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	10/25/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 19, 20, 23, 24, and 25, 2023. Facility number: 000224 Provider number: 155331 AIM number: 100267700 Census Bed Type: SNF/NF: 83 SNF: 16 Total: 99 Census Payor Type: Medicare: 19 Medicaid: 61 Other: 19 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/27/23.	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 19, 20, 23, 24 and 25, 2023. 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 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Janeczko	Executive Director	11/09/2023

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	(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents.			
	Based on observation and interview, the facility failed to have the results of the State survey findings easily accessible for all residents to review. This had the potential to affect the 99 residents who resided in the facility. Finding includes: On 10/24/23 at 9:14 a.m., a Resident Council Meeting was conducted with six residents. All six residents were unaware of where to find the most recent State survey results. On 10/24/23 at 10:26 a.m., a sign was observed posted by the Secretary's office that indicated the State survey results were located on the Secretary's door. A file folder was observed in a basket towards the top of the door. The folder was out of reach and not easily accessible for	F 0577	F 577 1 The state survey results had been posted in a public area in the facility; however, the facility moved the survey results to a wheelchair accessible location immediately upon notification. 2. The Executive Director and/or designee will educate all staff and current residents on the new location of the survey results. The facility will also review how to locate the survey results during future scheduled resident council meetings to ensure ongoing education is provided. This will be completed by the date of	11/17/2023

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	residents who were in wheelchairs. Interview with the Activities Director on 10/24/23 at 10:28 a.m., indicated she was new to the position and was unaware where the State survey results were located. Interview with the Administrator on 10/24/23 at 11:23 a.m., indicated they would move the State survey results to an area that was easily accessible to all residents. 3.1-3(b)(1)		compliance. 3. The Activity Director and/or designee will discuss where to locate the survey results during future scheduled resident council meetings to ensure ongoing education is provided. The facility will also add information in the admission packet that is provided to incoming residents upon admission to our facility as well and new employees will receive this information in orientation by date of compliance. 4. The ED or Designee will audit for compliance weekly for six months utilizing a “State Survey 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: November 17, 2023	
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			

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	comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of a scabbed area on the skin for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident 68) Finding includes: On 10/24/23 at 11:48 a.m., a family interview was conducted for Resident 68. The family member indicated the resident had a scabbed area to her left elbow and was unsure how she received it. The resident was observed sitting in a Broda chair in her room. The left outer elbow had a small black scabbed area. On 10/24/23 at 3:13 p.m., Resident 68 was observed sitting in a Broda chair in her room. The scabbed area was still observed to the resident's outer left elbow. Record review for Resident 68 was completed on 10/24/23 at 2:06 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia right dominant side (paralysis on right side of body), atrial fibrillation, hypertension, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 10/13/23, indicated the resident was severely cognitively impaired. The resident was dependent on staff for bathing, toilet use, dressing and personal hygiene. The resident had an impairment on side of the upper and lower extremities for functional limitation in range of motion. The resident had received an	F 0684	F 684 1. Resident #68's physician and family were notified with new orders received and initiated immediately. 2. An in house audit was completed by the wound nurse or designee for residents with skin integrity issues to ensure no other concerns by date of compliance and no other issues were noted. 3. Nursing staff will be educated by the wound nurse or designee on assessing and notifying the wound nurse of any identified areas or change in skin 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. 4. The wound nurse or designee will audit for compliance weekly for six months utilizing a "Skin Integrity Audit Tool" for all skin integrity issues ongoing for any changes and document appropriately. Audits will be presented to the QAPI committee monthly x 6 months and the committee will determine the need for further audits.	11/17/2023

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	anticoagulant (blood thinning) medication. The Weekly Skin Integrity Data Collection, dated 10/22/23, lacked any documentation related to the scabbed area on the resident's left elbow. Interview with the Director of Nursing on 10/25/23 at 9:50 a.m., indicated she could not provide any documentation the scabbed area was observed, assessed and monitored prior to the day before. She had completed an assessment of the area and notified the family and Physician of the area. 3.1-37(a)		DATE CERTAIN: November 17, 2023	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a Physician's Order was in place for a palm protector for	F 0688	F 688 1. Resident #40 had no negative	11/17/2023

