| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GREEN OAKS OF VALPARAISO | 2550 MORTHLAND DRIVE, VALPARAISO, , 46383 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey.<br><br>Survey dates: August 26 and 27, 2025<br><br>Facility number: 015426<br><br>Residential Census: 116<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on 9/2/25. | R 0000 | | |
| R 0116 | Personnel - Noncompliance<br><br>410 IAC 16.2-5-1.4(a)<br><br>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance | R 0116 | R116-<br>Personnel-Noncompliance<br><br>Based on record review and interview, the facility failed to ensure reference checks, and a criminal background check was obtained for employees prior to starting | 09/26/2025 |

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| | with IC 16-28-13-3.<br><br>Based on record review and interview, the facility failed to ensure a background check was completed for an employee prior to starting employment at the facility for 1 of 5 employee files reviewed. (Dietary Aide 2)<br><br>Finding includes:<br><br>The employee files were reviewed on 8/27/25 at 10:15 a.m. Dietary Aide 2's start date was 4/29/25. There was a criminal background check request form in their file, but no results.<br><br>During an interview on 8/27/25 at 2:45 p.m., the Business Manager indicated she was unable to find the background check results and had no further information to provide.<br><br>During an interview on 8/27/25 at 3:38 p.m., the Business Manager indicated Dietary Aide 2 worked regularly at the facility and had last worked on 8/23/25.<br><br>A facility policy, titled "Abuse, Neglect, and Financial Exploitation Prevention," received as current from the Administrator, indicated, "...All staff will undergo a criminal background check...All employees must receive favorable results from the screenings in order to join the | | employment at the facility for 1 of 5 employee files reviewed.<br><br>Employee Dietary Aid 2 background check will be completed by 9/19/25; the staff member has been removed from the schedule until it is completed.<br><br>BOM was in-serviced on the Personnel policy by ED.<br><br>Employee files audit was conducted by BOM/Appointee on 9/12/25 and any discrepancies found were corrected. (Attachment A)<br><br>Employee files will be audited by BOM/Appointee twice monthly for six months. (Attachment A)<br><br>Audits and compliance will be reviewed during monthly QAPI meetings for the next 6 months. Variances will be corrected at the time of observation.<br><br>Executive Director will be responsible for continued compliance of the regulation. | |

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| | staff or continue employment..."<br><br>Based on record review and interview, the facility failed to ensure a background check was completed for an employee prior to starting employment at the facility for 1 of 5 employee files reviewed. (Dietary Aide 2)<br><br>Finding includes:<br><br>The employee files were reviewed on 8/27/25 at 10:15 a.m. Dietary Aide 2's start date was 4/29/25. There was a criminal background check request form in their file, but no results.<br><br>During an interview on 8/27/25 at 2:45 p.m., the Business Manager indicated she was unable to find the background check results and had no further information to provide.<br><br>During an interview on 8/27/25 at 3:38 p.m., the Business Manager indicated Dietary Aide 2 worked regularly at the facility and had last worked on 8/23/25. | | | |

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| | A facility policy, titled "Abuse, Neglect, and Financial Exploitation Prevention," received as current from the Administrator, indicated, "...All staff will undergo a criminal background check...All employees must receive favorable results from the screenings in order to join the staff or continue employment..." | | | |
| R 0121 | Personnel - Noncompliance<br><br>410 IAC 16.2-5-1.4(f)(1-4)<br><br>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:<br><br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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, | R 0121 | R121-Personnel-Noncompliance<br><br>Based on record review and interview, the facility failed to ensure employees received the required tuberculin skin testing (Mantoux) and a health screen upon hire and completed annual TB (tuberculosis) screening or education for 5 of 5 employee records reviewed.<br><br>Employees file for Dietary Aide 2, LPN 1, CNA1 and QMA1 were updated with completed TB testing/screening on 9/12/25. Dietary Aide 2 no longer works at the community.<br><br>BOM was in-serviced on the Personnel policy by ED. | 10/03/2025 |

