STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 24, 25, 26, 27, and 28, 2022. Facility number: 000224 Provider number: 155331 AIM number: 100267700 Census Bed Type: SNF/NF: 74 SNF: 10 Total: 84 Census Payor Type: Medicare: 11 Medicaid: 59 Other: 14 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/1/22.	F 0000	I respectfully request consideration for paper compliance. I have forwarded the signed 2567 via fax to 1-317-233-7322. I will also forward all documents, inservices, etc. upon date certain to the same number listed above. Please reference the attached 2567 as “Credible Allegation of Compliance” for our annual survey conducted on October 24-28, 2022. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you! Amber Janeczko, Executive Director	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Janeczko	Executive Director	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure a dependent resident was provided activities to meet her interests for 1 of 1 residents reviewed for activities. (Resident 10) Finding includes: On 10/25/22 at 2:32 p.m., 10/27/22 at 11:30 a.m., and 1:23 p.m., Resident 10 was observed in her bed with her eyes closed. On 10/26/22 at 12:54 p.m., 2:18 p.m., and 3:10 p.m., the resident was observed awake in her bed. On 10/26/22 at 8:23 a.m., 10:55 a.m., 10/27/22 at 8:51 a.m., and 10/28/22 at 8:56 a.m. the resident was observed seated in her wheelchair in her room. At no time during the observation days was the resident observed outside her room. The resident's record was reviewed on 10/26/22 at 10:14 a.m. The resident was admitted on 12/15/21. Diagnoses included, but were not limited to, Alzheimer's dementia and failure to thrive. The current Activities Care Plan indicated the resident loved activities but needed reminders due to her diagnoses of dementia. She enjoyed bingo, current news, movies, music, games, radio, reading, sing a longs, socials and church. The goal was to have the resident attend at least one activity a week and provide her with blocks, crayons and an activity apron to give her something to do through the next review.	F 0679	**F 679** 1 Resident #10's care plan and care directive were updated on 10-28-22 to reflect current interests/preferences and 1 x 1 activity visits. 2. The Activity Director and/or designee will be directed to re-interview all current residents to ensure their activity interests/preferences are reflective on their care plan and care directives. All new admission activity/preferences will also be added to their care plan and care directives when completing their initial assessment. 3. Ongoing, the Activity Director and/or designee will discuss and update interests/preferences with the resident/family quarterly based on the care plan schedule and/or as needed to ensure current practices reflect the resident activity choices. Education will be provided to the Activities staff regarding this process and ensuring activity participation is documented on behalf of the resident by 11-18-22. 4. The ED or Designee will audit for compliance two times per week for six months utilizing a "Resident Interest/Preference/Activity	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The activity calendar posted in the main hallway, indicated there was a movie on 10/26/22 at 1:30 p.m., on 10/27/22 there were manicures at 9:00 a.m., and reading hour at 3:30 p.m. The resident's activity log indicated the resident attended church and had a visit one time in August. In September the resident was visited by a pet one time, and had a visit two times in October 2022. The activity log indicated the resident watched television daily and had a family visit daily. Interview with the resident's family member on 10/25/22 at 11:20 a.m., indicated someone in the family tried to visit her every morning. She said staff would often say they were going to take her to an activity, but she had never seen her go to one. Interview with the Activity Director, on 10/28/22 at 9:13 a.m., indicated they tried to visit the residents daily, but did not record on the resident's activity log. She indicated the events on the activity log were the only events the resident had attended. 3.1-33(a)		Attendance Audit Tool" developed by the ED. