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 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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a skin assessment was completed following an angiogram for 1 of 1 resident reviewed for change in condition and medications were administered as ordered for 3 of 5 residents reviewed for unnecessary medications. (Residents G, 24, 72, and 96)Findings include: 1. The record for Resident G was reviewed on 2/18/26 at 1:30 p.m. Diagnoses included, but were not limited to, heart failure and peripheral vascular disease. 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. A Nurse's Note, dated 12/1/25 at 6:32 p.m., indicated the resident arrived back to the facility from a physician's appointment. The resident was alert and in no distress. The resident was scheduled for a follow up appointment on 12/23/25 at 8:30 a.m. A note from the vein clinic, dated 12/1/25, indicated the resident had an angiogram (a minimally invasive procedure to visualize blood flow and diagnosis blockages or damage) and discharge instructions were given to her. A hand written note on the bottom of the page indicated the resident was to have a right angiogram on 12/23/25. The next documented entry in the nurse's notes was on 12/3/25, and was completed by behavioral health. There was no documented assessment of the area after the angiogram. There was also no documentation related to the resident going to her appointment on 12/23/25. Discharge instructions from the vein clinic on 12/23/25 indicated the resident had a right angiogram. Again, there was no documentation of an assessment to the area after the angiogram. Nurse's Notes, dated 1/4/26 at 4:05 p.m., indicated the resident had an appointment for a left angiogram on 1/21/26 at 10:00 a.m. Nurse's Notes, dated 1/21/26 at 8:45 a.m., indicated the resident exited the facility for her appointment. The resident returned to the facility at 1:39 p.m. There was no documentation of an assessment to the angiogram site after the resident returned. A Weekly Skin Assessment, dated 1/22/26, did not address the angiogram site. During an interview on 2/19/26 at 11:54 a.m., the Director of Nursing indicated she would look into the documentation to see if there was an assessment after the resident returned. During an interview on 2/19/26 at 2:00 p.m., the Nurse Consultant indicated there was no assessment of the resident after all of the angiograms, nor was there documentation on 12/23/25 of when the resident left or returned from the appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The record for Resident 72 was reviewed on 2/18/26 at 2:50 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar type. A Care Plan, updated 4/18/24, indicated the resident used psychotropic medications related to schizoaffective disorder. The interventions included to administer psychotropic medications as ordered. A Physician's Order, dated 11/12/24, indicated Haldol decanoate 100 milligrams per milliliter (mg/ml), inject 100 milligrams (mg) intramuscularly every 28 days. The Medication Administration Record (MAR), dated 11/2025, indicated the Haldol injection was to be given on 11/11/25. The medication was not signed off as given and there were no electronic medication administration (eMAR) notes. The Quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated the resident received antipsychotic medication. The Medication Administration Record (MAR), dated 1/2026, indicated the Haldol injection was to be given on 1/6/26. The medication was not signed off as given and there were no electronic medication administration (eMAR) notes. The Medication Administration Record (MAR), dated 2/2026, indicated the Haldol injection was to be given on 2/3/26. The medication was not signed off as given. An eMAR note, dated 2/3/26 at 1:21 p.m., indicated awaiting pharmacy delivery. During an interview on 2/20/26 at 2:05 p.m., the Director of Nursing indicated the medication had not been documented as given. The Haldol had been delivered from the pharmacy, so she was unsure why it had not been given. 3. The record for Resident 96 was reviewed on 2/18/26 at 12:36 p.m. Diagnoses included, but were not limited to, dependence on renal dialysis and diabetes. A Care Plan, revised on 9/6/24, indicated the resident had diabetes. Interventions included monitoring blood sugar and administering medications as ordered. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/25, indicated the resident was cognitively intact for daily decision making, and was dependent in ADLs. a. A Physician's Order, dated 2/14/26, indicated Lantus Insulin (long-acting), inject 21 units every day shift. The February Medication Administration Record (MAR) indicated the Lantus Insulin was held on 2/14/26 and 2/15/26. There were no parameters or orders to hold the medication. b. A Physician's Order, dated 2/14/26, indicated Humalog Insulin (short acting) dosage to be given per a sliding scale, three times a day with meals. The Humalog Insulin was not given and no blood sugar was documented for the mornings of 2/18/26 and 2/20/26. