

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaint IN00159478.</p> <p>Complaint IN00159478- Substantiated. No deficiencies related to the allegations are cited</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: November 17 &amp; 18, 2014</p> <p>Facility number: 000224 Provider number: 155331 AIM number: 100267700</p> <p>Survey team: Regina Sanders RN, TC</p> <p>Census bed type: SNF: 23 SNF/NF: 76 Total: 99</p> <p>Census payor type: Medicare: 25 Medicaid: 61 Other: 13 Total: 99</p> <p>Sample: 3 Supplemental sample: 2</p>	F000000	<p>I respectfully request consideration for paper compliance. I have forwarded additional supportive documentation via fax today (12-1-14) to 1-317-233-7322. Please reference the attached 2567 as "Credible Allegation of Compliance" for a complaint survey conducted on November 17-18, 2014. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you. Amber Janeczko, Executive Director</p>	

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000441 SS=E	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 20, 2014, by Janelyn Kulik, RN.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observations, interview, and record review, the facility failed to ensure proper infection control practices and standards were maintained related to hand washing, blood pressure monitoring, oxygen saturation monitoring, glove usage, and blood sugar monitoring for 3 of 3 residents observed during a medication administration pass observation. This had the potential to effect 14 residents the Nurse was assigned to and 4 residents in the</p>	F000441	<p><b>F441 SS = E</b></p> <p>1.Residents #D, #E, and #F were assessed by licensed nursing staff on 11/25/14 and exhibited no signs or symptoms of an acute infection.</p> <p>2.Administrative nursing staff identified residents in rooms 301-309 as being cared for by RN#1 and at risk to be affected by lapses in infection control practices. Nursing assessments were completed on these identified residents on 11/25/14 and no signs or symptoms of an</p>	12/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/18/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>assignment who required blood sugar monitoring. (RN #1, Residents #D, #E, and #F)</p> <p>Findings include:</p> <p>During an observation on 11/17/14 at 4:50 p.m., RN #1 was sitting on Resident #D's bed, next to the resident and was monitoring the resident's blood pressure with a wrist cuff and then checked the resident's oxygen level with a finger oximeter. RN #1 then placed the oximeter probe in her pocket, administered the resident's medication and exited the Resident #D's room.</p> <p>RN #1 then immediately walked into Residents #E and #F's room across the hall at 5 p.m. RN #1 had not washed her hands and then obtained Resident #E's blood pressure with the same wrist cuff, which was used for Resident #D. RN #1 had not sanitized the blood pressure cuff. RN #1 also obtained the resident's oxygen level with oximeter probe, without cleansing the probe and then placed the probe back into her pocket. RN #1 then obtained a blood sugar for Resident #E with a glucometer. RN #1, used a lancet to prick the resident's finger, placed the glucometer strip, which was already placed in the glucometer, near the finger to obtain a sample of</p>		<p>acute infection were noted.</p> <p>3. The Staff Development Coordinator retrained RN#1 on the facility Infection Control Policy and provided specific training for cleaning the glucometer on 11/17/14. The Staff Development Coordinator also developed an in-service that addresses the facility Infection Control Policy with an emphasis upon glucometer cleaning after use, safe handling and sanitation of resident equipment and hand washing guidelines. This inservice will be provided to facility staff by 12/5/14 and will be accompanied by competency evaluations on hand washing for all licensed staff. In addition, audits were developed by the DON to monitor for compliance with Infection Control Practices such as hand washing, disinfection and safe handling practices for equipment that is used during resident assessments.</p> <p>4. Using the above facility Infection Control Audit Tool, the DON and/or designees will perform random audits five times weekly for six months to monitor compliance with Infection Control Guidelines. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/18/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>blood, then wiped the resident's finger with a alcohol prep pad and placed the glucometer and used lancet in her uniform pocket. RN #1 had no gloves on during the blood sugar check, and had still not washed her hands.</p> <p>RN #1 then walked over to Resident #F's bed in the same room, without washing her hands and used the wrist blood pressure cuff to obtain Resident #F's blood pressure. RN #1 still had not washed her hands nor sanitized the equipment between the resident usage.</p> <p>RN #1 exited Resident #E and #F's room, without washing her hands, and documented Resident #E's blood sugar result, place two boxes of medications into the drawer of the cart and then began to prepare Resident #E's medication.</p> <p>During an interview at this time, RN #1 denied obtaining the resident blood sugar, then looked at her notes and indicated she had obtained Resident #E's blood sugar. RN #1 then indicated she had not washed her hands nor used gloves when obtaining the resident's blood sugar. RN #1 then washed her hands and prepared Resident #E's medication and administered the medications.</p> <p>At 5:08 p.m., RN #1 then prepared three</p>		<p>necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.</p> <p>DATE CERTAIN 12/8/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>other resident's medications, using antibacterial hand wipes between giving the residents their medications. The glucometer remained in RN #1's pocket, without being sanitized from 5 p.m. through 5:15 p.m. At this time she removed the glucometer and placed it on top of the medication cart, still not sanitized.</p> <p>During an observation on 11/17/14 at 5:35 p.m., RN #1 then sanitized the glucometer prior to obtaining Resident #D's blood sugar.</p> <p>During an interview on 11/18/14 at 11:30 a.m., the Staff Development Director/Infection Control Nurse, indicated RN #1 should have used the bleach wipes to clean the oximeter and blood pressure cuff after each resident use and should have immediately sanitized the glucometer. She indicated gloves should have been worn when obtaining the blood sugar and hands should have been washed in between contact with each resident.</p> <p>A facility policy, dated 05/12, titled, "Hand Hygiene", received from the DoN (Director of Nursing) as current, indicated, "...To decrease the risk of transmission of infection by appropriate hand hygiene...considered the most</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/18/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>important single procedure for preventing nosocomial infections..."</p> <p>A facility policy, dated 03/10, titled, "Cleaning and Disinfection of the Glucometer", received from the DoN as current, indicated, "...The following procedure is to be completed in the resident's room after a glucometer check before leaving the room...Follow hand hygiene protocol."</p> <p>A Professional Resource, titled, "Division of Long Term Care Nurse Aide Training Program, July 1998", Topic 5: Infection Control, indicated, "...Every person is treated as potentially infectious. Sources of infections include: blood...Wearing gloves when indicated for resident care...Wash your hands before and after performing procedures..."</p> <p>A Professional Resource, titled, "Qualified Medication Aide Basic Curriculum, October 2003", "Lesson 60: Diabetic Testing (Urine and Finger Stick)", indicated, "...Finger Stick Blood Glucose Testing...Wash your hands and put on gloves...Discard the lancet into the sharps container..."</p> <p>3.1-18(b)(1)</p>						

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

PRINTED: 12/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155331	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/18/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	