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. DATE CERTAIN 11-29-22	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure skin discolorations were assessed and monitored for a resident on anticoagulants and wound dressings were changed as ordered. (Resident 39 and 237) Findings include: 1. On 10/24/22 at 11:12 a.m., two areas of discoloration were noted to Resident 39's left forearm. Resident 39's record was reviewed on 10/26/22 at 10:17 a.m. Diagnoses included, but were not limited to, hemiplegia (one-sided paralysis) following cerebral infarction affecting his right dominant side, heart failure, high blood pressure, and atrial fibrillation (irregular heart beat). The Quarterly Minimum Data Set (MDS) assessment, dated 9/2/22, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance with one person physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. A Physician's Order, dated 11/3/21, indicated Eliquis tablet (a blood thinner) 2.5 milligrams two times a day. A Physician's Order, dated 11/3/21, indicated to monitor for signs or symptoms for bleeding including black tarry stools, bleeding gums, bruising, and nose bleeds related to anticoagulant use and document every shift. A Care Plan, revised on 8/18/22, indicated the resident was at risk for abnormal bruising or	F 0684	F 684 1. Resident #39 had no adverse reactions and the physician and family were notified. The resident was seen by the physician on 10-28-22 with no new orders. Resident #237 also had no negative outcomes and no symptoms of infection. The physician and family were notified and no new orders. 2. An in house audit was completed by date of compliance by nursing management on residents on anticoagulant medications and residents requiring dressing changes and no other issues were noted. 3. Education will be provided to all licensed nursing staff and C.N.A.'s on appropriate assessing and documentation of any skin issues. Education will also be provided on how to document and educate on refusal of care and/or treatments by Nursing Management including who to notify. Care plans will be put in place for any resident with refusal of care concerns by date of compliance as well. Nursing staff who have not completed this education will not work until this has been completed. This education will be provided in orientation and at least annually thereafter. 4. Nurse Managers will audit weekly for compliance 5 clinical records of residents on	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	bleeding related to anticoagulant therapy, Eliquis and aspirin, for management of atrial fibrillation. Interventions included, but were not limited to, observe and report any adverse reactions of anticoagulant therapy such as, blood in urine, black tarry stools, headaches, nausea, vomiting, diarrhea, bruising, or shortness of breath. Weekly Skin Integrity Data Collection assessments were completed on 10/7/22, 10/14/22, and 10/21/22. The assessments indicated the resident's skin was intact and there were no new findings. The resident had a shower completed on 10/26/22 at 1:55 p.m. There was no documentation of any new skin conditions. Interview with the Director of Nursing (DON) on 10/27/22 at 3:54 p.m., indicated she had no further information to provide. Interview with the Medical Director on 10/28/22 at 10:39 a.m., indicated he had just been notified of the discolorations and assessed the resident. He indicated the resident had purpura (purple spots due to small blood vessels leaking blood into the skin) on his left forearm due to the Eliquis that he had been taking for his atrial fibrillation. 2. On 10/24/22 at 11:26 a.m., Resident 237 was noted to have bilateral lower leg dressings dated 10/22/22. The resident indicated the staff did not always get to it every day. Resident 237's record was reviewed on 10/25/22 at 1:45 p.m. Diagnoses included, but were not limited to, cellulitis of the right and left lower limbs, high blood pressure, anxiety disorder, chronic lung disease, and venous insufficiency.		anticoagulants and validate with a skin UDA completed by them as well x 3 months then 3 residents x 3 months. Nurse Managers will complete audits of 5 residents requiring treatments weekly x 3 months then 3 residents x 3 months. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. 5. Date of Compliance: 11-29-22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The Admission Minimum Data Set (MDS) assessment, dated 10/23/22, was still in progress. The Physician's Order, dated 10/20/22, indicated cleanse bilateral lower extremities with wound wash, pat dry, apply Xeroform dressing, abdominal pads, and wrap with Kerlix (woven gauze) every day shift. A Care Plan, dated 10/19/22, indicated the resident had bilateral lower extremity cellulitis. Interventions included, but were not limited to, complete treatment as ordered. Interview with LPN 3 on 10/25/22 at 2:42 p.m., indicated the dressing should have been changed daily as ordered and she was unsure why the treatment was not completed on 10/23/22. Interview with Director of Nursing (DON), on 10/26/22 at 12:59 p.m., indicated she spoke with the resident and she had indicated she refused the treatment on Sunday 10/23/22. This was not documented in the chart as the nurse who was supposed to do the treatment had already checked it off as completed prior to doing the treatment. