STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Tolleston Park	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to shaving, nail care, providing showers, and incontinence care for 6 of 11 residents reviewed for ADLs. (Residents H, E, G, D, F, B)Findings include: 1.During an interview on 2/16/26 at 3:24 p.m., Resident H indicated staff did not set him up to brush his teeth. He also indicated the razors were dull and shaving was very brutal, he would like an electric razor but no one had offered one. On 2/17/26 at 10:30 a.m., the resident was observed in his room and he had a large amount of facial hair. On 2/18/26 at 7:45 a.m. and 12:30 p.m, the resident's facial hair remained and oral care had not been provided. On 2/19/26 at 11:10 a.m., the resident had a large amount of facial hair and he indicated his teeth had not been brushed. At 11:17 a.m., CNA 3 searched the resident's drawers and she was unable to find a toothbrush or toothpaste. She indicated the midnight staff had gotten the resident up and dressed before she arrived to work. She had not completed or set up the resident to provide oral care. The record for the resident was reviewed on 2/19/26 at 2:20 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, chronic kidney disease, anxiety disorder, pain right wrist, and insomnia. The 2/7/26 5 Day Medicare Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident needed partial to moderate assistance with oral hygiene and bathing. A Care Plan, dated 1/31/26, indicated the resident had an ADL (activities of daily living) self-care/mobility performance deficit that could fluctuate with activity throughout the day. Interventions included, but were not limited to, oral hygiene was to be performed in the morning, after meals, and at bedtime. Brush teeth, rinse dentures, cleans gums with a toothette (a sponge on a stick used for oral care), and rinse mouth with wash. Supervision or touching assistance was needed for personal hygiene. Oral hygiene in the CNA task section indicated the resident was provided with oral hygiene 1/30/26 through 2/18/26 except for the days he was hospitalized . The resident was hospitalized [DATE]-[DATE]. Personal hygiene in the CNA task section indicated the resident was provided personal hygiene care 1/30/26 through 2/18/26 except for the days he was hospitalized . The resident was hospitalized [DATE]-[DATE]. There was no documentation the resident refused oral care. During an interview on 2/19/26 at 11:20 a.m., the Assistant Director of Nursing (ADON) was given the information and had no additional information to provide. During an interview on 2/19/26 at 11:55 a.m., the Director of Nursing indicated the facility had an electric razor the resident could have used. She had no additional information to provide. 2. On 2/16/26 at 11:20 a.m., Resident E was observed with food on his clothes, crumbs in his beard, his face was dry with peeling skin, and his hair was greasy. Staff were in the area, however, no one cleaned his face. On 2/18/26 at 12:10 p.m., the resident was seated in a chair in the dining room. He had dried mucus hanging from his nose and his hair remained greasy. At 12:20 p.m., the resident was removed from the dining room and checked for incontinence. When he (continued on next page)

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	returned to the dining room, his nose had been cleaned. At 4:15 p.m., the resident was seated in his wheelchair in the dining room. The front of his pants and in between his legs were wet. At 4:20 p.m. CNA 4 indicated she was going to take the resident to the bathroom and change him. When asked when the last time was that she checked or changed him, the CNA indicated it was before lunch and he was dry and she also checked him after lunch which was probably a little after 1:00 p.m. and the resident would not let her check him. This was the next time she had checked him for incontinence. She indicated at that time, she was supposed to check and change residents at least every two hours. On 2/19/26 at 9:19 a.m., the resident was seated in a wheelchair at a table in the dining room. He had food from breakfast on his face and crumbs on his clothes. Staff in the area had not wiped off his face or clothes. At 9:30 a.m., the resident was observed to self propel himself to the window where he liked to sit. At 9:40 a.m., a CNA moved him back to the table. The food crumbs remained on his face. The record for Resident E was reviewed on 2/20/26 at 9:15 a.m. Diagnoses included, but were not limited to, major depressive disorder, schizophrenia, autistic disorder, anxiety disorder, and intellectual disabilities. The 1/16/26 Annual Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident needed supervision with eating, toileting, and personal hygiene. He needed substantial to maximum assistance with toilet transfers. A current Care Plan indicated the resident had an ADL (activities of daily living) self-care/mobility performance deficit that may fluctuate with activity throughout the day. Interventions included, but were not limited to, supervision with eating and substantial to maximum assistance with toileting hygiene. Documentation related to urinary incontinence in the CNA task section indicated documentation was completed at least three times a day and the resident was mostly incontinent. There were some days when the resident was continent. Personal hygiene in the CNA task section had been signed out every shift for the last 14 days. There was no documentation indicating the resident refused care. During an interview on 2/19/26 at 11:20 a.m., the Assistant Director of Nursing (ADON) indicated the resident was supposed to be checked and changed at least every 2 hours. During an interview on 2/19/26 at 12:00 p.m., the Director of Nursing was given the information and had no additional information to provide. 