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| | a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br><br>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br><br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.<br><br>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.<br><br>Based on record review and interview, the facility failed to ensure employees received the required tuberculin skin testing (Mantoux) and a health screen upon hire and completed annual TB (tuberculosis) screening or education for 5 of 5 employee records reviewed. (Dietary Aide 1, Dietary aide 2, LPN 1, CNA 1, and QMA 1)<br><br>Findings include:<br><br>The Employee Records were reviewed on 8/27/25 at 10:15 a.m. | | Employee files audit was conducted by BOM/Appointee on 9/12/25 and any discrepancies found were corrected. (Attachment B)<br><br>Employee files will be audited by BOM/Appointee twice monthly for six months. (Attachment B)<br><br>Audits and compliance will be reviewed during monthly QAPI meetings for the next 6 months. Variances will be corrected at the time of observation.<br><br>Executive Director will be responsible for continued compliance of the regulation. | |

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| | a. Dietary Aide 1 was hired on 7/21/25. There was no health screen or tuberculin skin testing completed.<br><br>b. Dietary Aide 2 was hired on 4/29/25. There was no tuberculin skin testing completed.<br><br>c. LPN 1 was hired on 3/18/24. Tuberculin skin testing was last completed on 3/18/24. There was no annual TB screening or education completed.<br><br>d. CNA 1 was hired on 3/18/24. Tuberculin skin testing was last completed on 3/29/24. There was no annual TB screening or education completed.<br><br>e. QMA 1 was hired on 3/18/24. Tuberculin skin testing was last completed on 3/25/24. There was no annual TB screening or education completed.<br><br>During an interview on 8/27/25 at 2:45 p.m., the Business Manager indicated she had no further information to provide. | | | |

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| | Based on record review and interview, the facility failed to ensure employees received the required tuberculin skin testing (Mantoux) and a health screen upon hire and completed annual TB (tuberculosis) screening or education for 5 of 5 employee records reviewed. (Dietary Aide 1, Dietary aide 2, LPN 1, CNA 1, and QMA 1)<br><br>Findings include:<br><br>The Employee Records were reviewed on 8/27/25 at 10:15 a.m.<br><br>a. Dietary Aide 1 was hired on 7/21/25. There was no health screen or tuberculin skin testing completed.<br><br>b. Dietary Aide 2 was hired on 4/29/25. There was no tuberculin skin testing completed.<br><br>c. LPN 1 was hired on 3/18/24. Tuberculin skin testing was last completed on 3/18/24. There was no annual TB screening or education completed.<br><br>d. CNA 1 was hired on 3/18/24. Tuberculin skin testing was last completed on 3/29/24. There was no annual TB screening or education completed.<br><br>e. QMA 1 was hired on 3/18/24. Tuberculin skin testing was last completed on 3/25/24. There was no annual TB screening or | | | |

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| | education completed.<br><br>During an interview on 8/27/25 at 2:45 p.m., the Business Manager indicated she had no further information to provide. | | | |
| R 0217 | Evaluation - Deficiency<br><br>410 IAC 16.2-5-2(e)(1-5)<br><br>(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:<br><br>(1) The services offered to the individual resident shall be appropriate to the:<br><br>(A) scope;<br><br>(B) frequency;<br><br>(C) need; and<br><br>(D) preference;<br><br>of the resident.<br><br>(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.<br><br>(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. | R 0217 | R217- Evaluation – Deficiency<br><br>Based on record review and interview, the facility failed to ensure a resident's service plan was up to date related to home health services provided and skin care treatment needs for 1 of 8 residents reviewed. (Resident 2)<br><br>Resident 2 service plan was immediately updated to reflect selected home health provider and services received.<br><br>All resident service plans for residents receiving skilled nursing services for wound care were audited and updated to reflect services provided and treatment.<br><br>The DON and ADON were in-serviced by the Regional Director of Clinical Services on Resident Service Plans | 10/03/2025 |

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| | (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br><br>(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.<br><br>Based on record review and interview, the facility failed to ensure a resident's service plan was up to date related to home health services provided and skin care treatment needs for 1 of 8 residents reviewed. (Resident 2)<br><br>Finding includes:<br><br>A list received from the Director of Nursing on 8/26/25 indicated Resident 2 was receiving ancillary services for wound care.<br><br>Resident 2's record was reviewed on 8/26/25 at 11:01 a.m. Diagnoses included, but were not limited to, diabetes mellitus, stage 3 chronic kidney disease, edema, and peripheral vascular disease.<br><br>The Service Plan, dated 7/11/25, indicated the resident was cognitively intact. He may utilize third party provider | | Future orders for skilled nursing for wound care will have provider and services reflected in resident service plan. Community audit orders and service plans daily for 30 days, weekly for 8 weeks, and monthly for 3 months to ensure accuracy and compliance. (Attachment C)<br><br>Audits and compliance will be reviewed during monthly QAPI meetings for the next 6 months.<br><br>Variances will be corrected at the time of observation.<br><br>Executive Director will be responsible for continued compliance of the regulation. | |

