STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00418115, IN00419329, IN00419354, and IN00420185. Complaint IN00418115 - No deficiencies related to the allegations are cited. Complaint IN00419329 - No deficiencies related to the allegations are cited. Complaint IN00419354 - Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00420185 - Federal/State deficiencies related to the allegations are cited at F609. Survey dates: October 23, 24, and 25, 2023 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 121 Total: 121 Census Payor Type: Medicare: 6 Medicaid: 102 Other: 13 Total: 121 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/26/23.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests a desk review for compliance on or after 11/17/23.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Wolf	Executive Director	11/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the Indiana Department of Health (IDOH) immediately or within the 2 hour time period for 2 of 6 residents reviewed for abuse. (Residents F and G) The facility also failed to ensure an allegation submitted was not misleading with the	F 0609	**F 609 Reporting of alleged violations** It is the practice of this facility to complete an incident report and submit to ISDH gateway within 2 hours of staff to resident abuse allegations.	11/17/2023

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	facts reported by the resident. (Resident F). Findings include: 1. During an interview on 10/23/23 at 9:56 a.m., Resident F indicated a staff member had thrown water in her face. She had reported the incident to the Nurse. Resident F's record was reviewed on 10/24/23 at 2:53 p.m. The diagnoses included, but were not limited to, chronic respiratory failure and dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 9/20/23, indicated a moderately impaired cognitive status and she required oxygen, suctioning, and a tracheostomy. A Progress Note, dated 10/14/23 at 1 p.m. and written by the Memory Care Social Service Director, indicated the resident's daughter had provided details about an incident that had occurred. A reported incident to IDOH from the facility, indicated the incident date was 10/17/23 at 3:45 p.m. The allegation was reported to the IDOH on 10/18/23 and indicated Employee 1 had "splashed" water into her face while providing care on 10/14/23. During an interview with the Memory Care Social Service Director on 10/24/23 at 3:59 p.m., she indicated she had been the Manager on Duty on 10/14/23 and she had been contacted by the Administrator and asked to interview the resident about the allegation. The Administrator had informed her the resident made an allegation she had been squirted with water. She interviewed the		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Allegation for residents F and G was reported to ISDH via Gateway. Each resident was clarified in Gateway with the facts reported by the resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. Review of allegations of abuse in the last 30 days were reviewed by ED and Regional staff to ensure all allegations were reported timely and accurately per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was provided to the ED regarding timely and accurate reporting. Abuse identification, prevention and reporting education provided to staff on 10/31/23. ED will send all abuse allegations, with accurate statements, within 2 hours of notification to Gateway. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	resident and had written a statement. She was not sure what happened to the statement she had written up and could rewrite the statements from the interview. A written statement from the Memory Care Social Service Director, dated 10/24/23, indicated the statement had been obtained from the resident on 10/14/23. The statement indicated the Administrator informed her of the allegation and had asked her to interview the resident. After the interview, she notified the Administrator with the responses she received. She then had notified the resident's daughter and informed her of the incident. The resident had indicated Employee 1 entered her room to assist her with care. She had asked Employee 1 to help her with her tracheostomy because it had felt loose. Employee 1 then threw a cup of water on her. During an interview on 10/24/23 at 3:52 p.m., the Director of Nursing (DON) indicated she had not interviewed the resident on 10/14/23 because it had been reported to her that the water on her face was from the condensation from the tracheostomy tubes. It had not been reported to her that the allegation was a cup of water was thrown in her face. If she had been informed a cup of water was thrown in her face, she would have interviewed her when she was in the building due to another allegation of abuse. A signed statement from the DON, dated 10/16/23, indicated the resident had been interviewed on 10/16/23. The resident indicated she had informed Employee 1 three times her valve was coming off and after the third time, Employee 1 threw a cup of water in her face. After the water had been thrown, the employee left the room and she had not seen Employee 1 for the rest of the night.		**assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Abuse prohibition and investigation” weekly for 4 weeks, monthly for 6 months and quarterly thereafter during the facility’s QAPI meeting. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	A signed statement from the Respiratory Therapy Supervisor, dated 10/17/23, indicated she had received a phone call from Employee 2, who had spoken with the resident's daughter. The daughter had requested a return call to her. She notified the daughter and she requested Employee 1 not care for the resident again and stated Employee 1 had thrown water in her mother's face. It was explained to the daughter the resident has a tracheostomy and wears humidity to the tracheostomy tube. The tube could cause condensation and she could have had water on her face from the condensation of from being suctioned if the tube had not been connected tightly. The daughter was assured the incident would be investigated and Employee 1 would not be assigned to her Mother. The Administrator and the DON would be notified. The Administrator was interviewed on 10/24/23 at 3:15 p.m. and indicated when he was notified of the allegation he was told it could have been from the condensation. He acknowledged the allegations had not been reported to IDOH immediately or within 2 hours and it had not been reported until four days after the allegation. An interview with the Respiratory Therapy Supervisor on 10/24/23 at 3:30 p.m., indicated she had reported the resident said Employee 1 had thrown a cup of water in her face. 2. During an interview on 10/23/23 at 10:10 a.m., Resident G, who communicated with limited verbalization and with the nod of a head, indicated she had been abused one time. She moved her hand to her head and hit the side of her head. She shook her head yes when she was asked if it was a hard hit. She verbalized it was a female and she			