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed ensure a resident with a pressure ulcer received appropriate care related to accurate measurement, staging and date assessed for 1 of 3 residents reviewed for pressure ulcers. (Resident 46) Finding includes: On 10/27/22 at 10:10 a.m., Resident 46's wound care was observed with LPN 2. The resident had a pressure ulcer on her right heel. The wound was irregular and oval shaped. The wound bed was red and beefy, and there was slough (yellowish avascular tissue) present. The LPN indicated she hadn't seen the wound for a week, but it looked improved. The resident's record was reviewed on 10/25/22 at 2:29 p.m. The resident was admitted on 9/3/22. Diagnoses included, but were not limited to, a stage 2 pressure ulcer to the right heel and dementia. A weekly wound assessment, dated 10/27/22, indicated the wound was a stage 2, measured 1.4 centimeters (cm) by 1.0 cm, and was improving. There was no slough present. A weekly wound assessment, dated 10/18/22, indicated the wound was a stage 2, and measured	F 0686	F 686 1. Resident #46's physician and family were notified with new orders received and initiated immediately. 2. An in house audit was completed by the wound nurse for residents with pressure ulcers to assure no other concerns by date of compliance and no other issues were noted. 3. The DON will be educated by our corporate wound nurse, Angel Sutton RN, MSN on staging wounds correctly. Education will be provided to the DON by the Regional Director of Clinical Services on the actual policy and best practices related to weekly wound observation tools and time frame they are due within. Nursing staff will be educated by the wound nurse on notifying the wound nurse with a substantial change in wounds within 24 hours. Nursing staff who have not been educated will not work until this has been completed and all new hires will receive this education in orientation as well as at least annually.	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	1 cm x 1 cm. Granulation tissue was present. The wound was observed again on 10/28/22 at 9:30 a.m. with the Director of Nursing (DON). The DON indicated she did the weekly wound assessments. The DON measured the wound and indicated it was 4 cm x 2 cm, and it was a stage 3. She indicated the wound was substantially larger than before. She also indicated she had not assessed the wound on 10/27/22 as documented, but on that Monday instead. 3.1-40		4. The wound nurse or designee will observe weekly for compliance all pressure ulcers ongoing for any changes and document appropriately. The Regional Director of Clinical Services will audit 2 residents weekly utilizing the wound report to compare with the wound information, wound observation tool, treatment orders and care plans to assure compliance x 3 months. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. 5. Date of Compliance: 11-29-22	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure an injury prevention device had a care plan, Physician's order, or any monitoring being completed while in place for a resident with a history of falls for 1 of 2	F 0689	F 689 1. Resident #36 had no negative outcomes and a physician order was obtained and a care plan was initiated immediately.	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	residents reviewed for accidents. (Resident 36) Finding includes: On 10/25/22 at 11:05 a.m., Resident 36 was observed sitting in a wheelchair in the hallway. The resident was wearing a pink helmet with a strap underneath her chin. On 10/25/22 at 2:29 p.m., Resident 36 was observed sitting in a wheelchair in her room with her eyes closed. The resident was wearing a pink helmet with a strap underneath her chin. On 10/26/22 at 9:09 a.m., Resident 36 was observed sitting in a wheelchair in her room with her eyes closed. The resident was wearing a pink helmet with a strap underneath her chin. Record review for Resident 36 was completed on 10/26/22 at 2:35 p.m. Diagnoses included, but were not limited to, depression, and mild intellectual disabilities. The Quarterly Minimum Data Set (MDS) assessment, dated 8/29/22, indicated the resident was severely cognitively impaired. The resident required an extensive 1 person assist for bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene. A Care Plan, dated 12/23/21 and revised on 9/30/22, indicated the resident had an actual fall without injury and was at risk for further falls related to decreased mobility, weakness, abnormal posture, mild intellectual disabilities, asthma, macular degeneration, and depression. The helmet was not listed on the interventions to be worn as an injury prevention device.		2. An in house audit will be completed by date of compliance by nursing management on residents with adaptive safety devices and care plans will be audited and updated as required. Any issues will be addressed by date of compliance. 