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| | services as needed and was aware of therapy/home care companies available at the community for therapy/wound care needs per preference. He had fragile skin and may experience generalized bruising, skin tears, or rashes.<br><br>There were no orders for home health services or wound care.<br><br>A Third Party Provider Coordination Note, dated 7/2/25, indicated the resident received skilled nursing services for wound care. He had a wound to the left hand, right forearm, left ankle, and right shin. All wounds were healing with no problems.<br><br>A Third Party Provider Coordination Note, dated 7/8/25, indicated the resident received physical therapy.<br><br>A Third Party Provider Coordination Note, dated 7/14/25, indicated the resident received skilled nursing services for wound care.<br><br>A Third Party Provider Coordination Note, dated 7/25/25, indicated the resident received physical therapy and provided gait training and balance training during the session. He also received skilled nursing services for wound care.<br><br>During an interview on 8/27/25 | | | |

at 2:10 p.m., the Director of Nursing indicated the service plan would be updated to reflect what type of ancillary services he was receiving and his care needs related to his skin conditions.

Based on record review and interview, the facility failed to ensure a resident's service plan was up to date related to home health services provided and skin care treatment needs for 1 of 8 residents reviewed. (Resident 2)

Finding includes:

A list received from the Director of Nursing on 8/26/25 indicated Resident 2 was receiving ancillary services for wound care.

Resident 2's record was reviewed on 8/26/25 at 11:01 a.m. Diagnoses included, but were not limited to, diabetes mellitus, stage 3 chronic kidney disease, edema, and peripheral vascular disease.

The Service Plan, dated 7/11/25, indicated the resident was cognitively intact. He may utilize third party provider services as needed and was aware of therapy/home care companies available at the community for therapy/wound care needs per preference. He had fragile skin and may experience generalized bruising,

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| | skin tears, or rashes.<br><br>There were no orders for home health services or wound care.<br><br>A Third Party Provider Coordination Note, dated 7/2/25, indicated the resident received skilled nursing services for wound care. He had a wound to the left hand, right forearm, left ankle, and right shin. All wounds were healing with no problems.<br><br>A Third Party Provider Coordination Note, dated 7/8/25, indicated the resident received physical therapy.<br><br>A Third Party Provider Coordination Note, dated 7/14/25, indicated the resident received skilled nursing services for wound care.<br><br>A Third Party Provider Coordination Note, dated 7/25/25, indicated the resident received physical therapy and provided gait training and balance training during the session. He also received skilled nursing services for wound care. | | | |

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| | During an interview on 8/27/25 at 2:10 p.m., the Director of Nursing indicated the service plan would be updated to reflect what type of ancillary services he was receiving and his care needs related to his skin conditions. | | | |
| R 0297 | Pharmaceutical Services - Noncompliance<br><br>410 IAC 16.2-5-6(c)(1)<br><br>(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident:<br><br>(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.<br><br>Based on record review and interview, the facility failed to ensure timely notifications and follow-up were sent to the physician and pharmacy related to medications not available resulting in a delay in receiving the medications from the pharmacy for administration for 1 of 8 residents reviewed. (Resident 2)<br><br>Finding includes:<br><br>Resident 2's record was reviewed on 8/26/25 at 11:01 a.m. Diagnoses included, but | R 0297 | R297- Pharmaceutical Services<br><br>Based on record review and interview, the facility failed to ensure timely notifications and follow-up were sent to the physician and pharmacy related to medications not available resulting in a delay in receiving the medications from the pharmacy for administration for 1 of 8 residents reviewed. (Resident 2)<br><br>Resident 2 primary care provider was immediately notified of missed administrations due to pharmacy pending VA approval.<br><br>All Resident records were reviewed to ensure no other variances were identified. | 10/03/2025 |

