STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA VALPARAISO	1300 VALE PARK RD, VALPARAISO, , 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: July 7 and 8, 2025 Facility number: 012181 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/14/25.	R 0000	Aviva Valparaiso provides the following Plan of Correction “POC” without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of federal and state laws	
R 0026	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(a) (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their	R 0026	R 026 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ On 7/8/25, Resident 3 signed Resident Rights acknowledgement and it was uploaded to EHR.	08/07/2025

	implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on record review and interview, the facility failed to ensure resident rights were signed upon admission for 1 of 7 residents reviewed for resident rights. (Resident 3) Finding includes: Record review for Resident 3 was complete on 7/7/25 at 12:30 p.m. Diagnoses included, but were not limited to, heart failure and hypertension. The resident was admitted to the facility on 1/11/25. The record lacked any documentation indicating a Resident Rights document had been signed and completed upon admission. During an interview on 7/8/25 at		2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? ¿ On 7/18/25, ED audited current residents' records to ensure that there is a signed Resident Rights acknowledgement in place. ¿ On 7/22/25, ED uploaded current residents' acknowledgment of Resident Rights to the EHR. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? ¿ On 7/21/25, ED ensured the Resident Rights acknowledgement consent form was added the admission packet for new residents. ¿ Beginning 8/1/25, ED/designee will audit new resident records monthly x 3 months to ensure the Resident Rights acknowledgement is signed upon admission and uploaded to the EHR. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Results of all audits will be	

	8:46 a.m., the Director of Nursing indicated she could not locate Resident 3's signed Resident Right's document. Based on record review and interview, the facility failed to ensure resident rights were signed upon admission for 1 of 7 residents reviewed for resident rights. (Resident 3) Finding includes: Record review for Resident 3 was complete on 7/7/25 at 12:30 p.m. Diagnoses included, but were not limited to, heart failure and hypertension. The resident was admitted to the facility on 1/11/25. The record lacked any documentation indicating a Resident Rights document had been signed and completed upon admission. During an interview on 7/8/25 at 8:46 a.m., the Director of Nursing indicated she could not locate Resident 3's signed Resident Right's document.		discussed during monthly QA and will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. 5. By what date will the systemic changes be completed? 8/7/2025	
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall	R 0120	R 120 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ No residents were affected	08/07/2025

	include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice.		¿ On 4/15/25, QMA 1 completed annual inservice training with CBT (Relias). 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? ¿ No residents were affected by this deficient practice ¿ By 7/28/25, ED will audit current QMA employee files for required annual inservice compliance. Any QMA that has not completed annual inservice training will be required to do so by 8/7/25. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? ¿ On 3/10/25 and reviewed on 7/21/25, required annual QMA specific training was added to Relias and will automatically be assigned to current QMAs annually. ¿ Beginning 8/1/25, ED will audit newly hired QMA files monthly x 3 months to ensure required training has been completed. ¿ Beginning 10/31/25, ED and/or designee will audit current QMA in-service records annually to ensure	

	The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure all staff received annual inservice training related to six hour required training not completed by a Qualified Medication Assistant. (QMA 1) Finding includes: The Employee Records were reviewed on 7/8/25 at 11:20 a.m. There was no evidence QMA 1 had received annual inservice training in 2024. During an interview on 7/8/25 at 11:28 a.m., the Director of Nursing indicated only one of the QMAs had completed the required training. QMA 1 had completed the annual training in December 2023, it was missed in December 2024, and then he completed the training in April 2025. The Indiana Department of Health document, "QMA Annual Inservice Training," located on INhealth.gov website indicated, "QMA Annual Inservice Training (6 hours) must be completed every year and kept by the QMA. The six (6) hours of QMA Inservice must be obtained annually between January and		required training has been completed. ED will add recurring reminder to google calendar to prompt annual audit. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Results of all audits will be discussed during monthly QA and will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. 5. By what date will the systemic changes be completed? 8/7/2025	