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/26, the Director of Nursing (DON) indicated the insulin should have been administered as ordered. The resident went to dialysis on 2/18/26 and 2/20/26, but the nurse should have checked his blood sugar and administered the insulin as ordered before he left. 4. The record for Resident 24 was reviewed on 2/18/26 at 3:01 p.m. Diagnoses included, but were not limited to diabetes. The Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was not cognitively intact for daily decision making, and required supervision assistance with ADLs. a. A Physician's Order, dated 3/26/25, indicated insulin glargine (long acting), inject 65 units at bedtime. There were no parameters for holding the medication. The February 2026 MAR indicated the bedtime insulin was held on 2/4/26, 2/6/26, 2/7/26, and 2/13/26. b. A Physician's Order, dated 1/5/26, indicated insulin lispro (short acting) 25 units each morning, hold if the blood sugar was less than 110. The 2/3/26 morning blood sugar was 104, and the insulin was given. c. A Physician's Order, dated 1/5/26, indicated insulin lispro, 35 units each afternoon, hold if the blood sugar was less than 110. The 2/4/26 afternoon blood sugar was 135, and the insulin was held. The 2/15/26 afternoon blood sugar was 118, and the insulin was held. d. A Physician's Order, dated 1/5/26, indicated insulin lispro, 38 units each evening, hold if the blood sugar was less than 110. A Care Plan, revised 3/27/24, indicated the resident had diabetes. Interventions included and administering diabetes medications as ordered. The 2/2/26 evening blood sugar was 77, and the insulin was given. The 2/4/26 evening blood sugar was 130, and the insulin was held. The 2/8/26 blood sugar was 92, and the insulin was given. The 2/12/26 evening blood sugar was 91, and the insulin was given. The 2/13/26 evening blood sugar was 97, and the insulin was given. The 2/14 evening blood sugar was 82, and the insulin was given. The 2/15/26 evening blood sugar was 124, and the insulin was held. The 2/16/26 afternoon blood sugar was 66, and the insulin was given. During an interview on 2/24/26 at 10:15 a.m., the Director of Nursing was informed of the findings and indicated the nurses would be educated on administering insulin as per order. 3.1-37

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty and discolored floor tiles, marred walls and door frames, dusty ceiling vents, and dead insects in light fixtures for 2 of 3 units observed. (South and PCU) Findings include: During the environmental tour with the Environmental Supervisor on 2/24/26 at 1:37 p.m., the following was observed:1. South Unita. In the bathroom of room [ROOM NUMBER], the toilet paper holder was broken and detached from the wall. The bathroom door frame was scratched and marred. One resident resided in the room and used the bathroom. b. The wall behind the head of bed one in room [ROOM NUMBER] was scratched and marred. The floor tile around the base of the toilet was discolored with a white substance. Two residents resided in the room and used the bathroom. c. The floor tile located at the base of the toilet in room [ROOM NUMBER] was discolored with a white substance. Two residents resided in the room and used the bathroom. d. A stained ceiling tile was observed by the window in room [ROOM NUMBER]. The bathroom door frame was scratched and marred. Two residents resided in the room and used the bathroom. 2. PCU a. There were dead insects in the bathroom light fixture of room [ROOM NUMBER] and the ceiling vent was dusty. There were also dead insects in the light fixture of the main room light located on the ceiling. Two residents resided in the room and shared the bathroom. b. The door frames to the room and bathroom of room [ROOM NUMBER] were scratched and marred. The ceiling vent in the bathroom was dusty and the light fixture in the room and bathroom had an accumulation of dead insects. Two residents resided in the room and used the bathroom. c. The door frames to the room and bathroom of room [ROOM NUMBER] were scratched and marred. The ceiling vent in the bathroom was dusty. One resident resided in the room and used the bathroom. d. The bathroom ceiling vent in room [ROOM NUMBER] had an accumulation of dust. Two residents resided in the room and shared the bathroom. e. The bathroom ceiling vent in room [ROOM NUMBER] had an accumulation of dust. One resident resided in the room and used the bathroom. f. The bathroom ceiling vent in room [ROOM NUMBER] had an accumulation of dust. One resident resided in the room and used the bathroom. g. The bathroom ceiling vent in room [ROOM NUMBER] had an accumulation of dust. One resident resided in the room and used the bathroom. During an interview at the time, the Environmental Supervisor indicated all of the above were in need of cleaning and/or repair.3.1-19(f)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and