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	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVIVA VALPARAISO	1300 VALE PARK RD VALPARAISO, IN 46383

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 26 and 27, 2024 Facility number: 012181 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/5/24.	R 0000	Aviva Valparaiso provides the following Plan of Correction “POC” without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and/or executed solely because it is required by the provisions of federal and state laws	
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debby Atsas	Executive Director	04/30/2024

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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	Alzheimer ' s and dementia special care unit disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on record review and interview, the facility failed to have a current disclosure form for the Alzheimer's/Dementia Special Care Unit. This had the potential to affect all residents residing on the Dementia Care unit. Finding include: The Alzheimer's/Dementia Special Care Unit disclosure form was requested on 3/26/24 and the most recent form provided by the facility was dated 12/1/22. During an interview, on 3/27/24 at 1:15 p.m., with the Administrator indicated the dementia disclosure form should be updated annually.	R 0030	1 What corrective actions will be accomplished for those residents found to have been affected by deficient practice? ALZHEIMER'S / DEMENTIA SPECIAL CARE UNIT State Form 48896 (R / 6-18) has been updated and approved with expiration date of 12/31/2024. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Memory care residents have the potential to be affected. ALZHEIMER'S / DEMENTIA SPECIAL CARE UNIT State Form 48896 (R / 6-18) will be updated and submitted annually by 12/31 of each year. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? ED will add reminder note to calendar to assure that form is completed and approved timely. Beginning 03/28/2024, ED ensured the updated Alzheimer's/Dementia Special Care Unit disclosure form was added to the move in packet.	04/27/2024

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			4 How the corrective actions will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put in place? Beginning 04/01/2024 a monthly audit will be completed regarding assuring that the Alzheimer's/Dementia Special Care unit disclosure form is completed timely and within acceptable dates. Results of audits will be reviewed in monthly QA. 5 By what date the systemic changes will be completed? 4/27/24	
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure pets were up to date on vaccinations for 2 of 5 pet vaccination records reviewed. (Room 217) Finding includes: The Pet Policy and pet vaccination records were reviewed on 3/27/24. There were no records	R 0151	1 What corrective actions will be accomplished for those residents found to have been affected by deficient practice? Cats (2) will be taken to veterinary on 4/22/2024 by family. Cat's vaccinations will be updated at this time and copies of veterinary records were provided to	04/27/2024

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	available for two cats living in Room 217. During an interview with the Executive Director, on 3/27/24 at 12:00 p.m., she indicated she did not have any vaccination records for the cats. She had spoken with a family member the previous day and they did not have updated records for the cats. The current policy for pets indicated, "...Pets are allowed...You will be required to provide vaccination records and any required licensure if the state requires...."		community staff. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Current residents that have pets have a potential to be affected. Current pet vaccination records have been audited and determined to be in compliance. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Beginning 3/28/2024, ED or designee will collect pertinent pet information (updated veterinary records) prior to the pet moving in to the community. Beginning 3/28/24, ED or designee will track pertinent pet information on a spreadsheet and audit spreadsheet monthly. ED or designee will alert resident/POA within 30 days of vaccinations expiring. 4 How the corrective actions will be monitored to ensure that the deficient practice will not recur i.e, what quality assurance program will be put in place? Beginning 3/28/24, ED or designee will track pertinent pet information on a spreadsheet and	

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			audit spreadsheet monthly. ED will compile vaccination spreadsheet audit results and present in monthly QA. 5 By what date will the systemic changes will be completed? 4/27/24	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations			

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	subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure resident service plans were updated and/or signed by the resident or representative, for 5 of 7 service plans reviewed. (Residents 3, 5, 2, 6 and 8) Findings include: 1. The record for Resident 3 was reviewed on 3/26/24 at 10:45 a.m. The Resident Service Plan, dated 9/13/23, was unsigned by the resident or the resident's representative. 2. The record for Resident 5 was reviewed on 3/26/24 at 11:50 a.m. The Resident Service Plan, dated 2/21/24, was unsigned by the resident or the resident's representative. During an interview with the Director of Nursing, on 3/26/24 at 3:15 p.m., she indicated she did not have signed service plans for the residents. 3. Resident 2's record was reviewed on 3/26/24 at 10:38 a.m. Diagnoses included, but were not limited to, dementia, major depressive disorder, and prostate cancer. A Service Plan was completed on 2/14/24. It was not signed by the resident or responsible party.	R 0217	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #3 signed her service plan on 4/19/24 Resident #5 signed her service plan on 4/17/24 Resident #2 service plan was signed by resident's spouse on 4/18/24 Resident # 6 service plan was reviewed and updated on 4/11/24 Resident # 8 no longer resides in the community (discharge date 12/31/2023). 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Current residents have the potential to be affected. Beginning 3/28/24, RCD or designee will audit current resident service plans to assure that each service plan has been signed by the resident or their responsible party and are updated to include pertinent services. 3 What measures will be put	04/27/2024