	December..." Based on record review and interview, the facility failed to ensure all staff received annual inservice training related to six hour required training not completed by a Qualified Medication Assistant. (QMA 1) Finding includes: The Employee Records were reviewed on 7/8/25 at 11:20 a.m. There was no evidence QMA 1 had received annual inservice training in 2024. During an interview on 7/8/25 at 11:28 a.m., the Director of Nursing indicated only one of the QMAs had completed the required training. QMA 1 had completed the annual training in December 2023, it was missed in December 2024, and then he completed the training in April 2025. The Indiana Department of Health document, "QMA Annual Inservice Training," located on INhealth.gov website indicated, "QMA Annual Inservice Training (6 hours) must be completed every year and kept by the QMA. The six (6) hours of QMA Inservice must be obtained annually between January and December..."			

R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.	R 0217	R 217 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ On 7/8/25, RCD updated and received signatures on Resident 4's and Resident 6's service plan to reflect current needs/diagnosis. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? ¿ Current residents have potential to be affected by this deficient practice. ¿ By 8/7/25, RCD and/or designee will audit current resident service plans to ensure updated information is included and a signature is in place. Any service plan that is incomplete will be revised to achieve compliance. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? ¿ Beginning 8/1/25, RCD and/or designee will audit 24-hour report 4 times a week x 4 weeks, then weekly x4 weeks, then monthly x 1 month to	08/07/2025

	(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure Service Plans were signed and/ or updated with changes related to hospice services, blood sugar monitoring, insulin administration, and colostomy status for 2 of 7 service plans reviewed. (Residents 4 and 6) Findings include: 1. Resident 4's record was reviewed on 7/7/25 at 1:06 p.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic kidney disease. The July 2025 Physician's Order Summary indicated the resident received Lantus (insulin injections) 100 unit/milliliter, 20 units at 8:00 a.m. and 25 units at 8:00 p.m., and required blood sugar monitoring. A Nurses' Note, dated 4/13/25 at 10:13 a.m., indicated the resident was now receiving hospice services. The Service Plan, dated 2/14/25, was signed by the resident. The Service Plan did not indicate the resident		gather any pertinent information/resident changes that needs to be added/removed from the service plan ¿ Beginning 8/7/25, RCD and/or designee will audit 10 random resident records weekly x 4 weeks then monthly x 2 months to ensure service plans are accurate and reflect current services being provided to the resident, and service plans are signed. ¿ By 7/30/25, RCD will in-service current licensed nurses on adding changes/pertinent information to the 24-hour report and editing service plans when residents needs change. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Results of all audits will be discussed during monthly QA and will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. 5. By what date will the systemic	

	received insulin or blood sugar monitoring. The current Service Plan, last updated on 5/9/25, indicated the resident was cognitively intact, was receiving hospice services, and required monitoring of blood sugar levels more than once a day. The Service Plan was not signed by the resident. During an interview on 7/8/25 at 11:20 a.m., the Director of Nursing indicated the resident had been receiving insulin and blood sugar monitoring since arriving to the facility in 2022. The Service Plan should have reflected that and the most recent updated Service Plan should have been signed by the resident. 2. Resident 6's record was reviewed on 7/8/25 at 8:54 a.m. Diagnoses included, but were not limited to, diverticular disease of the intestine. The resident admitted to the facility on 9/19/19. The current Service Plan, dated 4/25/25, indicated the resident was cognitively intact and was independent for activities of daily living including, but not limited to, toileting, transfers, bathing, and mobility.		changes be completed? 8/7/2025	

The Nurses' Admission Record, dated 3/21/22, indicated the resident had a colostomy in 2019.

During an interview on 7/8/25 at 10:34 a.m., the Director of Nursing indicated the resident had a colostomy since admission to the facility and the resident was completed independent with all care for the colostomy. The colostomy status should have been reflected in the Service Plan.