3. Education will be provided to nursing staff, MDS, and nursing managers by the DON or designee requiring that safety adaptive devices must have a physician's order and be care planned and updated on the Kardex by date of compliance. Any required staff that has not received this education will not work until this has been completed. This education will be provided in orientation and at least annually. 4. Nurse Managers will audit weekly for compliance 5 residents x 3 months then 3 residents x 3 months to assure compliance to include the device has an order in place and it is care planned and on the Kardex. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. 5. Date of Compliance: 11-29-22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A Care Plan, dated 2/18/22, indicated the resident may exhibit behavioral episodes such as agitation, anxiety and irritability due to wanting her personal items in order and set up near her. The resident may exhibit irritability and yelling out if things are not her way even though she was non-verbal in other aspects. The resident does have an intellectual disability, so yelling out, pointing and head nods of yes and no are communication skills. The helmet was not listed on the interventions to be worn as an injury prevention device. The record lacked any documentation there was a Physician's Order or a Care Plan for the helmet to be worn. There was no documentation of when the helmet should be worn and if any monitoring of the helmet was being completed. Interview with the Director of Nursing (DON) on 10/27/22 at 8:59 a.m., indicated she was unsure why the resident wore the helmet. She would assume it was worn as an injury prevention device related to falls. The resident had worn the helmet ever since she was admitted to the facility and prior. The staff removed it when she went to bed. She would look into why there was no Physician's Order or Care Plan in place. Interview with LPN 1 on 10/27/22 at 10:18 a.m., indicated the resident could put on and remove the helmet herself, but the staff would put it on her when she woke up and take it off before she went to bed. Follow up interview with the DON on 10/27/22 at 11:15 a.m., indicated the resident should have had a care plan in place or some documentation as to why the helmet was being worn. There should have been some monitoring completed of when it was put on and taken off.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The DON further provided a Physician's Order, dated 10/27/22 at 11:44 a.m., which indicated the resident was to wear the helmet when out of bed, may remove for skin assessment and hygiene. Remove the helmet when in bed every shift for injury prevention due to falls. She indicated the Fall and Behavior Care Plans had also been updated on 10/27/22 to include the helmet and for nursing to check for placement. 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review and interview, the facility failed to ensure a resident	F 0693	F 693 1. Resident #10 had no negative	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	with a gastronomy tube (G-tube) received appropriate treatment related to checking tube placement prior to use for 1 of 1 residents reviewed for G-tubes. (Resident 10) Finding includes: On 10/27/22 at 1:35 p.m., LPN 2 was observed giving medications to Resident 10 via her G-tube. The LPN attempted to verify the placement of the G-tube by aspirating the contents. She inserted the syringe into the G-tube and pulled back on the plunger. The plunger did not move, nothing was drawn into the syringe. She then removed the plunger and placed the syringe upright to pour water into. The water did not go into the G-tube. The LPN indicated it must be clogged, she then massaged the tubing in several places until the water began to flow into the tubing. She then proceeded to give the medications. The current policy, "Enteral tube drug instillation, long-term care", was received from the Director of Nursing on 10/27/22 at 1:53 p.m. The policy indicated, "...Aspirate the tube contents and inspect the visual characteristic of the aspirate...." Interview with the LPN afterwards, she indicated if nothing was drawn into the syringe when the plunger was pulled, it likely meant the tube was clogged. She indicated she should have unclogged the tubing and then checked placement again prior to giving the medications. 3.1-44(a)(2)		outcomes. LPN #2 was educated by the DON and the physician and family were notified. 2. Nursing managers made random observations on residents with tube feeding in place by date of compliance to assure no other concerns and none were noted. 3. Education and competencies will be completed on licensed nursing staff and QMA's regarding the policy for checking for placement of a G-tube by nursing managers by date of compliance. Any required staff that has not received this education will not work until completed and all required new hires will receive this education in orientation as well as at least annually. 