3. On 2/16/26 at 2:55 p.m., Resident G was seated in her wheelchair by the nurse's station. The resident was observed with a large amount of white facial hair on her chin and face. On 2/17/26 at 10:33 a.m., the facial hair remained on the resident's chin. On 2/18/26 at 2:00 p.m. and 3:50 p.m., the facial hair remained on the resident's chin. On 2/19/26 at 9:10 a.m., the resident was observed in bed and the facial hair remained on her chin. The record for Resident G was reviewed on 2/18/26 at 1:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia without behavior disturbance. The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 12/9/25, indicated the resident was not cognitively intact for daily decision making. The resident needed partial to moderate assistance with personal hygiene. A Care Plan, dated 9/4/25, indicated the resident had an ADL (activities of daily living) self-care/mobility performance deficit that would fluctuate with activity throughout the day. Interventions included, but were not limited to, partial to moderate assistance was required for personal hygiene. Documentation in the Task Section of the record indicated the resident received a bed bath on 1/22 and 2/12/26 and a shower on 1/26, 1/29, 2/5, and 2/9/26. The resident refused bathing on 2/2, 2/16, and 2/18/26. There was no documentation the resident refused personal hygiene between 1/21 and 2/19/26. During an interview on 2/19/26 at 12:00 p.m., the Director of Nursing was given the information and had no additional information to provide. 4. During an interview on 2/16/26 at 11:00 a.m., Resident D was observed with a growth of facial hair and dirty fingernails to the left hand. At the time, the resident indicated it had been (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	several days since he had been shaved and he preferred to be clean shaven.On 2/17/26 at 2:00 p.m., the resident's fingernails remained dirty and he had not been shaved. On 2/18/26 at 12:15 p.m., the resident had been shaved, however, his fingernails remained dirty. During an interview at that time, the resident indicated he received a shave that day. The record for Resident D was reviewed on 2/18/26 at 12:47 p.m. Diagnoses included, but were not limited to, major depressive disorder, psychotic disorder, dementia without behaviors, and anxiety disorder. The 12/24/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident had no behaviors and required substantial to maximum assistance for personal hygiene. A current Care Plan indicated the resident had an ADL (activities of daily living) self-care performance deficit related to rhabdomyolysis (muscle breakdown), gait abnormality, lack of coordination, and cognitive deficit. Interventions included, but were not limited to, substantial to total dependence on staff for personal hygiene. There was no documentation the resident refused personal hygiene between 2/5/26 and 2/18/26. During an interview on 2/19/26 at 11:20 a.m., the Assistant Director of Nursing indicated she cleaned the resident's fingernails the previous afternoon and she shaved him on Tuesday during the late afternoon. 5. On 2/16/26 at 3:58 p.m., Resident F was observed with facial hair on her chin and face and her fingernails were long and jagged.On 2/17/26 at 11:14 a.m., the facial hair remained on the resident's face and chin and her fingernails remained long and jagged. On 2/18/26 at 7:58 a.m., the resident was dressed and propelling her wheelchair. The facial hair remained on her face and chin and her fingernails were jagged. At 12:15 p.m. and 4:10 p.m., the resident's facial hair had not been removed. The record for Resident F was reviewed on 2/18/26 at 8:03 a.m. Diagnoses included, but were not limited to, type 2 diabetes, depression, and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 1/23/26, indicated the resident was not cognitively intact for daily decision making and needed substantial to maximum assistance for personal hygiene. A Care Plan, dated 4/23/25, indicated the resident had a ADL (activities of daily living) self-care/mobility performance deficit that would fluctuate throughout the day related to dementia. Interventions indicated the resident required partial to moderate assistance with personal hygiene. There was no care plan indicating the resident refused to be shaved as well as no documentation indicating the resident refused to be shaved. The shower documentation in the Task section of the record indicated the resident had a shower on 1/23, 1/30, and 2/3/26. The resident received a bed bath on 1/20, 1/27, 2/6, 2/10, and 2/13/26. The resident had refused bathing on 2/15/26. During an interview on 2/19/26 at 11:15 a.m., CNA 3 indicated she was able to shave the resident that day.During an interview on 2/19/26 at 11:20 a.m., the Assistant Director of Nursing indicated the resident was shaved that day and had no additional information to provide. 6. The closed record for Resident B was reviewed on 2/17/26 at 2:35 p.m. Diagnoses included, but were not limited to, non-traumatic subarachnoid hemorrhage (bleeding of the brain) and chronic respiratory failure. The resident was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. The 11/24/25 admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident required substantial to maximum assistance for bathing. A Care Plan, dated 11/22/25, indicated the resident had an ADL (activities of daily living) self-care/mobility performance deficit that would fluctuate throughout the day related to activity intolerance. Interventions included, but were not limited to, adjust provision of ADLs to compensate for resident's changing abilities and the resident required substantial to maximum assistance with bathing. Shower documentation provided by the facility indicated the resident did not receive a shower on 11/24, 12/1, and 12/8/25. The resident received a shower on 12/4 and 12/11/25 and a bed bath on 11/27 and 12/15/25. A Nurse's Note, dated 12/3/25 at 1:54 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., indicated the resident had received a shower and her hair was washed. A Nurse's Note, dated 12/7/25 at 8:20 a.m., indicated the resident received patient care from the CNA. During an interview on 2/19/26 at 11:50 a.m., the Director of Nursing was informed the resident did not receive at least two showers a week and she had no additional information to provide. This citation relates to Intake 2705437. 