STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA PLACE	8253 VIRGINIA ST MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 12 and 13, 2021 Facility number: 010887 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/19/21.	R 0000		
R 0054 Bldg. 00	410 IAC 16.2-5-1.2(x) Residents' Rights - Deficiency (x) Residents have the right to confidentiality of all personal and clinical records. Information from these sources shall not be released without the resident ' s consent, except when the resident is transferred to another health facility, when required by law, or under a third party payment contract. The resident ' s records shall be made immediately available to the resident for inspection, and the resident may receive a copy within five (5) working days, at the resident ' s expense. Based on record review and interview, the facility failed to provide access to a resident's clinical record within five working days of a written request for 1 of 7 residents reviewed. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 4/12/21 at 2:41 p.m. The diagnoses included, but	R 0054	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in	05/13/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	were not limited to, dementia and hypertension. An Authorization for Release of Clinical Records form, dated 3/1/21 and signed by Resident 7's health care power of attorney (POA), requested a copy of Resident 7's medical record. Interview with the Care Service Manager (CSM) on 4/13/21 at 9:55 a.m. indicated the resident's POA had completed a written request for copies of the medical record on 3/1/21. She sent the request and all the required information to corporate. On 4/6/21 she was contacted by the Ombudsman, who had been contacted by the resident's POA, inquiring about the copies of the record and why she had not received anything yet. The CSM then contacted corporate to inquire about the status of the record request. They had needed some information re-sent to them and then approved the request. She called the resident's POA on 4/7/21 to let her know the copies were ready to pick up. The resident's POA picked up the copies on 4/8/21. She indicated there seemed to be some miscommunication with corporate regarding the medical record request and the copies had not been provided timely.		the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1.Resident records were provided to Resident 7's POA on 4/8/2021. 2.An audit of current resident's records in reference to medical records requests in the past 30 days will be completed by 5/7/2021 by the Care Services Manager and any issues identified will be corrected. 3.The Regional Care Specialists will provide re-education to the Care Service Manager or designee on the proper process for obtaining residents records by 5/7/2021 4.The Care Services Manager is responsible for sustained compliance. The Care Services Manager, or designee, will audit resident records for requests for clinical records weekly for four weeks, bi-weekly for four weeks, then monthly for one month. Results of the audit will be discussed in the monthly QI meetings. The QI committee will determine if continued auditing is necessary based on 3	

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			consecutive months of compliance. Monitoring will be ongoing.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (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 with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure reference checks were obtained for employees prior to starting employment at the facility, for 3 of 5 employee files reviewed. (LPN 1, Housekeeper 1, and HHA 1) Findings include: The employee files were reviewed on 4/13/21 at 12:50 p.m. 1. LPN 1's start date was 1/27/21. There were no reference checks completed prior to employment. 2. Housekeeper 1's start date was 12/28/20. There were no reference checks completed prior to employment. 3. HHA 1's start date was 4/7/21. There were no reference checks completed prior to employment.	R 0116	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1.Reference checks for LPN 1,	05/13/2021

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	Interview with the Regional Executive Director and Regional Care Specialist on 4/13/21 at 2:34 p.m. indicated the reference checks had not been completed.		Housekeeper 1, and HHA 1 were initiated on 4/14/2021 by the Executive Director and designee. 2.An audit of current employee's files was initiated on 4/14/2021 by the Executive Director and designee to ensure reference checks were obtained for employees prior to starting employment at the community and any issues identified will be corrected. 3.The Executive Director will provide re-education to Care Services Manager on the proper process for employee new hires by 5/7/2021. 4.The Executive Director is responsible for sustained compliance. The Executive Director, or designee, will audit newly hired employee files for proper documentation of references weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed in the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number,			

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	qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current first aid certificate scheduled for 6 of 21 shifts reviewed. Finding includes: Facility staffing schedules for 4/7/21 through 4/13/21 were reviewed on 4/13/21 at 12:50 p.m. The schedules indicated there were no staff members who were first aid certified on the following dates and shifts: Midnight shift on 4/7/21, 4/9/21 and 4/12/21. Evening shift on 4/8/21, 4/10/21, and 4/11/21.	R 0117	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts	05/13/2021

