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	08/08/2019

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VIRGINIA PLACE	8253 VIRGINIA ST MERRILLVILLE, IN 46410

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 7 and 8, 2019 Facility number: 010887 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/12/19.	R 0000	**Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.**	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice			

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

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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	education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure the required annual inservices were completed for 2 of 5 staff members reviewed. (CNA 1 and CNA 2) Finding includes: The employee records and facility inservices were reviewed 8/7/19 at 11:00 a.m. CNA 1 was hired 8/22/17. CNA 1's inservice transcript indicated he had only completed 2 hours of dementia training in 2018.	R 0120	1.The inservice requirements for 2018 for CNA 1 and CNA 2 cannot be corrected. 2.Audit of current employee files for annual training completed on 8/9/19. 3.Executive Director and Care Services Manager re-trained on 8/17/19 by the Regional Director of Care Services on in-service re: Annual Training Requirements in 410IAC 16.2-5 4.The Executive Director is	09/07/2019

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	CNA 2 was hired 6/25/08. CNA 2's inservice transcript indicated she had not completed any inservice hours for 2018. Interview with the Administrator on 8/7/19 at 2:30 p.m. indicated she was unable to find any documentation of CNA 2's 2018 inservices and CNA 1 had only completed the 2 hours of dementia training.		responsible for sustained compliance The Executive Director or designee will audit in-service records monthly to ensure compliance with annual in-service requirements. Results of the audit will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 5 consecutive months of compliance. Monitoring will be on-going	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.			
	Based on observation, record review, and interview, the facility failed to ensure Physician's Orders were followed related to medication administration for 2 of 5 residents observed during medication administration. (Residents 9 & 10). The facility also failed to ensure Physician's Orders were followed as written related to sliding scale insulin administration for 1 of 7 residents reviewed. (Resident 3) Findings include: 1. During an observation of a medication pass with LPN 4 on 8/7/19 at 8:38 a.m. with Resident 9, LPN 4 prepared the following medications: - transdermal scopolamine (to prevent motion	R 0241	1.Medication orders for residents 3, 9, and 10 were clarified with their physicians on 8/7/19 with clarification orders written and followed. 2.The medication administration record was audited on 8/13/19 by the Care Services Manager and medications ordered to be given before meals were clarified with the physician. Current residents who receive sliding scale Insulin were audited to ensure MD orders are followed related to sliding scale Insulin and documented correctly by the Care Services	09/07/2019

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	sickness) patch - aspirin 81 mg (milligrams), 1 tablet once a day before breakfast at 8 a.m. - ferrous sulfate (iron supplement) 325 mg, 1 tablet once a day with breakfast at 8:00 a.m. - metoprolol succinate extended release (to treat high blood pressure) 25 mg, 1 tablet once daily - pantoprazole sodium (to reduce stomach acid) 40 mg, 1 tablet once daily - ramipril (to treat high blood pressure) 2.5 mg, 1 tablet once daily - hydralazine (to treat high blood pressure) 10 mg, 1 tablet twice a day At 8:45 a.m., LPN 4 administered the oral medications to Resident 9 in the main dining room. An interview with the resident after the medications were administered, indicated he had just eaten some fruit and oatmeal. Interview with LPN 4 on 8/7/19 at 8:46 a.m., indicated she did not know why the aspirin was ordered to be administered before breakfast. 2. During an observation of a medication pass with LPN 4 on 8/7/19 at 9:18 a.m. with Resident 10, LPN 4 prepared the following medications: - cerovite (supplement) 1 tablet, once a day - escitalopram (antidepressant) 10 mg (milligrams), 1 tablet once a day - ferrous sulfate (iron supplement) 325 mg , 1 tablet once daily - pantoprazole (reduce stomach acid) 20 mg, 1 tablet once daily before a meal at 8:00 a.m. - calcium 600 with vitamin D3 400 tablet, 1 tablet twice a day - memantine (to improve memory) 5 mg, twice a day LPN 4 then proceeded to administer the resident		Manager and/or designee on 8/13/2019 with results of these findings presented to residents MD as needed 3.Current Nursing staff including LPN 4 were retrained on 8/13/19 by the Care Services Manager on following physician orders related to medication administration 4.The Care Services Manager is responsible for sustained compliance. The Care Services Manager will observe medication administration for 5 residents 3 times per week for 4 weeks beginning 8/13/19, followed by monthly observations for 3 months to ensure medications are administrated as ordered. Results of audit will be discussed in monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 5 consecutive months of compliance. Monitoring will be on-going.	