Based on record review and interview, the facility failed to ensure Service Plans were signed and/ or updated with changes related to hospice services, blood sugar monitoring, insulin administration, and colostomy status for 2 of 7 service plans reviewed. (Residents 4 and 6)

Findings include:

1. Resident 4's record was reviewed on 7/7/25 at 1:06 p.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic kidney disease.

The July 2025 Physician's Order Summary indicated the resident received Lantus (insulin injections) 100 unit/milliliter, 20 units at 8:00 a.m. and 25 units at 8:00 p.m., and required blood sugar monitoring.

A Nurses' Note, dated 4/13/25

at 10:13 a.m., indicated the resident was now receiving hospice services.

The Service Plan, dated 2/14/25, was signed by the resident. The Service Plan did not indicate the resident received insulin or blood sugar monitoring.

The current Service Plan, last updated on 5/9/25, indicated the resident was cognitively intact, was receiving hospice services, and required monitoring of blood sugar levels more than once a day. The Service Plan was not signed by the resident.

During an interview on 7/8/25 at 11:20 a.m., the Director of Nursing indicated the resident had been receiving insulin and blood sugar monitoring since arriving to the facility in 2022. The Service Plan should have reflected that and the most recent updated Service Plan should have been signed by the resident.

2. Resident 6's record was reviewed on 7/8/25 at 8:54 a.m. Diagnoses included, but were not limited to, diverticular disease of the intestine. The resident admitted to the facility on 9/19/19.

The current Service Plan, dated 4/25/25, indicated the resident was cognitively intact and was independent for activities of

	daily living including, but not limited to, toileting, transfers, bathing, and mobility. The Nurses' Admission Record, dated 3/21/22, indicated the resident had a colostomy in 2019. During an interview on 7/8/25 at 10:34 a.m., the Director of Nursing indicated the resident had a colostomy since admission to the facility and the resident was completed independent with all care for the colostomy. The colostomy status should have been reflected in the Service Plan.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, record review and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed for medication administration. (Resident 9) Finding includes: On 7/7/25 at 11:13 a.m., QMA 2	R 0247	R 247 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ Resident 9 did not exhibit any adverse effects from deficient practice 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? ¿ Current residents have the potential to be affected by the	08/07/2025

	was observed administering Resident 9's inhaler. QMA 2 instructed Resident 9 to breathe in on cue, she placed the inhaler in the resident's mouth and squeezed the inhaler. The resident partially breathed in and some medication was observed in a mist outside of the resident's mouth. QMA 2 then administered a second puff to the resident. During an interview on 7/7/25 at 11:19 a.m., QMA 2 indicated the resident did not receive the medication on the first puff so she administered a second puff. Record review for Resident 9 was completed on 7/7/25 at 11:59 a.m. The Physician's Order Summary, dated 4/2025, indicated to inhale albuterol HFA (inhaler) 1 puff by mouth every 6 hours. During an interview on 7/8/25 at 11:12 a.m., the Director of Nursing indicated she understood the concern and had no additional information to provide. Based on observation, record review and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed for medication administration. (Resident 9)		deficient practice. ¿ By 7/30/25, RCD will re-educate current QMAs on the proper medication administration procedures related to MDI. 1. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? beginning 8/1/25, RCD/designee will audit 3 random medication passes weekly x12 weeks to ensure that they are following proper medication administration practices. 2. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Results of the audit will be discussed during monthly QA and will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	

