Judith M Sipich

PRINTED: 07/22/2025 FORM APPROVED OMB NO. 0938-039

05/20/2025

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | í í | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 04/30/2025 | | | |
|--|---|---|--|---|--|---|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER BROOKDALE VALPARAISO | | | | STREET ADDRESS, CITY, STATE, ZIP COD 2601 VALPARAISO ST VALPARAISO, IN 46383 | | | | | |
| (X4) ID PREFIX TAG R 0000 | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | TE | (X5) COMPLETION DATE | | |
| Bldg. 00 | This visit was for a State Residential Licensure Survey. Survey dates: April 28, 29, and 30, 2025 Facility number: 010757 Residential Census: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/5/25. | | R 00 | 000 | The following is the Plan of Correction for Brookdale Valparaiso regarding the Statement of Deficiencies dated 4/30/2025. The Plan of Correction is not to be construed as an admission of or agreement with the findings and sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective. | | | | |
| R 0273 Bldg. 00 | Based on observation review, the facility is | on, interview, and record failed to maintain safe and | R 02 | 273 | 1a. AL refrigerator will be clea at the end of each shift | | 06/20/2025 | | |
| sanitary kitchens related to a build up of grease LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | | | Dining Service Manager/desig | nee | (X6) DATE | | |

Any defiency statement 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 disclodays 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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Executive Director

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|--|---|-----------------------------------|--------------------|--|--|------------------|------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | COMPLETED | |
| | | B. WI | B. WING 04/30/2025 | | | /2025 | |
| | | | | STREET / | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ALPARAISO ST | | |
| BROOKDALE VALPARAISO | | | | | RAISO, IN 46383 | | |
| DITOONE | TALL VALI AIVAIOC | , | | VALIA | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | on the oven, food and unknown debris and | | | | to check cleanliness of | | |
| | | frigerators, outdated cooking | | | refrigerators | | |
| | liquids in the dry storage, and scoops inside dry | | | | weekly | | |
| | food storage bins for 2 of 2 kitchens observed. | | | | Dining Service Manager will | | |
| | This had the potential to affect all 29 residents | | | | re-inservice staff involved in the | | |
| | who received meals prepared in the Assisted | | | | dining process relating to | | |
| | Living Kitchen and all 27 residents who received | | | | cleanliness/sanitation of the | | |
| | meals prepared in the Memory Care Unit Kitchen | | | | kitchen | | |
| | · | Assisted Living Kitchen and | | | To assist with compliance, the | | |
| | Memory Care Unit | Kitchen/Kitchenette) | | | Executive Director will monitor | | |
| | | | | | kitchen refrierators for cleanlir | ness | |
| | Findings include: | | | | one time a week for 5 weeks | | |
| | 1. The Assisted Living Kitchen tour was | | | | 1b. AL stove, oven, flat top an | | |
| | completed on 4/28/25 at 9:27 a.m., with Cook 1. | | | | grease drip trays to be cleane | d at | |
| | The following was observed: | | | | the end | | |
| | | | | | of each shift | | |
| | a. The refrigerator had an unknown red liquid | | | | Dining Service Manager/desig | | |
| | spilled on the inside of the door and inside bottom | | | | to check AL stove, oven, flat to | ор | |
| | base of the refrigerator. There was also a build up of dried food and unknown debris on the inside | | | | and grease drip trays weekly | | |
| | | | | | Dining Service Manager will | | |
| | bottom base of the | refrigerator. | | | re-inservice staff involved in th | ne | |
| | 1 771 1 | 1.11 6 4 | | | dining | | |
| | | y build up of grease on the | | | process relating to | | |
| | | d front of the oven, in front of | | | cleanliness/sanitation of the | | |
| | _ | de the grease tray for the flat | | | kitchen stove, oven, | | |
| | 1 - | grease drip trays for the stove | | | flat top and grease drip trays | | |
| | 1 - | oven doors, oven hood, and | | | To assist with compliance, the | | |
| | back splash of the oven. | | | | Executive Director will monitor | | |
| | a The day stomes as some he d - floor him and - | | | | kitchen stove, oven, flat top ar | | |
| | c. The dry storage room had a flour bin and a sugar bin that had the scoops inside the bins. | | | grease drip trays for cleanliness 1 time | | 33 I | |
| | sugai oin mat nad the scoops inside the bins. | | | | a week for 5 weeks | | |
| | d. A large bottle of rice vinegar had a date written | | | | a week ioi o weeks | | |
| | on it that it was opened 3/30/21. There was a best | | | | 1c. Scoops for dry storage bin | ıs in | |
| | | /14/22 also labeled on the | | | Assisted Living will be kept | | |
| | bottle. | | | | outside of the | | |
| | | | | | bins | | |
| | During an interview | v at the time of the tour, Cook 1 | | | Dining Service Manager/desig | inee | |
| | | had been wiped down that | | | to check weekly for scoops be | | |
| indicated the stove had been wiped down that | | | | 15 5115511 11551119 101 5550000 | 9 | | |

