

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 01/16/2024	
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 IN00416830 and IN00419837. Complaint IN00416830 - State deficiency related to the allegations is cited at R0349. Complaint IN00419837 - No deficiencies related to the allegations are cited. Survey date: January 16, 2024 Facility number: 015221 Residential Census: 80 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/22/24.	R 0000					
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain	R 0349	What we have done to correct			04/01/2024	

clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:

- (1) Complete.
- (2) Accurately documented.
- (3) Readily accessible.
- (4) Systematically organized.

Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to lack of documentation of a medication administration error and medication not administered as ordered for 2 of 3 residents reviewed for medications. (Residents B and C)

Findings include:

this is all nurses and QMA's were educated on reading the MAR orders thoroughly from the computer screen (not from memory), and documenting sign medication sign outs after administration. Training starts on 1/24/24

We will prevent it by having DON or ADON audit MAR's weekly to ensure Meds are being checked out accurately. Disciplinary action will be warranted to anyone not following the correct procedures.

DON, ADON or designee will be in charge

4/01/2024-is expected resolved date

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1. During an interview on 1/16/24 at 1:40 p.m., Resident B indicated a few months after he moved in to the facility, a nurse administered medication to him that was not his prescribed medication. He noticed the pills looked unfamiliar and returned them to the nurse. The nurse explained to him the medications were for another resident that had the same name. The resident had reported the incident to the Director of Nursing.

Resident B's record was reviewed on 1/16/24 at 1:00 p.m. Diagnoses included, but were not limited to, chronic kidney disease, high blood pressure, and type 2 diabetes mellitus.

The Service Plan, dated 6/16/23, indicated the resident was oriented and able to recall or retain information. He required daily supervision of medication and would be supported to take all medications safely and as ordered.

There was no documentation related to the event in Resident B's record.

During an interview on 1/16/24 at 1:58 p.m., the Director of Nursing indicated she was informed of the nurse administering the wrong

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medications to the resident. She should have documented the event when she became aware of what had occurred.

2. Resident C's record was reviewed on 1/16/24 at 2:40 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) following a stroke affecting the right side and cognitive communication deficit.

The Service Plan, dated 6/18/23, indicated the resident was oriented and able to recall or retain information. She required help with medications due to cognitive loss and would be supported to take all medications safely and as ordered.

A Physician's Order, dated 11/10/23, indicated baclofen (a muscle relaxant) oral tablet 10 milligrams (mg) 1.5 tablets by mouth three times a day.

The December 2023 Medication Administration Record (MAR) indicated the baclofen was not administered as ordered on the following dates and times:

- 6:00 a.m. on 12/5/23, 12/9/23, 12/10/23, 12/22/23, 12/23/23, 12/27/23

- 2:00 p.m. on 12/6/23, 12/7/23, 12/14/23, 12/15/23, 12/25/23

- 10:00 p.m. on 12/3/23,

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12/12/23, 12/15/23, 12/18/23,
12/19/23, 12/23/23, 12/24/23,
12/27/23

The January 2023 MAR indicated the baclofen was not administered as ordered on 1/6/24 at 6:00 a.m., 1/8/24 at 2:00 p.m., and 1/10/24 at 6:00 a.m.

During an interview on 1/16/24 at 3:01 p.m., the Director of Nursing indicated she was unable to locate documentation related to the baclofen administration.

This citation relates to Complaint IN00416830.

Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to lack of documentation of a medication administration error and medication not administered as ordered for 2 of 3 residents reviewed for medications. (Residents B and C)

Findings include:

1. During an interview on 1/16/24 at 1:40 p.m., Resident B indicated a few months after he moved in to the facility, a nurse administered medication to him that was not his prescribed medication. He noticed the pills looked unfamiliar and returned them to the nurse. The nurse

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2. Resident C's record was reviewed on 1/16/24 at 2:40 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and

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- 10:00 p.m. on 12/3/23, 12/12/23, 12/15/23, 12/18/23, 12/19/23, 12/23/23, 12/24/23, 12/27/23

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This citation relates to Complaint IN00416830.

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