interview, the facility failed to maintain a resident's dignity related to wearing a hospital gown during the day for 1 of 3 residents reviewed for dignity. (Resident 35)Finding includes: During random observations on 2/16/26 at 11:13 a.m., 2/18/26 at 10:27 a.m., 2/20/26 at 9:03 a.m., 10:56 a.m., and 2:39 p.m., and 2/24/26 at 10:12 a.m., Resident 35 was observed in his bed, wearing a hospital gown. During interviews on 2/16/26 at 11:13 a.m., 2/20/26 at 2:39 p.m., and 2/24/26 at 10:12 a.m., the resident indicated he did not want to wear a hospital gown, and he had his own clothes in his closet. The resident's record was reviewed on 2/18/26 at 10:48 a.m. The Medicare-5 Day Minimum Data Set (MDS) assessment, dated 2/14/26, indicated the resident was cognitively intact for daily decision making, and was dependent in activities of daily living (ADLs). The resident's record lacked documentation that the resident preferred to wear a hospital gown during the day.During an interview on 2/24/26 at 10:15 a.m., the Director of Nursing was informed of the findings and indicated the Care Plan would be updated to include that the resident may chose to wear a hospital gown during the day at times. 3.1-3(t)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure evidence was provided related to Level 1 and Level 2 PASARR (Pre admission Screening and Annual Resident Review) screening for 1 of 1 resident reviewed for PASARR. (Resident 2)Finding includes:The record for Resident 2 was reviewed on 2/19/26 at 10:30 a.m. Diagnoses included, but were not limited to, post traumatic stress disorder (PTSD) and major depressive disorder. The resident was admitted to the facility on [DATE] from another long term care facility. The admission Minimum Data Set (MDS) assessment, dated 1/31/26, indicated the resident was cognitively intact for daily decision making. The resident had the coded diagnoses of post traumatic stress disorder and depression. A Care Plan, dated 2/6/26, indicated the resident suffered from trauma informed care due to military trauma or exposure. Interventions included, but were not limited to, provide emotional support and psychiatry/psychology services. A Level 1 PASARR (Pre admission Screening and Annual Resident Review), dated 9/16/24, indicated a Level 2 was not required. A new Level 1 at the time of admission was not available for review. During an interview on 2/17/26 at 11:45 a.m., the Social Service Director indicated a new Level 1 and 2 were not completed at the time of admission for the resident. She did not do a new one based on the 9/16/24 Level 1 outcome, however, she was not aware of the resident's current diagnoses of PTSD and major depressive disorder. 3.1-29(a)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a comprehensive care plan was in place for pain for a resident receiving opioid (narcotic pain medication) medication for 1 of 31 residents whose care plans were reviewed. (Resident 131)Finding includes:The record for Resident 131 was reviewed on 2/19/26 at 10:07 a.m. Diagnoses included, but were not limited to, polyneuropathy.A Physician's Order, dated 11/9/25 and discontinued on 2/12/26, indicated hydrocodone-acetaminophen 5-325 milligrams (mg) 1 tab twice a day. A Physician's Order, dated 2/13/26, indicated hydrocodone-acetaminophen 5-325mg 1 tab every 6 hours as needed for pain.The Quarterly Minimum Data Set (MDS) assessment, dated 1/15/26, indicated the resident had received scheduled pain medication and had received opioid medication in the past seven days.The Medication Administration Record, dated 2/2026, indicated the resident had received the opioid medication as ordered.There was a lack of any care plan for pain or opioid medication use.During an interview on 2/19/26 at 12:03 p.m., the Director of Nursing was made aware there was no care plan for pain or opioid medication use.During an interview on 2/19/26 at 2:08 p.m., the MDS Consultant indicated there was no care plan in place for pain or opioid use.3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure a care plan conference was held quarterly for 1 of 1 resident reviewed for care planning. (Resident 1)Finding includes:During an interview on 2/16/26 1t 11:20 a.m., Resident 1 indicated he was his own responsible party and had not been invited to or participated in any care plan conferences for a while.The record for Resident 1 was reviewed on 2/18/26 at 1:25 p.m. A Care Plan Meeting Progress Note, dated 9/30/25, indicated a care plan conference was held and the resident had attended. The Quarterly Minimum Data Set (MDS) assessment, dated 1/9/26, indicated the resident was moderately cognitively impaired.There was lack of documentation the resident had been invited to any care plan meetings, or any care plan meetings had been held since 9/30/25.During an interview on 2/19/26 at 12:05 p.m., the Nurse Consultant indicated the last care plan conference was completed in September 2025. She was unable to find any further care plan meeting