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	Interview with the Regional Executive Director and Regional Care Specialist on 4/13/21 at 2:34 p.m. indicated there was no staff with current first aid certification working the above shifts.		alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1.An audit of current employee files was initiated on 4/14/2021 by the Executive Director and designee to identify staff with current first aid certification. Direct care employees identified as needing first aid certification will have first aid certification obtained by 5/7/2021. 2.On 4/28/2021 the Executive Director provided education to the Care Services Manager on the requirement to have minimum of one staff member with a current first aid certification scheduled for each shift. 3.The Executive Director is responsible for sustained compliance. The Executive Director, or designee, will audit employee files and work schedule to ensure one employee with current first aid certification is scheduled for each shift for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed in the monthly QI meeting. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	

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R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (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: (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, 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. (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. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited			

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	to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure employees of the facility received a first and second step Mantoux test (test for tuberculosis) and health screen upon hire for 1 of 5 employee files reviewed. (Housekeeper 1) Finding includes: Employee files were reviewed on 4/13/21 at 12:50 p.m. Housekeeper 1 was hired on 12/28/20. She had not had any health screen or Mantoux testing completed. Interview with the Regional Executive Director and Regional Care Specialist on 4/13/21 at 2:34 p.m. indicated the health screen and Mantoux testing had not been completed.	R 0121	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1.A Health Screen for Housekeeper 1 will be initiated prior to employee returning from FMLA. 2.An audit of current employee files was initiated on 4/14/2021 by the Executive Director and designee to ensure employees received a first and second Mantoux test and health screen upon hire and any issues identified will be corrected. 3.The Executive Director will provide re-education to Care Service Manager on the requirement for employees to	05/13/2021

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			receive a first and second step Mantoux test and health screen upon hire by 5/7/2021. 4.The Executive Director is responsible for sustained compliance. The Executive Director, or designee, will audit newly hired employee files for proper documentation of first and second step Mantoux and Health Screens completion upon hires weekly for four weeks, biweekly for four weeks, then monthly for one month. Results of the audit will be discussed in the monthly QI meeting. The QI committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure food was stored under safe and sanitary conditions related to open and unlabeled foods. This had the potential to affect the 28 residents who resided in the facility and were served food from the kitchen. (Kitchen)	R 0273	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who	05/13/2021

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	Findings include: Upon initial tour of the Kitchen with the Assistant Chef on 4/12/21 at 9:45 a.m., the following was observed: 1. In the freezer: - A plastic bag of hamburger patties open to air and undated. - A plastic bin on the bottom shelf with multiple plastic bags of food that were open to air and undated. Some of the items were not identifiable and were not labeled. Interview with the Assistant Chef at the time of the observation identified some of the items as chicken and sausage. She indicated she just "knows what everything is." 2. In the dry storage area: - Two bags of potato chips open to air and undated. - A plastic bag of powdered sugar open to air and undated. Interview with the Assistant Chef on 4/12/21 at 10:00 a.m. indicated all of the items should be closed and labeled with an open date. A facility policy titled, "Storage of Products," received as current, indicated ".... Once opened, items should be dated and sealed/covered appropriately for storage."		drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1.Identified food open to air, undated and/or unlabeled was discarded by Assistant Chef on 4/12/2021. 2.An audit of the refrigerator, freezer and dry storage was completed by the Chef on 4/27/2021 to ensure food stored under safe and sanitary conditions. Any unlabeled or undated food was discarded. 3.The Regional Executive Director will provide re-education to the Chef and Assistant Chef on food preparation and serving areas being mainlined in accordance with state and local sanitation and safe food handling standards by 5/7/2021. 4.The Executive Director is responsible for sustained compliance. The Executive Director, or designee, will audit the refrigerator, freezer and dry storage weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure food is stored under safe and	

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			sanitary conditions. The results of the audit will be discussed in the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain 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 the resident's clinical record was complete and accurate related to the lack of documentation that blood glucose testing was completed for 2 of 7 records reviewed. (Residents 8 & 5) Findings include: 1. Record review for Resident 8 was completed on 4/12/21 at 10:31 a.m. Diagnoses included, but were not limited to diabetes mellitus, and dementia. The Physician's Order Summary (POS), dated April 2021, indicated an order to complete blood	R 0349	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts	05/13/2021