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| | were not limited to, diabetes mellitus, stage 3 chronic kidney disease, and heart failure.<br><br>The Service Plan, dated 7/11/25, indicated the resident was cognitively intact. The resident was diabetic and required staff assistance in management of his diabetes with weekly injections. The resident required staff assistance with all medication administration. He had a specified pharmacy preference on file for medications and could use the community preferred pharmacy as needed.<br><br>A Physician's Order, dated 1/17/25, indicated glimepiride (medication to manage blood sugar) 4 milligram (mg) tablet, 1 tablet in the morning and at bedtime.<br><br>The July 2025 Medication Administration Record (MAR) indicated the glimepiride was not administered as ordered on the following dates and times:<br><br>- Morning: 7/8, 7/9, 7/10, 7/12, 7/13, 7/14, 7/15, 7/17, 7/18, 7/19, 7/20, 7/22, and 7/23/25<br><br>- Bedtime: 7/7, 7/8, 7/10, 7/11, 7/12, 7/13, 7/14, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21, and 7/22/25<br><br>A Physician's Order, dated 4/8/25, indicated Jardiance (used to treat type 2 diabetes, | | Staff in-service to be completed by 9/19/2025 by DON/Designee with regard to medication administration and physician notification.<br><br>Community will audit bi-weekly medication administration reports for 6 months to audit for unavailable medication administration with notification of primary care provider to ensure accuracy and compliance. (Attachment D)<br><br>Audits and compliance will be reviewed during monthly QAPI meetings for the next 6 months.<br><br>Variances will be corrected at the time of observation.<br><br>Executive Director will be responsible for continued compliance of the regulation. | |

chronic kidney disease, and heart failure) 25 milligram tablet, 1 tablet once daily.

The July 2025 MAR indicated the Jardiance was not administered as ordered from 7/12/25 thru 7/31/25.

The August 2025 MAR indicated the Jardiance was not administered as ordered from 8/1/25 thru 8/23/25.

A Nurses' Note, dated 7/15/25 at 10:20 a.m., indicated the [Name of Pharmacy] was refilling Jardiance 25 mg and getting the medication expedited. [Name of Pharmacy] was sending the physician a request for renewing the glimepiride. The pharmacy stated that the glimepiride would be expedited once it was renewed.

During an interview on 8/27/25 at 2:10 p.m., the Director of Nursing indicated she was unable to find documentation of contact with the physician or pharmacy before 7/15/25. The [Name of Pharmacy] often was delayed in getting residents' medications timely.

A policy was received and was not applicable to the citation.

Based on record review and interview, the facility failed to ensure timely notifications and follow-up were sent to the

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| | physician and pharmacy related to medications not available resulting in a delay in receiving the medications from the pharmacy for administration for 1 of 8 residents reviewed. (Resident 2)<br><br>Finding includes:<br><br>Resident 2's record was reviewed on 8/26/25 at 11:01 a.m. Diagnoses included, but were not limited to, diabetes mellitus, stage 3 chronic kidney disease, and heart failure.<br><br>The Service Plan, dated 7/11/25, indicated the resident was cognitively intact. The resident was diabetic and required staff assistance in management of his diabetes with weekly injections. The resident required staff assistance with all medication administration. He had a specified pharmacy preference on file for medications and could use the community preferred pharmacy as needed.<br><br>A Physician's Order, dated 1/17/25, indicated glimepiride (medication to manage blood sugar) 4 milligram (mg) tablet, 1 tablet in the morning and at bedtime. | | | |

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| | The July 2025 Medication Administration Record (MAR) indicated the glimepiride was not administered as ordered on the following dates and times:<br><br>- Morning: 7/8, 7/9, 7/10, 7/12, 7/13, 7/14, 7/15, 7/17, 7/18, 7/19, 7/20, 7/22, and 7/23/25<br><br>- Bedtime: 7/7, 7/8, 7/10, 7/11, 7/12, 7/13, 7/14, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21, and 7/22/25<br><br>A Physician's Order, dated 4/8/25, indicated Jardiance (used to treat type 2 diabetes, chronic kidney disease, and heart failure) 25 milligram tablet, 1 tablet once daily.<br><br>The July 2025 MAR indicated the Jardiance was not administered as ordered from 7/12/25 thru 7/31/25.<br><br>The August 2025 MAR indicated the Jardiance was not administered as ordered from 8/1/25 thru 8/23/25. | | | |