4. The DON or designee will observe residents with G-tubes weekly for compliance x 6 months. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. 5. Date of Compliance: 11-29-22	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review and interview, the facility failed to ensure a resident with dementia was provided activities to meet his interests for 1 of 1 residents reviewed for dementia care. (Resident 59) Finding includes: On 10/26/22 at 8:33 a.m., 3:10 p.m., 10/27/22 at 9:58 a.m., 10:30 a.m., 12:00 p.m., 10/28/22 at 8:56 a.m., Resident 59 was observed seated in his wheelchair in his room. On 10/26/22 at 12:54 p.m., 2:18 p.m., 10/27/22 at 1:23 p.m., and 2:50 p.m., the resident was observed laying in his bed. The resident's record was reviewed on 10/26/22 at 12:57 p.m. The resident was admitted on 7/27/19. Diagnoses included, but were not limited to, vascular dementia. The current Activity Care Plan indicated the resident enjoyed animals, current events, educational programs, exercise, movies and watching sports on television. Interventions included to encourage him to attend activities of his interest, give him verbal reminders of activities and transport him to activities. The resident's activity log indicated he attended current events, exercise and had a visit one time in August, in September he had a pet visit and a visit one time, and a visit one time in October 2022. Television and family/friend visits were marked daily.	F 0744	**F 744** 1. Resident #59's care plan and care directive were updated on 10-28-22 to reflect current interests/preferences and 1 x 1 activity visits. 2. The Activity Director and/or designee will be directed to re-interview all current residents to ensure their activity interests/preferences are reflective on their care plan and care directives. All new admission activity/preferences will also be added to their care plan and care directives when completing their initial assessment. 3. Ongoing, the Activity Director and/or designee will discuss and update interests/preferences with the resident/family quarterly based on the care plan schedule and/or as needed to ensure current practices reflect the resident activity choices. Education will be provided to the Activities staff regarding this process, the importance of ensuring residents attend activities and to ensure activity participation is documented on behalf of the resident by 11-18-22. 4. The ED or Designee will audit for compliance two times per week for six months utilizing a "Resident	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The activity calendar posted in the main hallway indicated there was a movie on 10/26/22 at 1:30 p.m., and exercise at 10:30 a.m., on 10/27/22 there was a reading hour at 3:30 p.m. The resident was not taken to any of these activities. Interview with the Activity Director, on 10/28/22 at 9:13 a.m., indicated if the resident was in the hall, they would take him to activities to provide stimulation. She indicated they tried to visit the residents daily, but did not always record the visits. Interview with the Administrator on 10/28/22 at 10:32 a.m., indicated they were trying to improve dementia care by keeping residents engaged. The resident was often taken to sit near the nurses station in the evenings because he had behaviors. She also indicated the Activity Director should be documenting visits to the residents. 3.1-37		Interest/Preference/Activity Attendance Audit Tool" developed by the ED. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. DATE CERTAIN: 11-29-22	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure a sanitary kitchen related to built up food debris on the stove top and testing the dishwasher sanitation level with faulty test strips in 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect all 84 residents who received food from the kitchen. Findings include: 1. During the initial kitchen tour on 10/24/22 at 8:50 a.m. with Cook 1 the following was observed: a. The stove top had a build up of food debris. b. The dishwasher was observed and noted to be a low temperature, chemical system. Cook 1 obtained a testing strip, dipped it into the dishwasher water and compared it to the results on the side of the testing strip container. The strip did not have a readily discernable color change. The results were unable to be compared as the bottle of test strips had a label that had disintegrated. The expiration date on the bottle was also unable to be read. 2. During the follow-up tour in the kitchen on 10/26/22 at 9:29 a.m., Cook 1 indicated whoever was working in the dish cleaning area was to check the temperature and sanitation level of the dishwasher at breakfast, lunch, and dinner shifts.	