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	sugar checks three times a day before meals. The Blood Glucose Monitoring Sheet, dated March 2021, indicated the resident's blood sugars were not documented on the following dates and times: - 3/2/21, before dinner - 3/15/21, before breakfast - 3/19/21, before dinner - 3/28/21, before dinner - 3/30/31, before dinner The resident's record lacked any documentation the blood sugars were documented on the above dates and times. Interview with the Care Services Manager on 4/13/21 at 8:45 a.m., indicated she was unable to provide any documentation the blood glucose monitoring was completed on the above dates and times. 2. Record review for Resident 5 was completed on 4/12/21 at 1:49 p.m. Diagnoses included, but were not limited to diabetes mellitus, and hypertension. The POS, dated April 2021, indicated the following orders: - check blood sugar at HS (at bedtime) - Lantus (insulin) 5 units at bedtime The Blood Glucose Monitoring Sheet, dated March 2021, indicated the resident's blood sugars were not documented on the following dates and times:		alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1.Residents 5 and 8 suffered no negative outcomes related to these findings. 2.An audit of current resident's with orders for blood glucose testing will be completed by 5/7/2021 by the Care Services Manager to ensure clinical records are complete and accurate related to documentation of order blood glucose test and any issues identified will be reviewed with resident's physician. 3.The Care Services Manager will provide re-education to the licensed nurses on the proper process to document blood glucose monitoring by 5/7/2021. 4.The Care Services Manager is responsible for sustained compliance. The Care Services Manager, or designee, will audit 5 residents records with orders for blood glucose monitoring weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure records reflect complete and accurate documentation. Results of the audit will be discussed in the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be	

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	- 3/11/21, at HS - 3/12/21, at HS - 3/13/21, at HS - 3/14/21, at HS - 3/15/21, at HS - 3/16/21, at HS - 3/19/21, at HS - 3/23/21, at HS - 3/29/21, at HS - 3/30/21, at HS The resident's record lacked any documentation the blood sugars were documented on the above dates and times. Interview with the Care Services Manager on 4/13/21 at 11:30 a.m., indicated she was unable to provide any documentation the blood glucose monitoring was completed on the above dates and times.		ongoing. 1.Residents 5 and 8 suffered no negative outcomes related to these findings. 2.An audit of current resident's with orders for blood glucose testing will be completed by 5/7/2021 by the Care Services Manager to ensure clinical records are complete and accurate related to documentation of order blood glucose test and any issues identified will be reviewed with resident's physician. 3.The Care Services Manager will provide re-education to the licensed nurses on the proper process to document blood glucose monitoring by 5/7/2021. 4.The Care Services Manager is responsible for sustained compliance. The Care Services Manager, or designee, will audit 5 residents records with orders for blood glucose monitoring weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure records reflect complete and accurate documentation. Results of the audit will be discussed in the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA PLACE	8253 VIRGINIA ST MERRILLVILLE, IN 46410

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			of compliance. Monitoring will be ongoing.	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (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; (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 complete a discharge summary and transfer form for 1 of 7 clinical records reviewed. (Resident 2) Finding includes: The closed record for Resident 2 was reviewed on 4/12/21 at 11:10 a.m. The resident was discharged and transferred to another facility on 3/13/21. There were no transfer or discharge forms completed in the record The last progress note was entered on 3/12/21 and indicated the resident had received his COVID vaccine.	R 0354	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or	05/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA PLACE	8253 VIRGINIA ST MERRILLVILLE, IN 46410

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	Interview with the Regional Nurse on 4/12/21 at 2:30 p.m., indicated there should be a progress note documenting the details of the resident's discharge. Interview with the Care Service Manager on 4/13/21 at 1:30 p.m., indicated the resident had transferred to another facility. She was unable to locate a copy of the resident's transfer form and indicated there were no progress notes regarding his discharge.		agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. 1.Resident 2 no longer resides in the community. 2.An audit of resident's records transferred from community in the past 30 days will be completed by 5/7/2021 by the Care Services Manager to ensure a discharge summary and transfer form was completed. Results of audit will be reviewed with Executive Director. 3.The Care Services Manager will provide re-education to the licensed nurses on the proper documentation requirements for resident's who transfer from the community by 5/7/2021. 4.The Care Services Manager is responsible for sustained compliance. The Care Services Manager, or designee, will audit transferred residents' records weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure records reflect discharge summary and transfer form. Results of the audit will be discussed in the monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on all 3 consecutive months of compliance. Monitoring will be ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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