN 46404				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	indicated the resider roommate. Residen bathroom sitting on entered the bathroo going to hit her, so and hit her first and resident had fallen were separated and different room and checks.  An abuse allegation Administrator on 9, 7/29/24, Resident 9 down. Both residen checks and they bo	rogress Note, dated 7/31/24, and had an altercation with her to 94 indicated she was in the athe toilet and her roommate and told the her she was Resident 94 got off the toilet alleft the room. The other to the ground. Both residents Resident 94 was moved to a was placed on 15 minute and incident, received by the 1/19/24 at 9:40 a.m., indicated on 1/19/24 at 9:40		I. What corrective action(s) accomplished for those reside found to have been affected deficient practice; Resident had no adverse outcomes related to the alleged deficient practice.  II. How other residents having 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 be affected by the alleged deficient practice.  III. What measures will be public and what systemic characteristics.	dents by the 94 ient ig the ie			
	computer in the tast documented in the increments:  - 8/1/24: 12:00 a.m documented was 12  - 8/1/24: was blank  - 8/1/24: 7:00 a.m. documented was 1:  - 8/1/24: 3:00 p.m. documented was 7:  The time document either before the ac	from 1:30 a.m. to 6:45 a.m. to 2:45 p.m., the time 57 p.m. to 8:30 p.m., the time		deficient practice does not re DON/designee will educate nursing staff on completing minutes checks as schedul and documenting the check timely.  IV. How the corrective action will be monitored to ensure the deficient practice will not receive., what quality assurance program will be put into place DON/designee will audit 15 minute checks to ensure the are being completed as scheduled and timely. Aud will be completed 5x week weeks, 3x week x 4 weeks, then weekly x 4 months.	g 15 led ks n(s) hhe e; ney its			
		ninute checks were time		The results of these audits v	vill be			

of the resident.

stamped either before or way after the observation

reviewed in Quality Assurance

until an average of 90%

Meeting monthly for 6 months or

PRINTED: 10/28/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155580 B. WING 09/20/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 3.1-50(a)(2)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. F 0880 483.80(a)(1)(2)(4)(e)(f) SS=D Infection Prevention & Control Bldg. 00 Based on observation, record review, and F 0880 The facility requests paper 10/14/2024 interview, the facility failed to ensure infection compliance for this citation. control practices were in place related to hand This Plan of Correction is the hygiene during glove use for 1 of 1 glucometer center's credible allegation of blood sugar checks observed, staff failing to donn compliance. personal protective equipment (PPE) for a resident who was in enhanced barrier precautions (EBP), Preparation and/or execution of and ensuring Foley (urinary) catheter bags were this plan of correction does not not on the floor during random infection control constitute admission or agreement observations. (Residents 3, 36, and 113) by the provider of the truth of the facts alleged or conclusions set Findings include: forth in the statement of deficiencies. The plan of 1. On 9/18/24 at 4:00 p.m., LPN 1 was observed correction is prepared and/or completing a glucometer (a test to check the executed solely because it is resident's blood sugar) procedure for Resident 3. required by the provisions of The LPN entered the resident's room, proceeded federal and state law. to donn a pair of gloves and completed the Tag number: F880 Infection glucometer check. The LPN sanitized her hands Control after removing her gloves. She did not wash her I. What corrective action(s) will be hands or use hand sanitizer upon entering the accomplished for those residents resident's room or before donning the gloves. found to have been affected by the deficient practice; Residents 3, 36 During an interview on 9/20/24 at 2:28 p.m., the and 113 had no adverse Nurse Consultant indicated hands should be reactions related to the alleged

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prior to donning gloves.

The facility policy titled "Hand

washed and/or sanitized upon room entry so it

would be expected for staff to sanitize their hands

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deficient practices.