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	her medications. Interview at that time with Resident 10, indicated she already had eaten breakfast. Interview with LPN 4 on 8/7/19 at 9:22 a.m., indicated she did not see the order on the medication card to administer the pantoprazole medication before breakfast, even though it was scheduled for 8:00 a.m. Interview with Resident 10 on 8/7/19 at 11:50 a.m., indicated she could not remember if she normally received her pantoprazole before breakfast. 3. Record review for Resident 3 was completed on 8/7/19 at 11:11 a.m. Diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure. The July 2019 Physician's Order Summary indicated the following orders: - Novolin R (insulin) per sliding scale TID (three times a day). The order was discontinued on 7/17/19. Blood Sugar (BS) = 151-200: 1 unit BS = 201-250: 2 units BS = 251-300: 3 units BS = 301-350: 4 units BS = 351-400: 5 units - Novolin R per sliding scale TID. The order started on 7/17/19. BS = 70-139: 0 units BS = 140-180: 3 units BS = 181-240: 4 units BS = 241-300: 6 units BS = 301-350: 8 units BS = 351-400: 10 units The July 2019 Medication Administration Record			

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	indicated the resident received the incorrect dosage of insulin according to the sliding scale on the following dates and times: - 7/16/19 at 12:00 p.m., the BS was 326. The resident received 5 units of insulin. The resident should have received 4 units of insulin. - 7/18/19 at 8:00 a.m., the BS was 364. The resident received 8 units of insulin. The resident should have received 10 units of insulin. - 7/26/19 at 12:00 p.m., the BS was 231. The resident received 8 units of insulin. The resident should have received 4 units of insulin. Interview with the Care Services Manager on 8/7/19 at 1:33 p.m., indicated according to the sliding scale, the insulin documented as administered was not correct.			
R 0328 Bldg. 00	410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division.			
	Based on record review and interview, the facility failed to ensure the Activity Director met the appropriate requirements. Finding includes: Employee files were reviewed on 8/7/19 at 11:00 a.m. The Activity Director was hired on 7/18/15.	R 0328	1.The activity director will be enrolled in training course Rowlett and Laker Certificate program. The application was submitted 8-23-19. 2.An audit of the credentials of other employees was completed on 8/9/19 by the Executive Director. No issues identified. 3.Executive Director was	09/07/2019

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	The facility was unable to provide documentation that the Activity Director had met the requirements to be designated as the Activity Director. Interview with the Administrator on 8/8/19 at 11:35 a.m. indicated the Activity Director had started working at the facility as a CNA in 2015 and then transitioned to Activity Director in 2016. She had not completed any Activity Director training class and had not received any official consultation hours. She was going to enroll in the class today.		retrained by Regional Director of Care Services on 8-16-19 regarding activity director requirements. 4.The Executive Director is responsible for sustained compliance. The Executive Director will monitor the progress of the activity director in completing training requirements monthly. Executive Director will report progress to QI. Monitoring will be on-going as Internship Supervisor.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.			
	Based on record review and interview, the facility failed to ensure an emergency file was immediately accessible and complete for staff to review for 2 of	R 0356	1.An emergency file was completed and corrected for resident 2 and 3 on 8/8/2019 by	09/07/2019

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	5 residents reviewed. (Residents 2 & 3) Findings include: 1. Record review for Resident 2 was completed on 8/7/19 at 1:43 p.m. The resident was admitted to the facility on 7/31/19. The facility emergency file binder lacked an emergency file for Resident 2. 2. Record review for Resident 3 was completed on 8/7/19 at 11:11 a.m. The resident was admitted to the facility on 12/23/16. The emergency file was reviewed for the resident. The file lacked a picture of the resident. Interview with the Care Services Manager on 8/7/19 at 1:50 p.m., indicated nursing was supposed to update the emergency files when a resident was admitted. Resident 3's picture must have fallen out of the book and she would update it with a new picture.		the Care Services Manager. 2.An audit of current Residents' emergency files was completed on 8/13/19 by the Care Services Manager and corrected at that time. 3.The Care Services Manager was retrained on 8/16/19 by the Regional Director Clinical Services regarding the requirement to ensure an emergency file for residents is complete and immediately accessible to staff. Staff were retrained by the Care Services Manager on 8/13/19 regarding the requirement to ensure an emergency file for residents is complete and immediately accessible to staff 4.The Care Services Manager is responsible for sustained compliance. The care services manager or designee will audit emergency files weekly for 4 weeks beginning 8/13/19 then monthly for 3 months. Confirmation of accessibility will also be completed at this time. Results will be discussed in monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 5 consecutive months of compliance. Monitoring will be on-going.	