documentation.3.1-35(d)(2)(B)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review, and interview, the facility failed to provide activities to support the psychosocial well-being of cognitively impaired, dependent residents for 1 of 2 residents reviewed for activities. (Resident 8)Finding includes: During a random observation on 2/16/26 at 3:23 p.m., Resident 8 was lying in bed. She was blankly staring at the wall, and did not respond to verbal stimulation. The television was on. No staff was observed interacting with resident. On 2/18/26 at 10:20 a.m., two staff members entered the resident's room, repositioned her, and immediately left the room. At 1:26 p.m., the resident was observed lying in bed, staring blankly. The television was on. At 1:42 p.m., the Activities Director entered the resident's room, spoke to her for 1-2 minutes, and left the room. On 2/19/26 at 10:43 a.m. and 3:06 p.m., the resident was observed lying in bed, staring blankly toward the wall. The television and radio were off. No staff interaction was observed. On 2/20/26 at 9:05 a.m. and 11:02 a.m., the resident was observed lying awake in bed. The television and radio were off. No staff interaction was observed. On 2/23/26 at 10:00 a.m., the resident was observed lying awake in bed. The radio was on. No staff interaction was observed. The record for Resident 8 was reviewed on 2/18/26 at 1:39 p.m. Diagnoses included, but were not limited to, anoxic brain damage, and persistent vegetative state. The Quarterly Minimum Data Set (MDS) assessment, dated 2/10/26, indicated the resident was not cognitively intact, and was dependent in activities of daily living (ADLs). The One-to-One Activities Record, received from the Activities Director on 2/23/26 at 3:00 p.m., indicated the following: On 1/8/26, the AA (activities aide) made sure tv was on; on 1/10/26, the AA played music for the resident, on 1/11/26 the AA played music; on 1/24/26, the AA read the Daily Chronicle to the resident; and on 1/25/26, the AA played music. A Quarterly Activities Review, dated 2/5/26, indicated the resident was to receive one-to-one room visits, and staff would read to her and play music for sensory stimulation. A Care Plan, revised on 8/24/24, indicated the resident had little or no activity involvement related to a brain injury. Interventions included providing one-to-one visits three times per week. During an interview on 2/23/26 at 3:10 p.m., the Activities Director indicated the resident should have been getting one-to-one visits three times a week. They used to have a staff member for one-to-one visits, but she left. 3.1-33(a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure accurate documentation of pressure ulcers was completed upon admission for 2 of 3 residents reviewed for pressure ulcers. (Residents 2 and 133)Findings include: 1.The record for Resident 2 was reviewed on 2/19/26 at 10:30 a.m. Diagnoses included, but were not limited to, stroke, history of traumatic brain injury, and severe protein calorie malnutrition. The resident was admitted to the facility from another long term care facility on 1/28/26. The admission Minimum Data Set (MDS) assessment, dated 1/31/26, indicated the resident was cognitively intact for daily decision making. The resident had two Stage 3 pressure ulcers (a full thickness skin loss exposing subcutaneous fat, but not muscle, tendon, or bone) that were present on admission. An admission Assessment, dated 1/28/26, indicated the resident had an ace wrap to the bilateral lower extremities. The resident refused a skin assessment. A discharge instruction sheet, dated 1/28/26 from the other long term care facility, indicated the resident's skin was intact, he had no open areas or treatments. Nurse's Notes, dated 1/28/26 at 6:25 p.m., indicated the writer attempted to communicate with resident at that time, the resident continued to be unapproachable, refusing to answer questions, refusing to allow writer to obtain vital signs, and unable to redirect, POA aware. Nurse's Notes, dated 1/29/26 at 2:13 p.m., indicated the resident refused all patient care during the shift. The resident refused to take his medications as well as his breakfast and lunch. The Physician was made aware. Nurse's Notes, dated 1/30/26 at 6:50 a.m., indicated staff attempted to perform a skin assessment related to him being a new admission. The resident refused and denied any skin impairments. The resident was encouraged to allow staff to assess him related to being at risk for skin breakdown due to impairments. The resident verbalized understanding and continued to refuse. The Unit Nurse was made aware and a message was left for the physician. Nurse's Notes, dated 1/30/26 at 11:07 a.m., indicated the resident's skin was assessed and impaired skin was noted to the right buttock measuring 1.1 centimeters (cm) in length by 2 cm in width by 0.1 cm deep with 70% granulation and 30% intact skin. The wound edges were attached and the surrounding skin was intact. Impaired skin was noted to the left buttock measuring 1 cm in