	Finding includes: On 7/7/25 at 11:13 a.m., QMA 2 was observed administering Resident 9's inhaler. QMA 2 instructed Resident 9 to breathe in on cue, she placed the inhaler in the resident's mouth and squeezed the inhaler. The resident partially breathed in and some medication was observed in a mist outside of the resident's mouth. QMA 2 then administered a second puff to the resident. During an interview on 7/7/25 at 11:19 a.m., QMA 2 indicated the resident did not receive the medication on the first puff so she administered a second puff. Record review for Resident 9 was completed on 7/7/25 at 11:59 a.m. The Physician's Order Summary, dated 4/2025, indicated to inhale albuterol HFA (inhaler) 1 puff by mouth every 6 hours. During an interview on 7/8/25 at 11:12 a.m., the Director of Nursing indicated she understood the concern and had no additional information to provide.		3. By what date will the systemic changes be completed? 8/7/2025	
R 0270	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(c)(1-3)	R 0270	R 270 1. What corrective action(s) will be accomplished for those residents	08/07/2025

	(c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review, and interview, the facility failed to ensure modified diets were prepared properly according to the recipe. This had the potential to affect 3 residents who resided in the facility and received a pureed diet. Finding includes: On 7/7/25 at 10:45 a.m., Cook 1 was observed preparing pureed peas for 3 residents. She washed her hands and donned gloves. Then she measured three servings of peas and placed them into the food processor, blended, and then added an unmeasured amount of hot water to the mixture and continued blending until achieving the pureed consistency. At the time, she indicated she was supposed to use the appropriate broth to add per the recipe posted on the wall above the food preparation area. For example, with pureed vegetables they were to use a		found to have been affected by the deficient practice? ¿ The residents that received the pureed peas at lunch did not exhibit any adverse effects from deficient practice. ¿ On 7/19/25, the Director of Culinary re-educated Cook 1 on the proper way to prepare pureed food items. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? ¿ Current residents that have an order for pureed diet have the potential to be affected by the deficient practice. ¿ On 7/18/25, the Director of Culinary re-educated current cooks on the proper way to prepare pureed food items. ¿ On 7/9/25, the Director of Culinary posted instructions on the wall above the robocoupe (food processor used for pureed food items) on how to prepare pureed food items. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?	

	vegetable broth. The kitchen was currently out of the vegetable broth so hot water was used for the puree instead. During an interview on 7/8/25 at 2:05 p.m., the Dietary Manager indicated she had no further information to provide. The policy titled, "Preparation of Pureed Foods for Pureed Diets," indicated, "1. Fill food processor or blender with four portions of the menu item using the portion size as per regular or modified menu. 2. Add 2-5 oz liquid: Hot broth to meats, hot broth to vegetables, juice to fruits, milk to desserts...3. Blend together. 4. Add additional liquid if needed..." The policy titled, "Pureed," indicated, "...Drain liquid from portions needed for pureed preparation. Reserve liquid in case additional liquid is needed when pureeing to the correct consistency. Never use water as the liquid added to a pureed item. If the liquid drained from the prepared item is not to be utilized, and no specific liquid is listed as an ingredient to be used on the pureed recipe, the following liquids would be acceptable to use when pureeing foods: prepared broth, gravy, sauce, milk, juice and melted margarine/butter..." Based on observation, record		¿ By 7/29/2025, the Director of Culinary will have each current cook do a return demonstration on preparing pureed food items. ¿ Beginning 8/1/25, the Director of Culinary will observe 2 random cooks prepare pureed food weekly x4 weeks, then every other week x 8 weeks to ensure compliance with food preparation. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Results of the audit will be discussed during monthly QA and will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. 5. By what date will the systemic changes be completed? 8/7/2025	

	review, and interview, the facility failed to ensure modified diets were prepared properly according to the recipe. This had the potential to affect 3 residents who resided in the facility and received a pureed diet. Finding includes: On 7/7/25 at 10:45 a.m., Cook 1 was observed preparing pureed peas for 3 residents. She washed her hands and donned gloves. Then she measured three servings of peas and placed them into the food processor, blended, and then added an unmeasured amount of hot water to the mixture and continued blending until achieving the pureed consistency. At the time, she indicated she was supposed to use the appropriate broth to add per the recipe posted on the wall above the food preparation area. For example, with pureed vegetables they were to use a vegetable broth. The kitchen was currently out of the vegetable broth so hot water was used for the puree instead. During an interview on 7/8/25 at 2:05 p.m., the Dietary Manager indicated she had no further information to provide. The policy titled, "Preparation of Pureed Foods for Pureed Diets," indicated, "1. Fill food			

