

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER VALPARAISO SENIOR VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 74 E JOURNEY WAY, 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 the Investigation of Complaint IN00443260. Complaint IN00443260 - State deficiencies related to the allegations are cited at R0243 and R0354. Survey date: October 24, 2024 Facility number: 015221 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/28/24.	R 0000			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records	R 0243	DON or designee will provide education and training to the nursing staff on proper administration readings. DON will monitor EMAR weekly to ensure medications are administered correctly till	11/24/2024	

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	that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure the correct dosage of insulin was administered per the Physician's Orders during an observation of medication administration. (Resident D and LPN 1) Finding includes: During an observation of medication administration on 10/24/24 at 10:38 a.m., LPN 1 was observed preparing an insulin injection for Resident D. LPN 1 indicated the resident had a blood sugar monitoring device and her blood sugar was 174. She performed hand hygiene, donned gloves, wiped the Novolog (insulin aspart) pen with an alcohol wipe, applied a new needle cap, primed the pen, and set the pen to 4 units of insulin. She entered the resident's room, wiped the back of the resident's arm with a alcohol wipe, injected 4 units of insulin, removed the pen, and disposed of the needle in the		12/31/2024 on a weekly audit sheet. Resident in question will be monitored by DON or designee to ensure correct dosage has been administered. Thereafter DON and ED will then conduct monthly reviews of EMAR during monthly QA.	
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sharps container. She removed her gloves and performed hand hygiene.

Resident D's record was reviewed on 10/24/24 at 11:56 a.m. Diagnoses included, but were not limited to, dementia and type 1 diabetes mellitus.

The Service Plan, dated 9/3/24, indicated the resident had mild to moderate disorientation and short-term memory loss. She required assistance with medications and injectables.

A Physician's Order, dated 9/22/24, indicated insulin aspart 100 unit/milliliter, inject subcutaneously as directed per the sliding scale twice daily. If blood sugar is 101-200: give 6 units; 201-300: give 8 units; 301-400: give 9 units; 401: 10 units and call the Physician for blood sugar over 401.

During an interview on 10/24/24 at 11:19 a.m., LPN 1 indicated she had given 4 units of insulin because when she typed the resident's blood sugar into the Medication Administration Record (MAR) it auto-populated how many units to give and it had said to give 4 units. She was going to clarify the orders.

During a follow-up interview on 10/24/24 at 11:42 a.m., LPN 1 indicated she had went back into the orders and discovered she should have given the

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resident 6 units of insulin. She went back to the resident and administered an additional two units because she was still in her window to administer the medication.

A policy titled, "Resident Medication Administration," indicated "...All medications are to be administered as ordered by the provider."

This citation relates to Complaint IN00443260.

Based on record review and interview, the facility failed to ensure the correct dosage of insulin was administered per the Physician's Orders during an observation of medication administration. (Resident D and LPN 1)

Finding includes:

During an observation of medication administration on 10/24/24 at 10:38 a.m., LPN 1 was observed preparing an insulin injection for Resident D. LPN 1 indicated the resident had a blood sugar monitoring device and her blood sugar was 174. She performed hand hygiene, donned gloves, wiped the Novolog (insulin aspart) pen with an alcohol wipe, applied a new needle cap, primed the pen, and set the pen to 4 units of insulin. She entered the resident's room, wiped the back of the resident's arm with a

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alcohol wipe, injected 4 units of insulin, removed the pen, and disposed of the needle in the sharps container. She removed her gloves and performed hand hygiene.

Resident D's record was reviewed on 10/24/24 at 11:56 a.m. Diagnoses included, but were not limited to, dementia and type 1 diabetes mellitus.

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During a follow-up interview on 10/24/24 at 11:42 a.m., LPN 1

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	indicated she had went back into the orders and discovered she should have given the resident 6 units of insulin. She went back to the resident and administered an additional two units because she was still in her window to administer the medication. A policy titled, "Resident Medication Administration," indicated "...All medications are to be administered as ordered by the provider." This citation relates to Complaint IN00443260.			
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care;	R 0354	DON or designee will provide the education regarding the transfer and discharges to nursing staff. DON or designee with monitor PCC weekly to ensure transfer discharge sheets have been uploaded to residents' chart going forward. DON or designee with monitor transfer discharge binder weekly to ensure all information is accurate and correct. Binder will be updated with new residents at move-in. Ed and DON will go over monthly transfer discharge documents during monthly QA going forward.	11/24/2024

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FORM APPROVED

OMB NO. 0938-0391

(C) medications;

(D) treatment; and

(E) current diet and condition on transfer.

(6) Diagnosis.

(7) Date of chest x-ray and skin test for tuberculosis.

Based on record review and interview, the facility failed to ensure transfer/discharge paperwork was completed for residents discharging to the hospital for 3 of 3 residents reviewed for hospitalization.(Residents B, E, and F)

Findings include:

1. Resident B's record was reviewed on 10/24/24 at 9:16 a.m. Diagnoses included, but were not limited to, end stage renal disease, dementia, and type 2 diabetes mellitus.

The Interim Service Plan (ISP), dated 8/20/24, indicated the resident was capable of independent decision making. The resident required assistance with medication administration, blood sugar checks, and injectable medications. He was independent for activities of daily living (ADLs) and mobility.

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A Nurse's Note, dated 8/27/24 at 7:50 a.m., indicated the resident was in the main dining room and had emesis two times. He was visibly shaking with chills and had complaints of feeling weak and nauseous. He was assisted back to his apartment and was having difficulty answering questions and swallowing. He was tested for Covid-19 with negative results. The resident agreed to going to the hospital for evaluation.

A Nurse's Note, dated 8/27/24 at 8:30 a.m., indicated the Physician was updated, 911 was called, and the resident was transported to the hospital. Report was given to the Emergency Department.