3.1-38(a)(3)(A)3.1-38(a)(3)(C)3.1-38(a)(3)(D)3.1-38(a)(3)(E)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were provided with adequate supervision to prevent falls and accident hazards were not present in resident rooms for 2 of 3 residents reviewed for accidents. (Residents B and C)Findings include: 1.The closed record for Resident B was reviewed on 2/17/26 at 2:35 p.m. Diagnoses included, but were not limited to, subarachnoid hemorrhage (bleeding in the brain) and chronic respiratory failure. The resident was admitted to the facility on [DATE], had a hospital admission on [DATE], returned to the facility briefly on 12/18/25, then was readmitted to the hospital on [DATE]. The admission Minimum Data Set (MDS) assessment, dated 11/24/25, indicated the resident was not cognitively intact for daily decision making. She had no history of falls, was dependent on staff for toileting, and was dependent on staff for transfers from the bed to the chair. A Care Plan, dated 11/22/25, indicated the resident was at risk for falls due to incontinence. Interventions included, but were not limited to, anticipate and meet the resident's needs, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, the resident needed prompt response to all requests for assistance, and ensure the resident was wearing appropriate footwear when ambulating or mobilizing in her wheelchair. A Fall Occurrence Note, dated 11/27/25 with no time, indicated the resident fell in front of the nursing station. A loud noise was heard and the resident was observed on the ground lying on her right side. Her wheelchair was tipped over and lying next to her. The resident indicated she was leaning forward to straighten her shoes and she tipped over. Interventions implemented were increased supervision and neuro checks were initiated. A Nurse's Note, dated 12/18/25 at 8:50 p.m., indicated staff were called into the resident's room by the CNA because the resident was found on the floor. When asked what happened, the resident indicated she was trying to go sit in her chair, she slid but was not hurt. The resident was assessed with no apparent injury. The Initial Fall Occurrence Note, dated 2/18/25 at 8:15 p.m., indicated the resident had an unwitnessed fall in her bathroom. During an interview on 2/18/26 at 3:26 p.m., the North Unit Manager indicated the resident was left on the toilet by herself and fell to the floor on 12/18/26 while attempting to transfer herself. The resident should not have been left alone on the toilet. 2. During a random observation on 2/17/26 at 11:05 a.m., Resident C was ambulating in his room. His right foot, ankle, and lower leg were visibly swollen. At that time, he indicated he hurt his foot a few days prior when he was trying to fix his broken closet door and it hit his foot. The closet door, visible from the doorway, was out of the track and hanging down, away from the closet. He indicated staff was aware, and he had tests done on his foot, but they did not show anything. He could walk with a cane, but his foot pain was making it difficult for him to walk. On 2/18/26 10:11 a.m. the resident was observed propelling himself in a wheelchair down the hallway (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with only the left shoe on. At that time, he indicated he could not walk due to the pain in his right foot and ankle, and his shoe wouldn't fit due to the swelling. The closet door remained hanging off. On 2/18/26 at 3:50 PM p.m., the resident was observed walking in hallway with cane, not wearing his right shoe. At that time, he indicated the pain medicine was helping him feel well enough to walk. On 2/19/26 at 3:00 p.m., the closet door was observed and remained hanging off of the track. The resident's record was reviewed on 2/18/26 at 4:56 p.m. The Quarterly Minimum Data Set (MDS) assessment, dated 1/9/26, indicated the resident was cognitively intact for daily decision making, and required supervision assistance with ADLs. In a follow-up note, dated 2/13/26, Nurse Practitioner 1 indicated, . Patient previously reported right foot pain after he states he hurt his foot on closet in room . During an interview on 2/19/26 at 3:48 p.m., Unit Manager 1 indicated the resident had doppler (a test of blood flow) and x-rays of his foot completed, but he did not tell her how it started hurting. She indicated she would have maintenance come fix the closet door. During an interview on 2/24/26 at 10:15 a.m., the Director of Nursing was informed of the findings and offered no additional information. This citation relates to Intake 2705437. 3.1-45(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure a medical record was complete and accurately documented related to a resident death for 1 of 5 residents reviewed for accidents. (Resident J)Finding includes:Resident J's record was reviewed on 2/20/26 at 2:36 p.m. Diagnoses included, but were not limited to, end stage renal disease.A Death in Facility Minimum Data Set (MDS) entry was completed on 12/11/25.A Progress Note, dated 12/11/25 at 9:39 a.m., indicated the resident had left the facility to go to dialysis. No acute distress noted at this time. There were no further progress notes documented.During an interview on 2/24/26 at 10:25 a.m., the Director of Nursing indicated the resident had gone out to dialysis and coded while there. She had passed away that day and had not returned to the facility. The resident's death had not been documented in the progress notes, but her discharge would have been reflected in the midnight census.This citation relates to Intake 2712287.3.1-50(a)(1)