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R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation,	R 0273	R 273 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ On 7/22/25, the Director of Culinary corrected the inverted storage of dishes. ¿ On 7/25/25, the Director of Culinary deep cleaned the fryer,	08/07/2025

	interview, and record review, the facility failed to maintain a safe and sanitary kitchen related to cookware and servingware stored improperly, spillage under cooking equipment, build up of debris on the cooking equipment, and kitchen staff touching food directly after touching non-food items for 1 of 1 kitchen observed. This had the potential to affect all 90 residents who received meals prepared in the Main Kitchen. (Server 1 and Cook 1) Findings include: 1. The kitchen tour was completed on 7/7/25 at 10:06 a.m., with the Dietary Manager. The following was observed: a. There were tulip cups, cereal bowls, pots and pans that were stored on a shelf not inverted. b. There was spillage and debris under the fryer and griddle. The fryer and griddle had a build up of debris. c. There was a build up of debris on the side and top of the stove. d. The steamer had a build up of debris on the doors. e. There was a large amount of liquid on the floor near the steam table. 2. During an observation of the		griddle, stove and steamer to remove the buildup of debris. ¿ On 7/7/25, the Director of Culinary removed the liquid on the floor near the steam table and assessed the equipment for any leaks. ¿ On 7/19/25, the Director of Culinary re-educated Cook 1 on proper serving/food handling techniques. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? ¿ On 7/25/25, the Director of Culinary re-inspected the kitchen to identify any other areas that have a “buildup of debris” and areas of concern were cleaned. ¿ On 7/18/25, the Director of Culinary re-educated current culinary team members on the proper way to store dishes, proper kitchen sanitation, and serving techniques. 1. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?	

	meal tray line on 7/7/25 at 11:25 a.m., Cook 1 was observed preparing the lunch meal. She washed her hands and donned new gloves. She started plating the food using the serving spoons and tongs for each item. She then reached behind her with her gloved hands and picked up a roll from a baking sheet sitting on top of the stove and placed the roll onto the plate. She started plating another meal and continued to touch the rolls with her gloved hands after touching the non-food items. During an interview at the time, Cook 1 indicated she should have used a pair of tongs to pick up the rolls. During an interview on 7/8/25 at 2:05 p.m., the Dietary Manager indicated Cook 1 was going to be inserviced related to touching food directly, and the cooking equipment and floors needed to be deep cleaned. A policy titled, "Safety Standards," indicated, "...Stove tops, ovens, and hoods will be routinely cleaned to keep them free of grease buildup and to prevent accidental grease fires...Spills and broken plastic/glass will be cleaned immediately to prevent employee falls..." Based on observation,		¿ On 7/18/25, the Director of Culinary revised kitchen cleaning lists to include weekly deep cleaning of kitchen surfaces. ¿ Beginning 8/1/25, the Director of Culinary will audit kitchen surfaces and dish storage areas weekly x 4 weeks, then every other week x 4 weeks, then monthly x1 month for “debris buildup”. ¿ Beginning 8/1/25, the Director of Culinary will observe meal service 3 times a week x 4 weeks, then weekly x 4 weeks, then every other week x4 weeks to ensure proper serving techniques are in place. 2. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Results of the audit will be discussed during monthly QA and will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. 3. By what date will the systemic changes be completed? 8/7/2025	

