STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA MERRILLVILLE	7900 RHODE ISLAND STREET, MERRILLVILLE, , 46410

(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 16 and 17, 2025 Facility number: 013733 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/22/25.	R 0000	This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. The Administrator will ensure all corrective action in the following Plan of Correction has been completed.	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	A. The maintenance Director has contacted the local fire department and Fire Marshall to obtain a date to participate in a fire drill.	08/15/2025

	alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the potential to affect all 53 residents residing in the facility. Finding includes:		B. Though all residents had the potential to be affected, no residents were affected by the alleged deficient practice. C. The maintenance Director was re-educated regarding the requirement to attempt to hold the fire and disaster drill in conjunction with the local fire department at least every 6 months. D. The Executive Director or his/her designee will discuss monthly at the Quality Assurance Committee to ensure ongoing compliance and to verify that it is being completed at least every 6 months. E. August 14, 2025	

	On 7/16/25 at 9:15 a.m., the monthly fire drill records were reviewed for the past twelve months. The records included the date, time and participants of the drills. There was no indication the fire department had been invited to or participated in any of the drills. During an interview on 7/16/25 at 2:45 p.m., the Maintenance Director indicated he had been with the facility since November 2024, and had not invited the fire department to attend a fire drill yet. He was unaware when the fire department had last been invited. Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the potential to affect all 53 residents residing in the facility. Finding includes: On 7/16/25 at 9:15 a.m., the monthly fire drill records were reviewed for the past twelve months. The records included the date, time and participants of the drills. There was no indication the fire department had been invited to or participated in any of the drills. During an interview on 7/16/25 at 2:45 p.m., the Maintenance Director indicated he had been with the facility since November			

	2024, and had not invited the fire department to attend a fire drill yet. He was unaware when the fire department had last been invited.			
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	R 0217	**R 217** **Evaluation- Deficiency** A. Residents #7 and 8 no longer reside in the community. The service plans for the other affected residents have been signed by the POA. B. To determine if other residents may have been affected the Director of Nursing or his/her designee are currently auditing all service plans for signatures and changes in conditions. Immediate action will take place if a service plan is found to be missing a signature or change in condition. C. All employees responsible for ensuring the service plans are updated with changes in condition and/or signed by the resident's responsible party have been in-serviced.	08/15/2025

	documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (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. 5. Resident 3's record was reviewed on 7/16/25 at 10:15 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and hemiplegia and hemiparesis following a stroke affecting the right dominant side. The current July 2025 Physician's Order Summary indicated the resident required wound care to the right lower extremity, which included cleansing the wound with saline, applying petroleum jelly, and covering the wound with a foam dressing twice weekly and as needed. The Active Wound Report indicated the resident acquired a cut/laceration/skin tear on the right back middle calf on 8/7/2024 that required an assessment every Monday. A Physician's Order, dated 6/6/25, indicated the resident was to continue to see skilled		D. The Executive Director or his/her designee will do monthly audits on random service plans looking for a signature on the service plan and any change in conditions such as home health and hospice services. The charted audits will be reviewed at the Quality Assurance Committee meetings to ensure ongoing compliance. E. August 14, 2025	

nursing services for wound management.

The Service Plan, dated 5/22/25, indicated the resident was cognitively impaired.

The Service Plan was not updated to reflect the wound care and skilled nursing visits. It was not signed by the resident's responsible party.

During an interview on 7/16/25 at 2:10 p.m., the Director of Nursing indicated she had never added skilled nursing services to the service plans and was working on getting service plans signed as she had been out of the facility.

6. Resident 5's record was reviewed on 7/16/25 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and atrial fibrillation (irregular heart beat).

The Service Plan, dated 6/23/25, indicated the resident was moderately cognitively impaired.

The Service Plan was not signed by the resident's responsible party.

During an interview on 7/17/25 at 11:49 a.m., the Director of Nursing indicated she had no further information to provide.