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| STATEMENT OF DEFICIENCIES X | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) I | | (X3) DATE | 3) DATE SURVEY | |
|--|--|---------------------------------|-----------------------------------|------------------------------------|--|----------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | a. building <u>00</u> | | 00 | COMPLETED | |
| | | | B. WING | | | 04/30/2025 | |
| | | | | _ | _ | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | ALPARAISO ST | | |
| BROOKDALE VALPARAISO | | | VALPARAISO, IN 46383 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | morning. There wa | as a large amount of grease | | | stored outside of dry storage b | oins | |
| | build up on top of t | he stove and oven. The | | | Dining Service Manager will | | |
| | refrigerators should | I have been wiped out and the | | | re-inservice staff involved in the | ne | |
| | vinegar should have | e been discarded. She was | | | dining | | |
| | unaware the scoops | s should not be stored inside | | | process relating to storing sco | ops | |
| | the bins. | | | | outside of dry storage bins | • | |
| | | | | | To assist with compliance, the | ; | |
| | | | | | Executive Director will monitor | | |
| | 2. The Memory Car | re Unit Kitchen/Kitchenette | | | kitchen | | |
| | tour was completed | l on 4/28/25 at 9:43 a.m. with | | | to insure scoops are being sto | red | |
| | Cook 2. The follow | ving was observed: | | | correctly one time a week for | | |
| | g : | | | | weeks | | |
| | a. The dry storage room had a flour bin, sugar bin, | | | | | | |
| | bread crumb bin, and rice bin that had the scoops | | | | 1d. Expired items to be discar | ded | |
| | inside the bins. | | | | from dry storage | | |
| | | | | | Dining Service Manager/desig | nee | |
| | b. A large bottle of rice vinegar had a date written | | | | to audit dry storage items for | | |
| | on it that it was opened 3/30/21. There was a best | | | | expiration dates weekly | | |
| | if used by date of 7/14/22 also labeled on the | | | | Dining Service Manager will | | |
| | bottle. | | | | re-inservice staff involved in the | ne | |
| | | | | | dining | | |
| | c. The Kitchenette | refrigerator had an unknown | | | process relating to expiration | | |
| red liquid spillage of | | over the shelves and the | | | dates for dry storage items an | d | |
| | bottom inside. The | freezer part also had an | | | when to | | |
| | unknown brown lig | quid frozen on the inside | | | discard | | |
| | bottom and inside of | loor shelf. | | | To assist with compliance, the | • | |
| | | | | | Executive Director will monitor | r the | |
| | During an interview at the time of the tour, Cook 2 | | | | dry | | |
| | indicated he was ur | naware the scoops should not | | | storage in Assisted Living for | one | |
| | be stored inside the | bins. The Kitchenette | | | time a week for 5 weeks | | |
| | refrigerator was use | ed by the nursing staff to put | | | | | |
| | things in they were | using for the residents. | | | 2a. Scoops for dry storage bin | ıs in | |
| | | | | | Memory Care will be kept outs | side | |
| | A policy titled "Kit | chen Cleaning" and received | | | of the | | |
| | as current from the | Administrator on 4/30/25, | | | bins | | |
| | indicated, "2. Foo | od service equipment is cleaned | | | Dining Service Manager/desig | nee | |
| | per cleaning schedu | ale and sanitized after each | | | to check weekly for scoops be | | |
| | use. 3. Food service | e areas (counters, drawers, | | | stored outside of dry storage t | - | |
| | | eas, cutting boards, bus | | | Dining Service Manager will | | |
| carts/trays) are clean and sanitized. 4. Kitchen | | | | re-inservice staff involved in the | ne | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 04/30/2025 | | | |
|--|--|--|--|---|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER BROOKDALE VALPARAISO | | | STREET ADDRESS, CITY, STATE, ZIP COD 2601 VALPARAISO ST VALPARAISO, IN 46383 | | | | | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | ON (X5) BE COMPLETION PRIATE DATE | | | | |
| TAG | areas (walls, cupber free from dust and A policy titled, "M Goods" and receive Administrator on 4 "Recommended M Unopened" "Vi A policy titled, "Di current form the A indicated, "Bulk labeled, and sanitiz preparation and dis stored on the outside | ards, ceiling, lights and vents) in good repair" aximum Storage Periods for Dry ed as current from the /30/25, indicated, Maximum Storage Period if | TAG | dining process relating to storing soutside of dry storage bins To assist with compliance, Executive Director will monkitchen to insure scoops ar stored correctly for one time week for 5 weeks 2b. Expired items to be disc from dry storage Dining Service Manager/deto audit dry storage items for expiration dates weekly Dining Service Manager wire-inservice staff involved in dining process relating to expiration dates for dry sitems and when to discard To assist with compliance, Executive Director will mond dry storage for one time a week for 5 week housekeeping Memory Care Program Coordinator to check kitcher refrigerator and freezer weekly for cleanliness Executive Director/designere-inservice housekeeping Memory Care Program Coordinator about cleaning kitchenette refrigerator To assist with compliance, Executive Director will mond cleaning kitchenette refrigerator To assist with compliance, Executive Director will mond cleaning kitchenette refrigerator | the itor the e being e a carded esignee or II nothe estorage the itor the estorage the itor the estorage enette e will and trator | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/30/2025 | | |
|---|----------------------------------|---|--|--|---|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER BROOKDALE VALPARAISO | | | STREET ADDRESS, CITY, STATE, ZIP COD 2601 VALPARAISO ST VALPARAISO, IN 46383 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION STATEMENT OF CORRECTION SHOULD BE SHO | | TE | (X5) COMPLETION DATE | |
| | | | | | and freezer one time a week fo weeks | or 5 | |

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