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	During an interview, on 3/27/24 at 10:18 a.m., the Director of Nursing indicated the Service Plan should have been signed by the resident and/or responsible party. 4. Resident 6's record was reviewed on 3/26/24 at 2:13 p.m. Diagnoses included, but were not limited to, cerebral infarction, heart disease, and chronic kidney disease. A Progress Note, dated 3/4/24 at 9:42 a.m., indicated the physical therapist informed the writer that the resident was complaining of urgency with urination. There was no updated Service Plan to review that indicated the resident had a change in status and was receiving therapy services. During an interview, on 3/27/24 at 11:23 a.m., the Director of Nursing indicated the resident was receiving therapy, however she had no further documentation related to the therapy services. 5. Resident's 8 record was reviewed on 3/27/24 at 1:39 p.m. Diagnoses included, but were not limited to, legally blind, macular degeneration, hypothyroidism, anxiety, obstructive and sleep apnea. The resident was admitted to the facility on 5/24/23. A Service Plan was completed on 5/24/23. It was not signed by the resident or responsible party. The facility policy titled, "Resident Evaluations and Service Plans" was provided by the Administrator on 3/27/24 at 11:17 a.m. The policy indicated, ..."the agreed upon service plan shall be signed and dated by the resident's or the resident's POA, and a copy of the service plan shall be given to the resident upon request"...		into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Beginning 3/28/24, the RCD/designee will complete a post admission medical record audit of new admissions to monitor compliance of signatures on service plans. Beginning 3/28/24, RCD/designee will audit updated/revised service plans for appropriate signatures monthly on an ongoing basis. By 4/27/24, current licensed nurses will be re-inserviced regarding service plan signatures. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Beginning 4/27/24, RCD/designee will audit 10 medical records weekly x 4 weeks then monthly x 6 months to ensure that service plans are accurate and reflect services being provided to resident. Audits will be discontinued after 6 months as long as 100% compliance has been maintained, then RCD/designee will do random audits to assure that compliance is maintained. Results of all audits will be compiled and reviewed in monthly QA.	

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	During an interview with the Director of Nursing on 3/27/24 at 1:55 p.m., she indicated she was unable to provide any further information.		5 By what date the systemic changes will be completed? April 27, 2024	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to properly prevent and or contain COVID -19, related to COVID positive residents not in isolation for the recommended time period, for 3 of 3 residents reviewed for infection control. (Residents 10, 11, and 12) Findings include: 1. Resident 10's record was reviewed on 3/26/24 at 2:43 p.m. A Progress Note, dated 1/1/24 at 9:57 p.m. indicated the resident had complained of cold symptoms, had tested positive for COVID, and had been informed about the 5-day isolation. The Infection Control Log indicated the resident had tested positive on 1/1/24 and the resolution date was 1/7/24, which was 5 days in isolation. 2. Resident 11's record was reviewed on 3/26/24 at 2:43 p.m. A Progress Note, dated 12/2/23 at 7:00 p.m.,	R 0406	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Previously affected residents #10, 11, and 12 are now COVID negative. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? COVID + residents have the potential to be affected by the deficient practice. COVID + residents will be put into TBP for a minimum of 10 days per CDC guidelines. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Community will follow the	04/27/2024

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	indicated the resident had a cough and was not feeling well. A test was completed, the result was positive for COVID, and the resident was placed in isolation. A Progress Note, dated 12/8/23 at 8:26 a.m., indicated the resident had been in isolation for 5 days, had tested negative for COVID that morning, and could now come out of his apartment with a mask for the next 5 days. The Infection Control Log indicated the resident had tested positive on 12/2/23 and the resolution date was 12/8/23, which was 5 days in isolation. 3. Resident 12's record was reviewed on 3/26/24 at 2:43 p.m. A Progress Note, dated 12/3/23 at 8:12 p.m., indicated the resident had a sore throat, cough, and diarrhea. A test was completed, the result was positive for COVID, and the resident was placed in isolation. A Progress Note, dated 12/8/23 at 6:07 p.m., indicated the resident was to be off isolation the following day. The Infection Control Log indicated the resident had tested positive on 12/3/23 and the resolution date was 12/9/23, which was 5 days in isolation. During an interview with the Director of Nursing (DON), on 3/26/24 at 3:55 p.m., she indicated the COVID positive residents had been in isolation for 5 days and then wore a mask for the following 5 days when they were out of their rooms. She had spoken with the local health department to get guidance on the current isolation recommendations, and she thought they had		CDC guidelines regarding quarantine protocols for COVID + residents. A list of COVID + residents will be kept at the 1st floor nurses station and the date of TBP/quarantine discharge will be on the list. By 4/27/24, current staff will be re-educated on the requirement for resident isolation if COVID +. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Effective immediately, RCD or designee will randomly audit COVID + residents to ensure they are on TBP/quarantine for the appropriate amount of time per CDC guidelines. Results of audit will be compiled and reviewed with monthly QA. 5 By what date the systemic changes will be completed? April 27, 2024	

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	provided her with the current CDC (Centers for Disease Control and Prevention) guidance. They told her for mild to moderate COVID, a resident should be in isolation for 5 days and then could come out but would need to wear a mask for the following 5 days. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, per the CDC's website, updated 5/8/23, indicated "...Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection...Patients with mild to moderate illness who are not moderately to severely immunocompromised: At least 10 days have passed since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved. Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised: at least 10 days have passed since the date of their first positive viral test..."			