	interview, and record review, the facility failed to maintain a safe and sanitary kitchen related to cookware and servingware stored improperly, spillage under cooking equipment, build up of debris on the cooking equipment, and kitchen staff touching food directly after touching non-food items for 1 of 1 kitchen observed. This had the potential to affect all 90 residents who received meals prepared in the Main Kitchen. (Server 1 and Cook 1) Findings include: 1. The kitchen tour was completed on 7/7/25 at 10:06 a.m., with the Dietary Manager. The following was observed: a. There were tulip cups, cereal bowls, pots and pans that were stored on a shelf not inverted. b. There was spillage and debris under the fryer and griddle. The fryer and griddle had a build up of debris. c. There was a build up of debris on the side and top of the stove. d. The steamer had a build up of debris on the doors. e. There was a large amount of liquid on the floor near the steam table. 2. During an observation of the			

meal tray line on 7/7/25 at 11:25 a.m., Cook 1 was observed preparing the lunch meal. She washed her hands and donned new gloves. She started plating the food using the serving spoons and tongs for each item. She then reached behind her with her gloved hands and picked up a roll from a baking sheet sitting on top of the stove and placed the roll onto the plate. She started plating another meal and continued to touch the rolls with her gloved hands after touching the non-food items.

During an interview at the time, Cook 1 indicated she should have used a pair of tongs to pick up the rolls.

During an interview on 7/8/25 at 2:05 p.m., the Dietary Manager indicated Cook 1 was going to be inserviced related to touching food directly, and the cooking equipment and floors needed to be deep cleaned.

A policy titled, "Safety Standards," indicated, "...Stove tops, ovens, and hoods will be routinely cleaned to keep them free of grease buildup and to prevent accidental grease fires...Spills and broken plastic/glass will be cleaned immediately to prevent employee falls..."

R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent infection during medication administration. (Resident 9 and QMA 2) Finding includes: On 7/7/25 at 11:13 a.m., Resident 9 was observed as his eye drops were administered by QMA 2. The resident received 1 drop in each eye by QMA 2 with ungloved hands. During an interview on 7/7/25 at 11:19 a.m., QMA 2 indicated	R 0407	R 407 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ Resident 9 did not exhibit any adverse effects from deficient practice ¿ On 7/15/25, the RCD re-educated QMA 2 on proper medication administration/infection control procedures related to eye drop administration. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? ¿ Current residents have the potential to be affected by the deficient practice. ¿ By 7/30/25, the RCD will re-educate current QMA on the proper administration of eye drops related to infection control measures/glove utilization. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? ¿ Beginning 8/1/25 , RCD/designee will audit 3 random medication passes weekly x12 weeks to ensure that	08/07/2025

	she forgot to put on gloves prior to administering Resident 9's eye drops. Resident 9's record was reviewed on 7/7/25 at 11:59 p.m. The resident had been admitted on 4/11/25. Diagnoses included, but were not limited to, hypertension (high blood pressure), heart failure, dementia, respiratory failure, and muscle weakness. The Physician's Order Summary, dated 5/2025, indicated to administer Artificial Tears (eye solution) as directed 3-4 times daily. During an interview on 7/8/25 at 11:12 a.m., the Director of Nursing (DON) indicated she understood the concern and had no additional information to provide. A facility policy titled, "Use of disposable gloves" and received as current from the facility, indicated, "...Disposable gloves should be used whenever providing direct resident care ..." "...2. Before touching excretions, secretions, blood, and any body fluids... 4. Before touching a resident's mouth, nose, or any mucus membrane ..." Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and		they are following proper medication administration practices. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Results of the audit will be discussed during monthly QA and will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. 5. By what date will the systemic changes be completed? 8/7/25	

implemented to properly prevent infection during medication administration. (Resident 9 and QMA 2)

Finding includes:

On 7/7/25 at 11:13 a.m., Resident 9 was observed as his eye drops were administered by QMA 2. The resident received 1 drop in each eye by QMA 2 with ungloved hands.

During an interview on 7/7/25 at 11:19 a.m., QMA 2 indicated she forgot to put on gloves prior to administering Resident 9's eye drops.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE