STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/13/2024

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: March 12 and 13, 2024 Facility number: 013733 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/19/24.	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 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, record review, and interview, the facility failed to ensure a resident's	R 0029	A.Resident 3 was provided a dignity bag over her foley immediately while IDOH was present. Three bags were ordered for future residents. B.To determine if other residents may have been affected the Director of Nursing or	04/13/2024

	dignity was maintained, related to not placing a dignity bag over a foley (urinary) catheter drainage bag, for 1 of 2 residents reviewed for urinary catheters. (Resident 3) Finding includes: On 3/13/24 at 11:07 a.m., Resident 3 was observed in a wheelchair in the common area participating in activities. The foley catheter bag was attached under the wheelchair and uncovered. On 3/13/24 at 2:31 p.m., Resident 3 was observed in a wheelchair in the common area watching the television. The foley catheter bag was attached under the wheelchair and uncovered. Resident 3's record was reviewed on 3/12/24 at 12:47 p.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, and high blood pressure. The Service Plan, dated 12/5/23, indicated the resident was moderately cognitively impaired for daily decision making. During an interview, on 3/13/24 at 2:45 p.m., the Director of Nursing indicated the resident usually had a leg bag so it had never been a problem in the past. The catheter bag should		his/her designee immediately checked all residents who had a foley catheter bag. C.The Director of Nursing or his/her designee will in-service all nursing staff regarding dignity bags/foley catheter bags/residents' rights. The Director of Nursing or his/her designee will audit randomly once a week until a pattern of compliance is obtained. D.Random weekly audits will continue until a pattern of compliance is obtained. The audit will be reviewed quarterly at the Quality Assurance meeting to ensure continued compliance. E.Date of completion is April 13, 2024.	

	have been covered. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained, related to not placing a dignity bag over a foley (urinary) catheter drainage bag, for 1 of 2 residents reviewed for urinary catheters. (Resident 3) Finding includes: On 3/13/24 at 11:07 a.m., Resident 3 was observed in a wheelchair in the common area participating in activities. The foley catheter bag was attached under the wheelchair and uncovered. On 3/13/24 at 2:31 p.m., Resident 3 was observed in a wheelchair in the common area watching the television. The foley catheter bag was attached under the wheelchair and uncovered. Resident 3's record was reviewed on 3/12/24 at 12:47 p.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, and high blood pressure. The Service Plan, dated 12/5/23, indicated the resident was moderately cognitively impaired for daily decision making. During an interview, on 3/13/24			

	at 2:45 p.m., the Director of Nursing indicated the resident usually had a leg bag so it had never been a problem in the past. The catheter bag should have been covered.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure as needed (PRN) medications were authorized by a licensed nurse prior to administration with documentation noting the time of contact, for 1 of 4 residents reviewed for PRN medications. (Resident 7) Finding includes: Resident 7's record was reviewed on 3/13/24 at 12:06 p.m. Diagnoses included, but were not limited to, dementia	R 0246	A. Resident 7 no longer resides in the community. QMA 1 has been in-serviced on AVIVA Senior Livings Policy and Procedure on administration of medication and state regulations regarding PRN administration by a QMA. B. To determine if other residents may have been affected the Director of Nursing or his/her designee are currently auditing all PRN medications administered by a QMA within the last 60 days. C. The Director of Nursing or his/her designee will in-service all QMAs regarding PRN administration and state requirements regarding PRN administration by a QMA. The Director of Nursing or his/her designee will audit randomly once a week until a pattern of compliance is obtained.	04/13/2024

	and high blood pressure. The Service Plan, dated 2/1/24, indicated the resident was severely cognitively impaired. Physician's Orders, dated 2/2/24, indicated the resident was to receive morphine sulfate solution 100 milligram (mg)/5 milliliter (ml) (a pain medication), 0.25 ml by mouth or sublingual (under the tongue) as needed every 4 hours. The February 2024 Medication Administration Record (MAR), indicated the morphine was signed out as administered on 2/3/24 at 6:36 a.m. by QMA 1. Physician's Orders, dated 2/4/24, indicated the resident was to receive morphine sulfate solution 100 mg/5 ml, 0.5 ml by mouth or sublingual as needed every 2 hours. The February 2024 Medication Administration Record (MAR), indicated the morphine was signed out as administered on 2/5/24 at 6:14 a.m. by QMA 1. The record lacked documentation of the QMA receiving authorization from a licensed nurse to administer the PRN medication. During an interview, on 3/13/24 at 2:55 p.m., the Director of Nursing indicated she was unable to provide further		D. Random weekly audits will continue until a pattern of compliance is obtained. The audit will be reviewed quarterly at the Quality Assurance meeting to ensure continued compliance. E. Date of completion is April 13, 2024.	

	information regarding administration of PRN medications without prior licensed nurse authorization. Based on record review and interview, the facility failed to ensure as needed (PRN) medications were authorized by a licensed nurse prior to administration with documentation noting the time of contact, for 1 of 4 residents reviewed for PRN medications. (Resident 7) Finding includes: Resident 7's record was reviewed on 3/13/24 at 12:06 p.m. Diagnoses included, but were not limited to, dementia and high blood pressure. The Service Plan, dated 2/1/24, indicated the resident was severely cognitively impaired. Physician's Orders, dated 2/2/24, indicated the resident was to receive morphine sulfate solution 100 milligram (mg)/5 milliliter (ml) (a pain medication), 0.25 ml by mouth or sublingual (under the tongue) as needed every 4 hours. The February 2024 Medication Administration Record (MAR), indicated the morphine was signed out as administered on 2/3/24 at 6:36 a.m. by QMA 1. Physician's Orders, dated			

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R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use.	R 0301	R301-Pharmaceutical Services A.Resident 3’s bottle of buspirone was labeled with a “direction change sticker” immediately. Residents MD sent a new prescription with the correct directions to the pharmacy for the next fill cycle. B.To determine if other residents may have been	04/13/2024

(F) Date of issue and expiration date (when applicable).

(G) Name and address of the pharmacy that filled the prescription.

If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.

Based on observation, record review, and interview, the facility failed to ensure a medication was accurately labeled, for 1 of 5 residents observed during medication pass. (Resident 3)

Finding includes:

On 3/13/24 at 11:45 a.m., LPN 1 was observed preparing Resident 3's medication. LPN 1 placed one 10 milligram (mg) buspirone tablet (an anti-anxiety medication) into a medication cup. The label on the prescription bottle indicated to give two 10 mg tablets of buspirone, three times a day. LPN 1 administered the medication to the resident.

Resident 3's record was reviewed on 3/13/24 at 10:52 a.m.

A Physician's Order, dated 7/22/21, indicated buspirone 10 mg oral tablet, take 1 tablet by mouth three times a day.

affected the Director of Nursing or his/her designee will audit all medications
for all residents to verify the orders in the EMAR match with the
bottles/labels. All medications in the carts that don’t match will have a sticker
(direction change sticker) applied and a correction will be sent to the
pharmacy for the next fill cycle.

C.The Director of Nursing or his/her designee will
in-service all nurses and QMAs regarding AVIVA Senior Living Policy and Procedures
on medication handling and packaging this is to include the state regulations.
The Director of Nursing or his/her designee will audit all medications weekly
until a pattern of compliance is obtained.

D.Weekly audits will continue until a pattern of
compliance is obtained. The audit will be reviewed quarterly at the Quality
Assurance meeting to ensure continued compliance.

E.Date of
completion is April 13, 2024.

During an interview, on 3/13/24 at 11:48 a.m., LPN 1 indicated she knew the medication label was incorrect. She had reviewed the Medication Administration Record (MAR) before administering the medication, which indicated the resident should receive one 10 mg buspirone tablet. The pharmacy was supposed to apply the correct label, and she had complained several times regarding wrong instructions found on medication bottles.

During an interview, on 3/13/24 at 12:35 p.m., the Director of Nursing indicated the pharmacy continued to put the same order labels from the past on the medication, even after being told several times to change the labels to match the current facility orders.

Based on observation, record review, and interview, the facility failed to ensure a medication was accurately labeled, for 1 of 5 residents observed during medication pass. (Resident 3)

Finding includes:

On 3/13/24 at 11:45 a.m., LPN 1 was observed preparing Resident 3's medication. LPN 1 placed one 10 milligram (mg) buspirone tablet (an anti-anxiety medication) into a medication cup. The label on the prescription bottle indicated to

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREMeriam Hillis	TITLEExecutive Director	(X6) DATE03/26/2024