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| | A Nurses' Note, dated 7/15/25 at 10:20 a.m., indicated the [Name of Pharmacy] was refilling Jardiance 25 mg and getting the medication expedited. [Name of Pharmacy] was sending the physician a request for renewing the glimepiride. The pharmacy stated that the glimepiride would be expedited once it was renewed.<br><br>During an interview on 8/27/25 at 2:10 p.m., the Director of Nursing indicated she was unable to find documentation of contact with the physician or pharmacy before 7/15/25. The [Name of Pharmacy] often was delayed in getting residents' medications timely.<br><br>A policy was received and was not applicable to the citation. | | | |
| R 0354 | Clinical Records - Noncompliance<br><br>410 IAC 16.2-5-8.1(g)(1-7)<br><br>(g) A transfer form shall include the following:<br><br>(1) Identification data.<br><br>(2) Name of the transferring institution.<br><br>(3) Name of the receiving institution and date of transfer.<br><br>(4) Resident ' s personal property when transferred to an acute care facility. | R 0354 | R354- Clinical Records<br><br>Based on record review and interview, the facility failed to ensure a resident who discharged to another healthcare facility received a transfer form with information for continuity of care, for 1 of 2 closed records reviewed. (Resident 9) | 10/03/2025 |

(5) Nurses ' notes relating to the resident ' s:

(A) functional abilities and physical limitations;

(B) nursing care;

(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 a resident who discharged to another healthcare facility received a transfer form with information for continuity of care, for 1 of 2 closed records reviewed. (Resident 9)

Finding includes:

The closed record review for Resident 9 was completed on 8/27/25 at 12:57 p.m. Diagnoses included, but were not limited to, hypertension and peripheral vascular disease.

A Nurse's Progress Note, dated 6/17/25 at 3:30 p.m., indicated the resident's son was moving his items out of the facility. The son indicated the resident was

All Discharge Records were audited by DON/ADON for compliance with the regulation.

Staff in-service on resident transfer/discharge policy to be completed by 9/19/2025 by DON/Designee.

DON/Designee to audit each discharge record within 24 hours of Resident’s discharge for the next 30 days, then every 3 months to ensure accuracy and compliance. (Attachment E)

Community will complete Transfer Form for each discharge effective 9/12/2025. (Attachment F)

Audits and compliance will be reviewed during monthly QAPI meetings for the next 6 months.

Variances will be corrected at the time of observation.

Executive Director will be responsible for continued compliance of the regulation.

being transferred to another healthcare facility that day. The nurse gave the resident's medications and a list of his medications to the son. The resident left the facility with his son.

There was a lack of documentation a transfer form was provided to the receiving facility which included, but was not limited to, functional abilities, physical limitations, nursing care, diagnoses, diet, and other information for continuity of care.

During an interview on 8/27/25 at 2:40 p.m., the Director of Nursing (DON) indicated they had been working with the resident and his son for the resident to be transferred to a skilled nursing facility. The resident had been accepted to the facility but they were unaware the son was transferring the resident on the day he left. The nurse did not send a transfer form to the receiving facility after she found out the resident was discharging.

Based on record review and interview, the facility failed to ensure a resident who discharged to another healthcare facility received a transfer form with information for continuity of care, for 1 of 2 closed records reviewed.

(Resident 9)

Finding includes:

The closed record review for Resident 9 was completed on 8/27/25 at 12:57 p.m. Diagnoses included, but were not limited to, hypertension and peripheral vascular disease.

A Nurse's Progress Note, dated 6/17/25 at 3:30 p.m., indicated the resident's son was moving his items out of the facility. The son indicated the resident was being transferred to another healthcare facility that day. The nurse gave the resident's medications and a list of his medications to the son. The resident left the facility with his son.

There was a lack of documentation a transfer form was provided to the receiving facility which included, but was not limited to, functional abilities, physical limitations, nursing care, diagnoses, diet, and other information for continuity of care.

During an interview on 8/27/25 at 2:40 p.m., the Director of Nursing (DON) indicated they had been working with the resident and his son for the resident to be transferred to a skilled nursing facility. The resident had been accepted to the facility but they were unaware the son was

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| | transferring the resident on the day he left. The nurse did not send a transfer form to the receiving facility after she found out the resident was discharging. | | | |

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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