A Nurse's Note, dated 8/27/24 at 1:12 p.m., indicated the resident was admitted to the hospital with hyperkalemia and pneumonia.

There were no transfer/discharge paperwork available for review in the resident's record.

During an interview on 10/24/24 at 2:29 p.m., the Administrator indicated she was unable to locate any transfer/discharge paperwork.

2. Resident E's record was reviewed on 10/24/24 at 1:21 p.m. Diagnoses included, but

were not limited to, chronic obstructive pulmonary disease, dementia, and high blood pressure.

An ISP, dated 8/31/24, indicated the resident had mild to moderate disorientation and required cueing. She was independent for ADLs and mobility.

A Nurse's Note, dated 9/9/24 at 12:29 a.m., indicated the note was a late entry due to the computer system being down. The resident was sent to the hospital for shortness of breath at 12:15 a.m. on 9/8/24. She was admitted on bipap and no diagnosis was given from the hospital.

There were no other Nurse's Notes or transfer/discharge paperwork related to the hospitalizations.

During an interview on 10/24/24 at 2:29 p.m., the Administrator indicated she had no further information to provide.

3. Resident F's record was reviewed on 10/24/24 at 1:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and stage 3 chronic kidney disease.

The Service Plan, dated 9/6/24, indicated the resident was oriented and independent for

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OMB NO. 0938-0391

decision making. She managed her own medications and required oxygen therapy.

A Nurse's Note, dated 10/19/24 at 10:30 a.m., indicated the resident's daughter was at the facility to take the resident to the hospital. The resident stated she was having difficulty breathing. Her pulse oximetry reading was 92%.

There were no other Nurse's Notes or transfer/discharge paperwork for review.

During an interview on 10/24/24 at 2:29 p.m., the Administrator indicated the resident's daughter often took the resident to the hospital without telling the facility beforehand, so they were unable to prepare any paperwork for the resident.

A policy, titled, "Termination of Residency, Involuntary Transfer-Discharge General Information," indicated "...Emergency Interfacility Transfer-Discharge Requirements (Less than 30 days notice) Notice may be made as soon as practicable before transfer or discharge when: ...The transfer or discharge is necessary for the resident's welfare due to the resident's needs cannot be met in the facility or cannot assure the safety and wellbeing of the other residents in he

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home...Documentation
Necessary for Interfacility
Transfer-Discharge...The
documentation must be made
by the following: Any physician
when transfer or discharge is
necessary under subdivision D.
Before an interfacility transfer or
discharge occurs, the facility
must, on a form prescribed by
the department, do the
following: Notify the resident of
the transfer or discharge and
the reasons for the move in
writing and in a language and
manner that the resident
understands. The Health facility
must place a copy of the notice
in the resident's clinical record
and transmit a copy to the
following: The resident. A family
member of the resident if
known..."

This citation relates to
Complaint IN00443260.

Based on record review and
interview, the facility failed to
ensure transfer/discharge
paperwork was completed for
residents discharging to the
hospital for 3 of 3 residents
reviewed for
hospitalization.(Residents B, E,
and F)

Findings include:

1. Resident B's record was
reviewed on 10/24/24 at 9:16
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renal disease, dementia, and type 2 diabetes mellitus.

The Interim Service Plan (ISP), dated 8/20/24, indicated the resident was capable of independent decision making. The resident required assistance with medication administration, blood sugar checks, and injectable medications. He was independent for activities of daily living (ADLs) and mobility.

A Nurse's Note, dated 8/27/24 at 7:50 a.m., indicated the resident was in the main dining room and had emesis two times. He was visibly shaking with chills and had complaints of feeling weak and nauseous. He was assisted back to his apartment and was having difficulty answering questions and swallowing. He was tested for Covid-19 with negative results. The resident agreed to going to the hospital for evaluation.

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pneumonia.

There were no transfer/discharge paperwork available for review in the resident's record.

During an interview on 10/24/24 at 2:29 p.m., the Administrator indicated she was unable to locate any transfer/discharge paperwork.

2. Resident E's record was reviewed on 10/24/24 at 1:21 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, and high blood pressure.

An ISP, dated 8/31/24, indicated the resident had mild to moderate disorientation and required cueing. She was independent for ADLs and mobility.

A Nurse's Note, dated 9/9/24 at 12:29 a.m., indicated the note was a late entry due to the computer system being down. The resident was sent to the hospital for shortness of breath at 12:15 a.m. on 9/8/24. She was admitted on bipap and no diagnosis was given from the hospital.

There were no other Nurse's Notes or transfer/discharge paperwork related to the hospitalizations.

During an interview on 10/24/24 at 2:29 p.m., the Administrator indicated she had no further information to provide.

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The Service Plan, dated 9/6/24, indicated the resident was oriented and independent for decision making. She managed her own medications and required oxygen therapy.

A Nurse's Note, dated 10/19/24 at 10:30 a.m., indicated the resident's daughter was at the facility to take the resident to the hospital. The resident stated she was having difficulty breathing. Her pulse oximetry reading was 92%.

There were no other Nurse's Notes or transfer/discharge paperwork for review.

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A policy, titled, "Termination of Residency, Involuntary

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Transfer-Discharge General Information," indicated "...Emergency Interfacility Transfer-Discharge Requirements (Less than 30 days notice) Notice may be made as soon as practicable before transfer or discharge when: ...The transfer or discharge is necessary for the resident's welfare due to the resident's needs cannot be met in the facility or cannot assure the safety and wellbeing of the other residents in he home...Documentation Necessary for Interfacility Transfer-Discharge...The documentation must be made by the following: Any physician when transfer or discharge is necessary under subdivision D. Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. The Health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following: The resident. A family member of the resident if known..."

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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
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