STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO SENIOR VILLAGE	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 a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on July 15, 2025. This visit included a PSR to the Investigation of Intakes IN00457361 and IN00457391 completed on July 15, 2025. Intake IN00457361 - Corrected. Intake IN00457391 - Corrected. Survey dates: September 11, 2025 Facility number: 015221 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/15/25.	R 0000		
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8)	R 0356	Director of nursing or designee will go through all resident face sheets	10/26/2025

	(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the Emergency Binder was complete and contained all the necessary information required for 5 of 5 current residents reviewed. (Residents 3, 23, 22, 24 & 25)		for completion. Director of nursing or designee will create checklist off all items needed in emergency binder. This checklist will be completed weekly on Wednesdays at collaborative wellness meetings. Executive Director will check binders monthly at weekly QA meeting.	

	Finding includes: The Emergency Binder was reviewed on 9/11/25 at 11:12 a.m. The following items were missing: - Resident 3: photograph and hospital preference - Resident 23: photograph and hospital preference - Resident 22: physician contact information, photograph and hospital preference - Resident 24: no information available in Emergency Binder - Resident 25: no information available in Emergency Binder During an interview on 9/11/25 at 11:35 a.m., the Consultant was made aware of the missing items. No additional information was provided. This deficiency was cited on 7/15/25. The facility failed to implement a systemic plan of correction to prevent recurrence. Based on record review and interview, the facility failed to ensure the Emergency Binder was complete and contained all the necessary information required for 5 of 5 current residents reviewed. (Residents 3, 23, 22, 24 & 25)			

	Finding includes: The Emergency Binder was reviewed on 9/11/25 at 11:12 a.m. The following items were missing: - Resident 3: photograph and hospital preference - Resident 23: photograph and hospital preference - Resident 22: physician contact information, photograph and hospital preference - Resident 24: no information available in Emergency Binder - Resident 25: no information available in Emergency Binder During an interview on 9/11/25 at 11:35 a.m., the Consultant was made aware of the missing items. No additional information was provided. This deficiency was cited on 7/15/25. The facility failed to implement a systemic plan of correction to prevent recurrence.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72)	R 0410	Director of nursing or designee will create checklist for 1st & 2nd step TB at move in. Check list will be checked every Wednesday during collaborative nursing meeting. Designee will create calendar reminders of 2nd step TB needs. They will then put documents	10/26/2025

	hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to maintain an effective infection control program related to incomplete tuberculosis (TB) testing for 1 of 1 record reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 9/11/25 at 9:32 a.m. Diagnoses included, but were not limited to, congestive heart failure, anemia, and chronic kidney disease. The resident was admitted to the facility on 8/21/24. A TB test was administered on		under immunizations in Point click care. Executive Director will then verify all TBs have been completed during monthly QA meetings.	

8/21/24. The test indicated the results should be checked in 48-72 hours. There was no indication or documentation the test results had been checked. There was no documentation the test had been repeated.

During an interview on 9/11/25 at 2:11 p.m., the Executive Director indicated they had not readministered the TB test to the resident.

This deficiency was cited on 7/15/25. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on record review and interview, the facility failed to maintain an effective infection control program related to incomplete tuberculosis (TB) testing for 1 of 1 record reviewed. (Resident 3)

Finding includes:

Resident 3's record was reviewed on 9/11/25 at 9:32 a.m. Diagnoses included, but were not limited to, congestive heart failure, anemia, and chronic kidney disease. The resident was admitted to the facility on 8/21/24.

A TB test was administered on 8/21/24. The test indicated the results should be checked in 48-72 hours. There was no indication or documentation the

	test results had been checked. There was no documentation the test had been repeated. During an interview on 9/11/25 at 2:11 p.m., the Executive Director indicated they had not readministered the TB test to the resident. This deficiency was cited on 7/15/25. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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 SIGNATUREJaclyn wolski	TITLEexecutive director	(X6) DATE09/26/2025