7. Resident's 7's closed record

	was reviewed on 7/17/25 at 9:20 a.m. Diagnoses included, but were not limited to, dementia, Alzheimer's disease, and mood disorder. The Service Plan, dated 1/28/25, indicated the resident had severe cognitive impairment. The Service Plan was not signed by the resident's responsible party. During an interview on 7/17/25 at 11:49 a.m., the Director of Nursing indicated she had no further information to provide. Based on record review and interview, the facility failed to ensure service plans were updated with changes in condition and/ or signed by the resident's responsible party for 7 of 7 service plans reviewed. (Residents 2, 4, 6, 8, 3, 5 and 7) Findings include: 1. Resident 2's record was reviewed on 7/16/25 at 10:15 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and diabetes mellitus. The Service Plan, dated 6/16/25, was not signed by the resident's responsible party. 2. Resident 4's record was reviewed on 7/16/25 at 11:45 a.m. Diagnoses included, but			

	were not limited to, dementia, atrial fibrillation and hypertension. The Service Plans, dated 9/4/24 and 4/8/25, were not signed by the resident's responsible party. 3. Resident 6's record was reviewed on 7/17/25 at 9:10 a.m. Diagnoses included, but were not limited to, acute kidney failure and diabetes mellitus. The Service Plans, dated 6/16/25 and 7/16/25, were not signed by the resident's responsible party. 4. Resident 8's closed record was reviewed on 7/17/25 at 11:18 a.m. The resident died in the facility on 4/11/25. The Service Plan, dated 1/24/25, was not signed by the resident's responsible party. During an interview on 7/16/25 at 2:05 p.m., the Director of Nursing indicated she was aware service plans had not been signed and was working to correct the issue. 5. Resident 3's record was reviewed on 7/16/25 at 10:15 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, and hemiplegia and hemiparesis following a stroke affecting the right dominant side.			

	The current July 2025 Physician's Order Summary indicated the resident required wound care to the right lower extremity, which included cleansing the wound with saline, applying petroleum jelly, and covering the wound with a foam dressing twice weekly and as needed. The Active Wound Report indicated the resident acquired a cut/laceration/skin tear on the right back middle calf on 8/7/2024 that required an assessment every Monday. A Physician's Order, dated 6/6/25, indicated the resident was to continue to see skilled nursing services for wound management. The Service Plan, dated 5/22/25, indicated the resident was cognitively impaired. The Service Plan was not updated to reflect the wound care and skilled nursing visits. It was not signed by the resident's responsible party. During an interview on 7/16/25 at 2:10 p.m., the Director of Nursing indicated she had never added skilled nursing services to the service plans and was working on getting service plans signed as she had been out of the facility. 6. Resident 5's record was			

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Based on record review and interview, the facility failed to ensure service plans were updated with changes in condition and/ or signed by the resident's responsible party for 7 of 7 service plans reviewed. (Residents 2, 4, 6, 8, 3, 5 and 7)

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R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.	R 0241	**R 241** **Health Services- Offense** A. Resident #5's EMAR was reviewed and at that time the physician was contacted and notified of metoprolol being given outside of the hold parameter orders. The order has been discontinued. B. All residents who have a hold parameter related to their blood pressure medication have the potential to be affected by the alleged practice. A hold parameter audit related to blood pressure medication will be completed on all residents	08/15/2025

	Based on record review and interview, the facility failed to ensure physician's orders were followed related to blood pressure medications administered outside of parameters for 1 of 7 residents reviewed. (Resident 5) Finding includes: Resident 5's record was reviewed on 7/16/25 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and atrial fibrillation (irregular heart beat). The June 2025 Physician's Order Summary indicated the resident received metoprolol 25 milligrams (mg) twice daily, hold for systolic blood pressure less than 120. The June 2025 Medication Administration Record indicated the metoprolol medication was administered when the systolic blood pressure was below 120 on the following days and times: - Morning: 6/22/25 blood pressure 103/64, 6/26/25 blood pressure 111/51 - Afternoon: 6/5/25 blood pressure 74/52, 6/8/25 blood pressure 105/69, 6/16/25 blood pressure 99/54, 6/22/25 blood pressure 106/67 During an interview on 7/17/25 at 11:49 A.M., the Director of		who have a hold parameter for the last 30 days to ensure they are followed. MDs will be notified immediately of any noted errors. C. All employees responsible for following physicians' orders related to hold parameters for blood pressure have been in-serviced. D. The Director of Nursing or his/her designee will do weekly audits on all residents who have hold parameters. The charted audits will be reviewed at the Quality Assurance Committee meetings to ensure ongoing compliance. E. August 14, 2025	