II. How other residents having the

potential to be affected by the same deficient practice will be

identified and what corrective

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/20/2024 155580 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **2350 TAFT ST** APERION CARE TOLLESTON PARK **GARY. IN 46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Hygiene/Handwashing" was provided on 9/20/24 action(s) will be taken; All at 1:54 p.m. by the Nurse Consultant and residents have the potential to identified as current. The policy indicated hand be affected by the alleged hygiene should be completed at room entry. deficient practices III. What measures will be put into 2. During a random observation on 9/16/24 at place and what systemic changes 11:07 a.m., CNA 1 was observed wearing gloves will be made to ensure that the and having close contact with Resident 36 by deficient practice does not recur; providing incontinence care and pulling up the DON/designee to educate resident' new brief and pants. There was a sign nursing staff on the policies above the resident's bed that indicated EBP for "Hand Hygiene/Handwashing" close contact: required a gown and gloves. and "Urinary Catheter Care" to include washing hands prior to During an interview at that time, CNA 1 indicated gloving and preventing urinary she thought the EBP was for the resident who bags/tubing from touching the resided in the first bed. She did not see the sign above Resident 36's bed. IV. How the corrective action(s) will be monitored to ensure the The record for Resident 36 was reviewed on deficient practice will not recur 9/20/24 at 8:18 a.m. Diagnoses included, but were i.e., what quality assurance not limited to, peripheral vascular disease and program will be put into place; dementia. DON/designee will conduct visual audits to ensure hand Physician's Orders, dated 5/14/24, indicated hygiene is taking place prior to Enhanced Barrier Precautions related to wounds gloving and that catheter and infection to left lower leg. bags/tubing are not touching the floor. Audits will be Physician's Orders, dated 9/13/24, indicated completed on 5 residents and 5 Gentamicin Sulfate External Ointment 0.1 %, apply nurses a week x 8 weeks, then to left lower extremity for wound healing. 3 resident's and 3 nurses a week x 4 months. The Wound Physician note, dated 9/13/24, The results of these audits will be indicated the resident had an arterial wound on reviewed in Quality Assurance the left lower leg that measured 9.5 centimeters Meeting monthly for 6 months or (cm) by 3 cm and had blue-green drainage. until an average of 90% compliance or greater is achieved During an interview on 9/19/24 at 1:50 p.m., x4 consecutive weeks. The QA Assistant Director of Nursing (ADON) 2 indicated Committee will identify any trends the resident was in EBP and the CNA should have or patterns and make donned a gown prior to contact. recommendations to revise the