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	had reported the incident. Resident G's record was reviewed on 10/24/23 at 3:36 p.m. The diagnoses included, but were not limited to, respiratory failure and ventilator dependent. A Quarterly MDS assessment, dated 9/20/23, indicated a severely impaired cognitive status and required oxygen, suctioning, tracheostomy and ventilator usage. A Nurse's Progress Note, dated 10/14/23 at 4:30 p.m., indicated the resident reported a short lady with dark hair was walking around her room in last night. This person hit her on the head with an open hand and told her to go to sleep. She denied pain or discomfort. Her husband was at the bedside. The Administrator, DON and the Physician were notified. An IDOH reported incident, dated 10/15/23, indicated on 10/14/23 at 3 p.m. the resident alleged that someone who matched the description of Employee 2 had been verbally inappropriate to her and then made contact to her head with an open hand. On 10/24/23 at 4:15 p.m., the Administrator indicated the allegation of abuse had not been reported to the IDOH within two hours. During an interview on 10/24/23 at 4:26 p.m., the Administrator indicated Employee 3 had notified him of the allegation and Employee 3 had notified the Respiratory Therapy Supervisor. The DON indicated the Administrator had notified her and she came to the facility to interview the resident. A signed statement from the DON, dated 10/14/23,			

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	indicated she had interviewed the resident and her husband because the resident informed her husband she had been hit in the head the previous night. The resident indicated it was a short, Caucasian woman with dark hair. The woman had hit her in the head and told her to go to sleep. The resident had asked for a popsicle and thought that may have been why she hit her in the head. There was no visible injury to the head. The resident was unable to name the person nor describe what the person was wearing at the time of the incident. During an interview on 10/25/23 at 4:35 p.m., Employee 3 indicated the resident has a book she writes everything down in and then tells her husband what she wrote. Her husband came to the Nurses' Station and indicated the resident did not have a very good night. She had asked an employee for a popsicle and the employee told her to go to sleep and hit her on the head. Employee 3 assessed and interviewed the resident after being informed of the incident by the husband. The resident indicated she had asked for a popsicle and was hit in the head and told to go to sleep. She described the employee as short, Caucasian, short hair and wore a black uniform. There were no visible injuries. She indicated she notified the Administrator immediately. A facility abuse policy, dated 6/2023, and received from the DON as current, indicated an incident report would initiated within two hours of the allegation. The Administrator would ensure the alleged violation of abuse would be reported immediately but no later than two hours to the IDOH. This citation relates to Complaints IN00419354 and IN00420185.			

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	3.1-28(c)			