length by 0.9 cm in width x 0.1 deep with 100% granulation noted. The wound edges were attached as well as the surrounding skin. Impaired skin to the left shin measured 11 cm in length by 5.5 cm in width by 0.1 cm deep with 70% intact skin and 30% granulation along with moderate, odorless, serous-sanguineous drainage (pink to light red drainage) . The wound edges were attached and the surrounding skin was intact. The resident's physician and guardian were notified. Physician's Orders, dated 1/30/26 and discontinued on 2/2/26, indicated the open areas to the left and right buttocks were to be cleansed with wound cleanser or normal saline, pat dry, and apply hydrocolloid (a wound care dressing) three times weekly and as needed (PRN). Cleanse the open area (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the left shin with wound cleanser or normal saline, pat dry, apply calcium alginate (a wound treatment) followed by ABD pad and kerlix dressing three times weekly and PRN as needed. The Wound Rounds notes indicated the left and right buttock pressure areas were identified on 1/30/26 and were classified as a Stage 3. A Care Plan, dated 1/30/26, indicated the resident had pressure ulcers to the right and left buttock related to immobility. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness and complete weekly treatment documentation to include measurements of each area of the skin breakdown's width, length, depth, type of tissue and exudate (drainage). There were no physician orders for the pressure ulcers at the time of admission. During an interview on 2/19/26 at 1:30 p.m., the Wound Nurse Consultant indicated the resident had refused a skin assessment on 1/28, 1/29 and 1/30/26, however, the wound nurse was finally able to assess the resident's skin later on 1/30/26. They documented the wounds were present on admission, however, no one saw his skin or was able to assess his skin on admission. She did not reach out to the sister facility who discharged him to confirm if his skin was intact at the time of discharge. During an interview on 2/19/26 at 2:10 p.m., the Nurse Consultant indicated she pulled the documentation up that was provided at the time of discharge and the resident had refused most of 12/2025 and 1/2026 skin assessments. She had called the facility and asked the nurse who discharged him and she indicated the resident had a large bowel movement right before he was getting ready to be transferred and the CNAs indicated the resident's buttocks were red. During an interview on 2/20/26 at 9:00 a.m., the Wound Nurse indicated she documented the wound on his left and right buttock were present upon admission. She had spoken with his family and they were aware he had the area on his shin. She had no additional information to provide. 2. On 2/20/26 at 9:02 a.m., the Wound Nurse was observed completing Resident 133's wound treatments. There was a red circular nickel-sized area to her right buttock and red circular quarter-sized area to her left buttock. Record review for Resident 133 was completed on 2/18/26 at 9:04 a.m. The resident was admitted to the facility on [DATE]. The 72 hour Admission/readmission Observation, dated 2/14/26, indicated the resident had a skin tear to her left breast. There were no other skin conditions documented. A Progress Note, dated 2/14/26 at 11:00 a.m., indicated the resident was admitted to the facility. She had a skin tear to her left breast and no other skin issues noted. A Care Plan, dated 2/16/26, indicated the resident had pressure ulcers to the right and left buttock related to immobility. A Wound Rounds Assessment, dated 2/16/26, indicated the resident had a stage 3 pressure ulcer to the left buttocks that was present upon admission. It measured 0.4 centimeters (cm) by 0.4 cm by 0.1 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cm. A Wound Rounds Assessment, dated 2/16/26, indicated the resident had a stage 3 pressure ulcer to the right buttocks that was present upon admission. It measured 2 cm by 1.5 cm by 0.1 cm. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 2/2026, lacked documentation of any treatments to the right or left buttocks until 2/16/26. During an interview on 2/19/26 at 12:03 p.m., the Director of Nursing indicated the Wound Nurse had documented the wounds as present upon admission because that was her admission assessment and note. During an interview on 2/19/26 at 1:32 p.m., the Wound Care Nurse Consultant indicated the Wound Nurse Practitioner (NP) had come in that day and assessed the resident's wounds. The NP felt the staging of the wounds was incorrect and they were re-staged as stage 2 pressure ulcers. The Wound Nurse's documentation was incorrect. During an interview on 2/20/26 at 8:53 a.m., the Wound Nurse indicated she had first assessed the buttocks wounds on 2/16/26. She had documented the buttocks wounds were present upon admission because she felt the wounds had probably been there upon admission and didn't feel they would have just appeared in the two days from when the resident was admitted until the wound nurse had completed her first assessment. Her documentation was incorrect. A facility policy, received as current from the Director of Nursing, titled Pressure Injury and Skin Condition Assessment, indicated .1. A skin condition assessment and pressure ulcer risk assessment will be completed at the time of admission/readmission .3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse . 