

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Tolleston Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 Taft St Gary, IN 46404	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

TITLE

(X6) DATE

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to conduct a thorough investigation of an allegation of abuse for 1 of 2 residents reviewed for abuse. (Resident B)Finding includes:An Indiana Department of Health (IDOH) report form, dated 12/19/25 at 9:01 a.m., indicated Resident C had reported to the Administrator that a male entered his room several times during the night and touched his roommate, Resident B, inappropriately. Resident C became very agitated, was evaluated by the Nurse Practitioner, who indicated he was having an acute exacerbation of his mental illness. Investigation included review of staffing and camera footage. The preventive measure taken was sending Resident C to the ER for psychiatric evaluation. The incident follow-up documented that Resident C was admitted to the hospital, and the care plan would be adjusted upon his return to the facility.The facility investigation notes, received as complete from the Administrator on 12/30/25 at 11:20 a.m., indicated the Director of Nursing performed a head-to-toe assessment on Resident B on 12/19/25, and no redness or bruising was observed. In an investigation note dated 12/19/25, the Administrator indicated when he asked Resident B if anyone touched him, he shook his head no, and when he asked if he was ok, he nodded yes. The administrator indicated, . there were no signs of any psychosocial or distress issues with him. The investigation record lacked interviews with other residents and employees.During an interview on 12/30/25 at 1:20 p.m., Resident C indicated he told the Administrator that he observed CNA 1 have oral sex with Resident B, who was unable to speak or take care of himself. Resident C indicated this led to a verbal altercation which resulted in him being sent to the hospital.During an interview on 12/30/25 at 1:47 p.m., QMA 1 indicated Resident B could not communicate-verbal or non-verbally. She indicated she could tell if he was happy or tired, but that was all. On 12/30/25 at 1:50 p.m., Resident B was observed in his wheelchair in the hallway near the nurse's station. He was awake, with his eyes open, but did not respond to verbal stimuli. No verbal or non-verbal engagement was observed. The record for Resident B was reviewed on 12/30/25 at 11:25 a.m. Diagnoses included, but were not limited to, spastic diplegic cerebral palsy, dysphagia, Down syndrome, intellectual disabilities and adult failure to thrive.The Annual Minimum Data Set (MDS) assessment, dated 9/26/25, indicated the resident had severe cognitive impairment, was rarely/never understood, and was dependent in activities of daily living (ADLs).The record for Resident B lacked any documentation about the reported incident on 12/19/25. There was no psychosocial follow-up assessment or notification of family/responsible party of the abuse allegation or investigation. During an interview on 12/30/25 at 3:15 p.m., the Administrator indicated no interviews with staff or other residents were conducted, no further assessments were performed for Resident B, and no family/responsible party was notified of the abuse allegation. A policy titled, Abuse Prevention and Reporting-Indiana, received as current from the Administrator on 12/30/25 at 11:22 a.m., indicated, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of goods and services by staff or mistreatment . This will be done by: . Filing accurate and timely investigative reports . All incidents will be documented, whether or not abuse . was alleged or suspected. Any incident or allegation involving abuse . will result in an investigation. Investigative Procedures: The appointed investigator will, at minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident, and the resident, if interviewable . Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual.This citation relates to Intake 2701897.3.1-28(d)</p>		