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	06/11/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview, the facility failed to prevent an avoidable pressure ulcer for an at-risk dependent resident resulting in the resident developing a facility-acquired stage four (full thickness of the skin) pressure ulcer with infection to the buttocks one month after admission to the facility. (Resident B)The immediate jeopardy began on 5/26/26, when the nursing staff found a malodorous stage four pressure ulcer to the buttocks which tested positive for infection when cultured. The Administrator, RN Corporate Wound Specialist, RN Consultant, Corporate Minimum Data Set (MDS) Nurse, and Director of Nursing (DON) were notified of the immediate jeopardy on 6/10/26 at 3:06 p.m. The immediate jeopardy was removed and the deficient practice corrected on 6/9/26, prior to the start of the survey, and was therefore Past Noncompliance. Finding includes: Resident B's closed record was reviewed on 6/10/26 at 9:54 a.m. The diagnoses included, but were not limited to, Parkinson's disease, stroke, and malignant cancer of the bladder.An admission Braden Scale assessment, dated 4/24/26, indicated a moderate risk for pressure ulcers.The Nursing admission Assessment, dated 4/24/26, indicated the skin was warm to touch, moist, and there were no pressure areas.A Nurse's Note, dated 4/25/26 at 10:10 a.m., indicated a risk for pressure areas. Maximum assistance was required for activities of daily living, the resident was incontinent of bowel and bladder, and redness was observed on the buttocks. Heel floats and an air mattress were in place.There were no further assessments of the redness of the buttocks. An admission Minimum Set Set (MDS) assessment, dated 4/27/26, indicated a moderately intact cognitive status, no impairment of the upper extremities, impairment of the bilateral lower extremities, maximum to dependent assistance required for toileting, bathing and hygiene, and moderate assistance was required for bed mobility. The resident was always incontinent of bowel and bladder, was a risk for pressure ulcers, and had no pressure ulcers/injuries present.A Care Plan, dated 4/27/26, indicated a potential for impaired skin integrity related to impaired mobility and incontinence. The interventions included, changes in the skin status would be reported to the physician.A Care Plan, dated 4/27/26, indicated bowel and bladder incontinence. The interventions included barrier cream was to be used after each incontinent episode, the resident would be checked and changed every two to three hours and as needed and incontinence care would be completed.A Weekly Skin Assessment, dated 5/22/26 at 1:41 p.m., indicated the skin was intact and no concerns were noted.A Nurse's Note, dated 5/26/26 at 9:00 p.m., indicated a pressure wound to the coccyx was observed. The measurement of the wound was 7 centimeters (cm) in length by 9 cm in width and 1.5 cm depth. The wound was draining a tan colored drainage. Treatment orders for the wound were obtained and a wound culture was completed.A Wound Nurse Progress Note, dated 5/27/26 at 12:53 p.m., indicated the coccyx wound measured 3.8 cm in length by 5 cm width with 1.8 cm depth. There was moderate purulent and malodorous drainage. The resident was a high risk for skin breakdown related to poor bed mobility, incontinence, chronic obstructive pulmonary disease and hemiparesis.A Wound Assessment Details Report, dated 5/27/26 at 5:37 a.m. and completed by the Wound Nurse, indicated the area on the coccyx was 30% red and 70% slough (a yellowish, soft, and often stringy material that forms in wounds as a result of dead or dying tissue, protein buildup, and bacterial contamination). The clinical stage was a stage four.The Wound Nurse Practitioner (NP) Progress Note, dated 5/29/26, indicated the wound culture showed multiple (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	bacteria in small quantities and a broad band antibiotic was ordered. There was a moderate amount of serosanguineous drainage with a strong odor from the wound. The wound had 71-80% eschar (a thick, dry layer of dead, necrotic tissue) and a surgical debridement was completed. The post debridement measurements were 3.9 cm length by 3.6 cm width by 2 cm depth.A Nurse's Note, dated 5/29/26 at 11:54 a.m., indicated the Wound NP ordered doxycycline (antibiotic) 100 milligrams (mg) twice a day for seven days. An X-Ray of the sacrum was also ordered to rule out osteomylitis (infection and inflammation of the bone.)The results of the sacrum X-Ray, dated 5/29/26, indicated the resident had been moving and yelling out during the testing due to pain, which resulted in suboptimal x-rays. An MRI was recommended to rule out osteomylitis.A Nurse's Note, dated 6/3/26 at 3:43 p.m., indicated the resident's blood pressure was 88/66 and pulse was 105. The NP ordered IV (intravenous) antibiotics.A Physician's Order, dated 6/3/26, indicated meropenem (antibiotic) 1 gram per IV every eight hours for bacterial infection for seven days.A Nurse's Note, dated 6/3/2026 at 4:24 p.m., indicated an IV was placed in the left hand.A Nurse's Note, dated 6/4/26 at 2:14 a.m., indicated the resident pulled the IV out.A Nurse's Note, dated 6/4/26 at 9:37 a.m., indicagted the resident's blood pressure was 88/58 and pulse was 108 and there were complaints of pain. A physician's order was obtained to transfer the resident to the hospital.A Nurse's Note, dated 6/4/26 at 4:56 p.m., indicated the resident had been admitted to the hospital.An NP progress Note, dated 6/4/26 at 11:45 p.m., indicated the resident had developed worsening sacral wound pain and infection. The wound culture grew moderate Pseudomonas aeruginosa. The antibiotics were changed from doxycycline to ciprofloxacin, then escalated to IV meropenem due to persistent infection and elevated C-reactive protein (CRP, used to detect general inflammation). The IV was pulled out by the resident during the night and staff were unsuccessful with reinsertion. This morning the resident had chills and experienced recurrent hypotension. She was transferred to the hospital Emergency Room.The Hospital History and Physical, dated 6/4/26, indicated the resident was admitted into the hospital with severe sepsis and wound infection.During interviews on 6/10/26 at 1:07 p.m., the Director of Nursing (DON) indicated the staff who had been assigned to the resident were interviewed and had said they either had not seen the area or the resident refused care. She indicated the resident was assessed with a red area on her butttocks on admission and barrier cream after incontinence care was initiated. She was unsure how the pressure area had not been observed by the staff when they were providing incontinence care, bathing, and other care multiple times daily.The past noncompliance immediate jeopardy began on 5/26/26. The immediate jeopardy was removed and the deficient practice corrected by 6/9/26 after the facility implemented a systemic plan that included the following actions:The facility determined a deficiency in their wound assessment program on 5/26/26 and immediately implemented a plan of improvement. An assessment and interventions were initiated for Resident B on 5/26/26. The facility educated 27 of 27 nurses on skin assessments that were to be completed weekly with the CNA and documented in the record. The assessments were to be co-signed by the nurse and the CNA. All skin impairments were to have a Risk Management Form initiated and the Physician and Responsible Party were to be notified. A treatment for the area was to be obtained and initiated. The DON and Wound Nurse were to be notified. The facility educated 57 of 57 CNA's that all skin impairments were to be reported to the nurse immediately and documented in the chart. They were to monitor and inspect the skin during all care provided. A full house skin sweep was conducted to ensure no other resident were affected. A full house audit was completed to ensure all interventions were in place and accurate. Seven Nurses, one QMA, and six CNA's from different shifts were interviewed and all were knowledgeable of the policies and procedures they were educated on. Audits had been completed and were still ongoing to ensure weekly skin assessments were completed timely and accurately and preventative skin interventions were in place. All information would be reviewed and submitted to the facility's Quality Assurance Program.This citation relates to Intake 3033261.410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(1)410 IAC 16.2-3.1-40(a)(2)