3.1-40(a)(2)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to obtaining a re-weight in a timely manner following a hospitalization for 1 of 4 residents reviewed for nutrition. (Resident H)Finding includes: The record for Resident H was reviewed on 2/19/26 at 2:20 p.m. Diagnoses included, but were not limited to, chronic kidney disease and anemia. The resident was admitted to the facility on [DATE].A Care Plan, dated 2/2/26, indicated the resident had a nutritional problem related to receiving a therapeutic diet and dietary restrictions. Interventions included, but were not limited to, provide and serve diet as ordered. The 2/7/26 5-Day Medicare Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision-making. The resident held food in his mouth, weighed 219 pounds, had a significant weight loss, and received a therapeutic diet.On 1/30/26 the resident weighed 237 pounds.On 2/7/26 the resident weighed 219 pounds. The resident was admitted to the hospital on [DATE] and returned to the facility on 2/7/26. The next documented weight after the hospital return was not until 2/14/26, which was 227 pounds. There was no reweight after the 18 pound weight loss following the hospital stay. There was no documentation the Registered Dietician (RD) was notified of the resident's weight loss after his hospital return. A Physician's Order, dated 2/7/26, indicated the resident was to receive a no added salt diet and was to have weekly weights obtained for four weeks. No supplements had been ordered for the resident since his weight loss and he was not seen by the RD until 2/20/26. During an interview on 2/20/26 at 10:25 a.m., the Director of Nursing indicated the RD was not notified after the resident returned to the facility even though he had a weight loss. The RD would be evaluating the resident today (2/20/26) and the resident was not reweighed after the 18 pound weight difference from the hospital return. The current and revised 10/17/19 Weights policy, provided by the Nurse Consultant on 2/20/26 at 11:59 p.m., indicated a re-weight should be obtained if there was a difference of 5 pounds or greater (loss or gain) since the previous recorded weight. A re-weight should be taken as soon as possible after an unanticipated weight change was noted. An undesired or unanticipated weight gain/loss of 5% in 30 days shall be reported to the physician and RD. 3.1-46(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure residents with a gastrostomy tube (g-tube, the surgical insertion of a feeding tube) received the appropriate treatment related to administration of the tube feeding for 2 of 2 residents reviewed for tube feedings. (Residents 50 and 133)Findings include:1. On 2/16/26 at 3:09 p.m., Resident 50 was observed lying in bed. The tube feeding, Jevity 1.5 (tube feeding formula), was connected and infusing at 75 milliliters per hour (ml/hr).The resident's record was reviewed on 2/18/26 at 10:33 a.m. Diagnoses included, but were not limited to, gastrostomy, dysphagia, and adult failure to thrive.A Care Plan, updated 11/23/25, indicated the resident had a swallowing problem and required the tube feeding.The 5-Day Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively impaired and received the majority of their nutrition by tube feeding.A Physician's Order, dated 2/4/26, indicated the resident was to receive Jevity 1.5 at 75 milliliters per hour (ml/hr) continuously for 21 hours for a total volume of 1575 milliliters (ml) per day. There were no documented times to turn on or turn off the tube feeding.The Medication Administration Record, dated 2/2026, indicated the tube feeding had been signed off every shift. There were no documented times to turn on or turn off the tube feeding. There was an area to document the amount of tube feeding infused for each shift. Some shift documentation were number of milliliters, some were percentages, and some were yes/no. None of the days added up to the 1575 ml per day the resident was to receive.During an interview on 2/19/26 at 10:47 a.m., the Nurse Consultant indicated there was an issue with how the tube feeding orders had been entered into the computer and they would be updated. 