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155580	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>		SURVEY LETED 0/2024
NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK		STREET ADDRESS, CITY, STATE, ZIP COD 2350 TAFT ST GARY, IN 46404				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE ROPRIATE	(X5) COMPLETION DATE
	p.m. and on 9/17/24 observed in bed and bag was on the flood During random obsa.m., 10:51 a.m., 11 resident was observed at those times, the stubing were observed wheelchair.  The record for Resi 9/19/24 at 12:00 p. not limited to, strok obstructive and refl hyperplasia, and ret The 8/19/24 Quarte assessment indicate cognitively intact for had an indwelling of Physician's Orders, Foley catheter 18 F. centimeters (cc) ball The resident had no infection.  During an interview Director of Nursing placing a leg bag or tubing from touching The current and rev Care" policy provide	ervations on 9/18/24 at 9:10 :10 a.m., and 1:57 p.m., the ed sitting in his wheelchair. resident's catheter bag and ed on the floor under his  dent 113 was reviewed on m. Diagnoses included, but were e, chronic kidney disease, ux uropathy, benign prostatic ention of urine.  rly Minimum Data Set (MDS) d the resident was not or daily decision making and atheter for urine.  dated 11/15/23, indicated rench with a 10 cubic loon to gravity drainage.  history of an urinary tract  of on 9/18/24 at 4:00 p.m., the indicated she would be at the resident to prevent the		plan of correction as indic	cated.	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
155580		155580	B. WING		09/20/2024		
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				2350 TA			
APERION CARE TOLLESTON PARK				IN 46404			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	drainage bags and to	abing shall be positioned to					
		touching the floor directly.					
	•	Ç					
	3.1-18(b)						
F 0921	483.90(i)						
SS=E	` '	anitary/Comfortable Environ					
Bldg. 00	Oalc/i dilctional/o	aritary/Gormortable Eriviron					
Diag. 00	Based on observation	on and interview, the facility	F 09	221	The facility requests paper		10/14/2024
		residents' environment was	1 0.	/21	compliance for this citation.		10/14/2024
		epair related to dirty and			This Plan of Correction is the		
	_	s, marred walls, dirty and			center's credible allegation of		
		broken mini blinds, dirty and			compliance.		
	_	issing toilet bolt covers, and					
		ad the toilet for 3 of 3 units			Preparation and/or execution of	of	
	observed. (North, S				this plan of correction does no		
	,	,			constitute admission or agreer		
	Findings include:				by the provider of the truth of t		
	C				facts alleged or conclusions se		
	During the environr	nental tour with the			forth in the statement of		
	_	ousekeeping Supervisors on			deficiencies. The plan of		
		, the following was observed:			correction is prepared and/or		
					executed solely because it is		
	1. North Unit				required by the provisions of		
					federal and state law.		
	a. In Room 124, the	floor in the room was			Tag number: F921 Environme	ntal	
	discolored and had	an accumulation of dirt and			I. What corrective action(s) wil	l be	
	debris along the bas	eboard throughout the room.			accomplished for those reside	nts	
	The left closet door	was off the track. There was			found to have been affected by	y the	
	dirt and debris along	g the track of the closet door.			deficient practice; No residents	S	
	The bathroom floor	had dirt and debris along the			were affected by the alleged		
	base board. There w	vas no trash can in the room.			deficient practice. Rooms 124,		
					127, 128, 201, 202, 213, 302,	313,	
		entry way trim had build-up of			314, and 318 will have all		
		ind the entry doorway there			necessary repairs completed b	ру	
		rt and debris. The floor in the			date of compliance.		
		ulation of dust and debris on			II. How other residents having	the	
		the base board. The floor tile			potential to be affected by the		
	was scuffed.				same deficient practice will be		
					identified and what corrective		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155580	B. W	B. WING		09/20/2024	
<u> </u>				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			AFT ST		
APERIO	N CARE TOLLESTO	ON PARK			IN 46404		
	Г		<u> </u>		 I		are:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION e door to the room was marred		TAG		-1 4	DATE
	· · · · · · · · · · · · · · · · · · ·				action(s) will be taken; All resi		
		floor in the room was dirty on			rooms/common areas have th		
		dried food spillage and debris			potential to be affected by the		
		throom walls were scratched			alleged deficient practice.The		
		or was dirty and the tile was			Maintenance		
	scuffed.				Director/Housekeeping Super		
	1 1 D 120 /1	Cl 1: 4 :41 CC			performed a 100% audit of the		
		e floor was dirty, with scuff			facility regarding any needs fo		
	_	The bathroom door was			wall repair, cleaning of rooms		
		ed, the floor in the bathroom			overall condition of each room		
		ecumulation of dirt and debris			III. What measures will be put		
	_	he tiles were discolored and			place and what systemic chan	٠ ا	
		rack in the bathroom was			will be made to ensure that the	e	
		all. The toilet bolts were dirty			deficient practice does not		
	and rusty. The totle	t bolt covers were missing.			recur;Administrator to re-educ	ate	
	<b>2</b> G . d <b>11</b>				Maintenance		
	2. South Unit				Director/Housekeeping Super	visor	
	I D 201 1				on ensuring Comfortable		
		e mini blinds were broken in			environment for all residents to	0	
	multiple areas on th	e blind.			include wall repairs, painting,		
	1 1 5 202 1				cleanliness.	,	
		e blinds were missing and			IV. How the corrective action(s	· .	
	broken.				will be monitored to ensure the		
	I D 212 1	11			deficient practice will not recui	ſ	
		e wall next to the bed was			i.e., what quality assurance		
		ed spillage on the base of the			program will be put into		
		The floor in the room with			place; Maintenance		
	_	s present. The door to the			director/designee will audit 5		
		ched and marred. The walls in			resident rooms weekly for any	У	
		narred. There were no toilet			necessary repairs.	]	
		oilet. The tile strip leading to			The results of these audits wil		
	ine room had an acc	cumulation of dirt buildup.			reviewed in Quality Assurance		
	A DOM				Meeting monthly for 6 months	or	
	3. PCU				until an average of 90%		
	I D 202 4	C			compliance or greater is achie		
		e floor was scuffed and marred			x4 consecutive weeks. The Q		
		hroom. The toilet had rusty			Committee will identify any tre	nds	
		toilet bolt covers, and caulk			or patterns and make		
	_	toilet. The trim was missing to			recommendations to revise the		
	the entrance to the	room.	1		I plan of correction as indicated		

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
		155580	B. WIN	IG		09/20/	2024
NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				2350 TA	IN 46404		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	tile. The walls were bathroom. The toile the floor was dirty in the floor in the room marks, the bathroom dusty, the toilet bolt toilet bolt covers, the rusty bolts and adher the baseboard.  d. In Room 318, the dusty and dirty.  During an interview Director and the Ho 9/20/24 at 3:23 p.m. aware of the issues were working on it	e bathroom were walls marred, in was scuffed with black in ceiling vent was dirty and its were rusty and missing the inere was dried urine by the ered dirt on the floor against e bathroom ceiling vent was  with the Maintenance busekeeping Supervisor on, they indicated they were with the environment and					

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