F 0812	F 812 1.The stove was taken apart and cleaned by Maintenance on 10-24-22 immediately following identification and after breakfast meal time was complete. On 10-26-22, the Maintenance Supervisor contacted Ecolab who came to the facility and supplied additional test strips and verified the dish machine was functioning at the proper levels per policy. 2. The Maintenance Supervisor, in the absence of the Dietary Manager, provided verbal education at the time of discovery of the concern on the policy/procedure related to sanitation and proper testing of the dishwasher sanitation levels. The Dietary Manager provided written inservicing on the above topic on 11-7-22. All residents had the potential to be affected. The Dietary Manager and/or designee is utilizing a “Food and Nutrition Services Department Review” tool to monitor for ongoing compliance. 3. The Dietician will provide	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The logs of the temperature and sanitation levels for the month of October were reviewed and indicated the wash temperature was 120 degrees Fahrenheit and 50 parts per million (PPM) for breakfast, lunch, and dinner shifts each day from October 1st thru October 25th, 2022. On 10/26/22 at 10:45 a.m., an employee from the contracted chemical company serviced the dishwasher and indicated the dishwasher had not been altered and the PPM tested appropriately according to his test strips. He would be providing these test strips to the facility to appropriately measure the chemical sanitation levels. He indicated the other strips were not working appropriately. The policy titled, "Sanitation and Maintenance" provided by the Administrator on 10/28/22 at 11:58 a.m. and identified as current, indicated "...Procedure...9. Mechanical Ware Washing...Low Temp Dish Machine...The temperature and parts per million of the sanitizer (50-100 ppm for chlorine) will be recorded on the Low Temperature Dish Machine Log a minimum of three times per day." 3.1-21(i)(3)		additional education to the Dietary staff, as needed, regarding sanitation and proper testing of the dishwasher sanitation levels by 11-23-22. Inservice education specific to sanitation has been developed by the Dietary Manager or designee and was presented to Dietary staff by 11-7-22. Audits of the completed “Food and Nutrition Services Department Review” tool to ensure compliance with sanitation guidelines are being completed weekly by the Executive Director and/or designee. 4. The Dietary Manager or designee will audit for compliance two times per week for six months utilizing the “Food and Nutrition Services Department Review” tool developed by our corporate office. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. 5. DATE CERTAIN 11-29-22	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review and interview, the facility failed to ensure infection control measures were implemented related to incontinence care and hand hygiene during incontinence care for 1 of 2 residents reviewed for urinary tract infections. (Resident 46) Finding includes: On 10/26/22 at 11:13 a.m., Resident 46's incontinence care was observed with a CNA and Qualified Medication Aide (QMA) 1. The resident was lying on her back in bed. The QMA was wearing gloves and unfastened her brief. Using wipes, she cleansed the front of her by wiping	F 0880	F 880 1. Resident #46 has had no negative outcomes and no symptoms of infection noted. 2. CNA and QMA #1 were educated immediately by the Infection Preventionist and Director of Nursing. Competencies were performed for hand hygiene, when to change gloves and peri-care. 3. Education and competencies will be completed on licensed nursing staff, including QMA's, Nurses and C.N.A.'s on the policy	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	from the top down towards her perineal area. The resident was then turned on her side. The QMA cleansed her by wiping from the top of her buttocks down toward her perineal area. She then removed the old brief and placed a clean brief on and fastened it. The QMA did not change gloves or complete hand hygiene. The CNA and QMA 1 then retrieved the mechanical lift to transfer the resident from her bed to her wheelchair. Using her same gloved hands, QMA 1 combed the resident's hair, placed her glasses on and held her hand. She then removed her gloves and washed her hands. The current policy, "Perineal care of the female patient", was received from the Administrator on 10/26/22 at 12:30 p.m., indicated, "...clean from the front to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina...." and, "...After cleaning the perineum, perform hand hygiene, apply new gloves...." Interview with the QMA after the observation, indicated she should have cleansed from the front to the back and changed her gloves when she was done. 3.1-18(b)		for hand hygiene, peri-care and glove usage by the Infection Preventionist or designee by date of compliance. Nursing staff will not work until this has been completed. This education will be provided in orientation as well as at least annually. 