2. On 2/16/26 at 11:52 a.m., Resident 133 was observed lying in bed. The tube feeding, Osmolite 1.5 (tube feeding formula), was connected and infusing at 50 milliliters per hour (ml/hr).The resident's record was reviewed on 2/18/26 at 9:04 a.m. Diagnoses included, but were not limited to, dysphagia. A Care Plan, updated 2/15/26, indicated the resident had a swallowing problem and required the tube feeding.The Physician's Order Summary, dated 2/2026, indicated the resident was to receive Osmolite 1.5 at 50 ml/hr continuously for 21 hours. There were no documented times to turn on or turn off the tube feeding.The Medication Administration Record, dated 2/2026, indicated the tube feeding had been signed off every shift. There were no documented times to turn on or turn off the tube feeding. During an interview on 2/19/26 at 10:47 a.m., the Nurse Consultant indicated there was an issue with how the tube feeding orders had been entered into the computer and they would be updated.A facility policy, received as current from the Nurse Consultant, titled Gastrostomy Tube-Feeding and Care, indicated, .1. Licensed nurse will review physician's order for type of formula, concentration, rate of flow, and method of administration .3.1-44(a)(2)

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure medications were not left unattended on top of the medication cart during medication administration for 2 of 6 residents observed during medication pass. (Residents 7 and 46)Findings include:1. On 2/18/26 at 3:52 p.m., a punch card containing two pills was observed unattended on top of the medication cart on the PCU Unit. There was no name on the punch card. At 4:03 p.m., the Assistant Director of Nursing and LPN 3 were observed sitting behind the nursing station and the medication was still on top of the medication cart. During an interview on 2/18/26 at 4:24 p.m., LPN 3 indicated she thought the pills were empty, she then pulled them out of the garbage can where she threw them away and indicated there were 2 pills left and they were Aricept (medication to manage dementia). 2. On 2/18/26 at 3:55 p.m., LPN 4 was observed completing a glucometer blood sugar check for Resident 46. The LPN gathered her supplies and entered the resident's room at 3:59 p.m. to wash her hands. She left the resident's insulin pen unattended on top of the medication cart while she washed her hands. She exited the resident's room at 4:00 p.m. and then proceeded to enter the resident's room again and closed the door. The insulin pen was again left on top of the medication cart while the LPN completed the glucometer check. During an interview on 2/18/26 at 4:25 p.m., the Assistant Director of Nursing indicated the insulin should not have been left unattended on top of the medication cart while not in view of the nurse. The current and undated Storage of Medications policy provided by the Director of Nursing on 2/19/26 at 9:19 a.m., indicated medications were stored safely, securely, and properly following manufacture's recommendations.3.1-25(m)

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

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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 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)

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to the storage of urinals and wash basins on 1 of 3 units. (The South Unit) The facility also failed to ensure a catheter port was cleansed prior to administering intravenous (IV) antibiotics for 1 of 1 resident observed for IV medication administration. (Resident 7)Findings include:1.On 2/16/26 at 2:30 p.m., two urinals were observed hanging from the grab bar in the bathroom. A yellow wash basin was observed on the floor underneath the bathroom sink. The urinals and wash basin were not contained. On 2/24/26 at 1:50 p.m., three urinals were observed hanging from the grab bar in the bathroom and the wash basin remained on the floor underneath the bathroom sink. Again, the urinals and wash basin were not contained. Two residents resided in the room and used the bathroom.During an interview on 2/24/26 at 3:45 p.m., the Director of Nursing indicated the urinals and wash basin should have been contained in plastic bags when not in use. 2. On 2/18/26 at 7:39 a.m., LPN 3 was observed administering an intravenous (IV) antibiotic to Resident 7. The LPN donned a gown, gloves, and mask and entered the resident's room. After administering the resident's oral medications, the LPN removed the cap from the resident's PICC (peripherally inserted central catheter) line port and flushed the port with normal saline. The LPN did not cleanse the port with an alcohol wipe prior to attaching the syringe. The port then touched the resident's sheets, and the LPN did not cleanse the port prior to connecting the IV antibiotic tubing. During an interview on 2/18/26 at 4:24 p.m., LPN 3 indicated she thought the orange cap was an alcohol cap, and that was what she used before administrating the saline flush, she indicated she did not wipe the single lumen with an alcohol wipe prior to administrating the IV antibiotic. The current and undated Central Venous Catheter policy, provided by the Director of Nursing on 2/19/26 at 9:19 a.m., indicated the procedure for flushing a catheter was to clean the valve with alcohol allow to dry, flush catheter, remove syringe, cleanse valve with alcohol and insert agent.3.1-18(b)