Nursing indicated the medications should not have been administered outside of parameters and she would be inservicing the staff.

Based on record review and interview, the facility failed to ensure physician's orders were followed related to blood pressure medications administered outside of parameters for 1 of 7 residents reviewed. (Resident 5)

Finding includes:

Resident 5's record was reviewed on 7/16/25 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and atrial fibrillation (irregular heart beat).

The June 2025 Physician's Order Summary indicated the resident received metoprolol 25 milligrams (mg) twice daily, hold for systolic blood pressure less than 120.

The June 2025 Medication Administration Record indicated the metoprolol medication was administered when the systolic blood pressure was below 120 on the following days and times:

- Morning: 6/22/25 blood pressure 103/64, 6/26/25 blood pressure 111/51

- Afternoon: 6/5/25 blood pressure 74/52, 6/8/25 blood

	pressure 105/69, 6/16/25 blood pressure 99/54, 6/22/25 blood pressure 106/67 During an interview on 7/17/25 at 11:49 A.M., the Director of Nursing indicated the medications should not have been administered outside of parameters and she would be inservicing the staff.			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure a medication cart was locked at all times while unattended during a medication pass observation for 1 of 2 medication carts observed. (Medication Cart 1) Finding includes: On 7/16/25 at 11:46 a.m., QMA 1 was observed at her medication cart in the hallway preparing to pass medications.	R 0304	**R 304** **Pharmaceutical Services-Deficiency** A. No residents were affected by the alleged deficient practice. The QMA was immediately educated by the Director of Nursing on always locking the medication cart while unattended. B. Though all residents had the potential to be affected, no residents were affected by the alleged deficient practice.	08/15/2025

	She unlocked the cart, prepared a medication in a medication cup, and then closed the drawer. She picked up the medication cup and walked to a resident in the back of the dining room to administer the medication. The medication cart was left unlocked and was not in sight of QMA 1. After administering the medication, QMA 1 returned to her cart and opened the cart drawer to prepare another medication to pass. During an interview at the time, QMA 1 indicated she had left her medication cart unlocked. During an interview on 7/17/25 at 11:53 a.m., the Director of Nursing indicated that QMA 1 should have locked her cart in between medication passes. Based on observation and interview, the facility failed to ensure a medication cart was locked at all times while unattended during a medication pass observation for 1 of 2 medication carts observed. (Medication Cart 1) Finding includes: On 7/16/25 at 11:46 a.m., QMA 1 was observed at her medication cart in the hallway preparing to pass medications. She unlocked the cart, prepared a medication in a medication cup, and then closed the		C. The Director of Nursing has educated all nurses and QMAs on always locking the medication cart while unattended. D. The Director of Nursing or his/her designee will do random weekly audit checks during medication administration times to verify that all medication carts are appropriately locked except when authorized personnel are present. The charted weekly audits will be reviewed quarterly at the Quality Assurance Committee meetings to assure ongoing compliance. E. July 31, 2025	

	drawer. She picked up the medication cup and walked to a resident in the back of the dining room to administer the medication. The medication cart was left unlocked and was not in sight of QMA 1. After administering the medication, QMA 1 returned to her cart and opened the cart drawer to prepare another medication to pass. During an interview at the time, QMA 1 indicated she had left her medication cart unlocked. During an interview on 7/17/25 at 11:53 a.m., the Director of Nursing indicated that QMA 1 should have locked her cart in between medication passes.			

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