4. The Infection Preventionist or designee will audit 5 staff weekly x 3 months then 3 staff weekly x 3 months for compliance. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. 5. Date of Compliance: 11-29-22	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring appropriate use of antibiotic therapy and reduce antibiotic resistance by initiating therapy based on the McGeer Criteria for true infections for 3 resident Infection Reports reviewed. (Residents 33, 42, and 238) Findings include: On 10/27/22 at 2:00 p.m. the Infection Surveillance Line Listing Report was reviewed. The months of July, September, and October 2022 had residents who received antibiotic therapy and did not meet the criteria for a true infection based on the McGeer Criteria. The Infection Report sheets for the residents indicated the following: 1. Resident 33 had an urinary tract infection on 9/28/22. She had increased confusion. The urinalysis (UA) and and urine culture and sensitivity was performed and reported on 9/30/22. The culture report indicated escherichia coli 50-100,000 colonies/milliliter (ml). The infection did not meet the McGeer's criteria for a true infection. The resident was given rocephin daily for two days. Nurses' Note, dated 9/28/22 at 6:30 p.m., indicated the results from the UA and urine culture and sensitivity were reviewed with the Medical Director and there were no new orders. 2. Resident 42 had an urinary tract infection on 7/20/22. She had increased confusion. The urinalysis and urine culture and sensitivity was performed and reported on 7/20/22. The culture	F 0881	**F 881** 1. Resident # 33, 42, and 238 are no longer receiving antibiotic therapy. No negative outcomes were noted.. 2. A listing of all current residents with antibiotic orders was developed on 11-18-22 and reviewed by the DON and the Infection Control Preventionist on 11-18-22 to determine whether the infection meets McGreer's criteria. Those residents with infection diagnoses that do not meet this criteria will have the physician contacted to re-evaluate the need for continued antibiotic therapy by date of compliance by 11-22-22. 3. Education via letter drafted by the Center for Disease Control for their Core Elements of Antibiotic Stewardship for Nursing Homes initiative was provided to all prescribing physicians on 11-22-22. Education for all licensed nursing staff was developed utilizing components from the Centers of Disease Control's Antibiotic Stewardship resources as well as Omnicare Pharmacy educational materials and presented by the DON or designees by date of compliance. The facility leadership team consisting of the physician champion, the nursing champion, the infection prevention champion	11/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155331	A. BUILDING 00 B. WING	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	report indicated escherichia coli 50-100,000 colonies/ml. The infection did not meet the McGeer's criteria for a true infection. The resident was given macrodantin 50 milligrams two times a day for six days. 3. Resident 238 had an urinary tract infection on 10/24/22. She had symptoms of painful urination and urinary urge. The urinalysis and and urine culture was performed on 10/24/22 at 3:00 p.m. and reported on 10/27/22 at 9:53 a.m. The culture report indicated escherichia coli 50-100,000 colonies/ml. The infection did not meet the McGeer's criteria for a true infection. The resident was given rocephin daily for four days. Interview with the Infection Control Nurse, on 10/28/22 at 10:30 a.m., indicated she was aware many did not meet the criteria for a true infection, but the Medical Director was very resistant to taking residents off of antibiotics even when notified that the infection does not meet the McGeer criteria.		and the pharmacy champion were contacted to renew the statement of commitment for Antibiotic Stewardship by the DON by date of compliance. All antibiotic orders initiated will be reassessed by the DON/IP or designee when the culture results are available and action taken in response to these results that include but are not limited to discontinuing antibiotics, continuing antibiotics or switching antibiotics. An audit tool was created by the DON and designees to monitor orders for antibiotic therapy to ensure McGreer's criteria is utilized per policy. 4. The DON/IP or designee will audit for compliance two times per week for six months utilizing the "Antibiotic Stewardship Audit Tool" developed by the DON. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits. 5. Date of Compliance: 11-29-22	