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	treatment of limited range of motion for 1 of 1 residents reviewed for range of motion. (Resident 40) Finding includes: On 10/19/23 at 11:38 a.m., Resident 40 was observed seated in her room working on a puzzle. She had a palm protector in place to her right hand. On 10/23/23 at 2:48 a.m., Resident 40 was observed with the palm protector in place to her right hand. On 10/24/23 at 10:31 a.m., Resident 40 was seated in her wheelchair near the main entrance. The palm protector was in place to her right hand. The resident's record was reviewed on 10/23/23 at 11:31 a.m. Diagnoses included, but were not limited to, right hand contracture and hemiplegia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/30/23, indicated the resident required staff assistance for all activities of daily living (ADLs) and had impaired range of motion on one side to both the upper and lower extremities. The Physician's Order Summary, dated 10/2023, lacked any orders for a right hand palm protector or monitoring of the resident's skin. The ADL self care deficit care plan, updated 8/2/23, lacked documentation of the right hand palm protector as an intervention. Interview with the Assistant Director of Nursing (ADON) on 10/24/23 at 12:01 p.m., indicated there		outcomes and a physician order was obtained and a care plan was initiated immediately. 2. An in house audit will be completed by date of compliance by nursing management on residents with adaptive devices and care plans and kardex will be audited and updated as required. Any issues will be addressed by date of compliance. 3. Education will be provided to nursing staff, therapy, 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 utilizing an "Adaptive Devices Audit Tool" weekly for compliance 5 residents x 3 months then 3 residents x 3 months to ensure 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.	

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	was no order in place for the palm protector. There was a note about it, but the order had not been put in the computer correctly. 3.1-42(a)(2)		5. Date Certain: November 17, 2023	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration flow rate for 1 of 1 residents reviewed for respiratory care. (Resident 1) Finding includes: On 10/20/23 at 9:37 a.m. Resident 1 was observed seated in the dining area at a table. His portable oxygen tank was set at 2.5 liters. On 10/20/23 at 10:55 a.m. Resident 1 was observed seated in the dining area. His oxygen tank was set at 2.5 liters. On 10/23/23 at 11:44 a.m. Resident 1 was observed sitting in the dining area. His oxygen tank was set at 3 liters.	F 0695	F 695 1. Resident #1 had no negative outcomes. The charge nurse received verbal education immediately upon identification by the DON. 2. Nursing managers made random observations on residents with oxygen 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 regarding the policy for oxygen by nursing managers by date of compliance. Any required staff that has not received this education will not work until	11/17/2023

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	Record review for Resident 1 was completed on 10/23/23 at 11:56 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and dependence on supplemental oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 9/22/23, indicated the resident was cognitively impaired. The Physician's Order Summary, dated 10/2023, indicated an order for oxygen 2 liters continuously per nasal cannula. Interview with RN 1 on 10/23/23 at 11:57 a.m., indicated the oxygen flow rate should have been set at 2 liters. A facility policy, titled, "Oxygen Administration/Safety/Storage/Maintenance," received from the Assistant Director of Nursing as current, indicated "...Oxygen will be administered in accordance with physician orders and current standards of practice..." 3.1-47(a)(6)		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 oxygen utilizing an “Oxygen Audit Tool” 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 Certain: November 17, 2023	
F 0812 SS=E 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			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling 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 burnt food debris on the stove top and bottom inside of the convection oven. There was a build up of grease inside the convection oven doors, back splash on the oven, and side of the oven for 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect 96 residents who received food from the kitchen. Findings include: During the initial kitchen tour on 10/19/23 at 9:29 a.m., with the Dietary Manager (DM) the following was observed: a. The stove top had a build up of burnt food debris and a build up of grease on the back splash and side of the stove top. b. The convection oven had a build up of burnt food debris on the bottom inside and a build up of grease on the inside of the doors. Interview during the time of the observation with Cook 1 indicated the convection oven had a build up in the bottom for "a long time" and no "elbow grease" would be able to clean it. They would need to use a "special degreaser" for it.	F 0812	F 812 1.The stove top and the convection oven were both taken apart and cleaned immediately upon identification on 10-19-23. 2. The Dietary Manager initiated immediate verbal and written education regarding proper cleaning procedures on 10-19-23 to all Dietary staff. 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 additional education to the Dietary staff, as needed, regarding proper cleaning procedures by date of compliance. Inservice education specific to sanitation was developed by the Dietary Manager or designee and was presented by date of compliance. No Dietary employee will work unless this education is completed prior to the date of	11/17/2023

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	Interview during the time of the observation with the DM indicated the convection oven and stove was supposed to be cleaned weekly. He would make sure both were deep cleaned right away. 3.1-21(i)(3)		compliance and any new Dietary employees will receive this education during their orientation. 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: November 17, 2023	
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: §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	F 0881	F 881	11/17/2023

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	ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to a Physician initiating antibiotic therapy for a non-true infection based on the McGreer's Criteria and prescribing a resistant antibiotic based on urine culture results for 1 of 1 residents reviewed for urinary tract infections. (Resident 28) Finding includes: The record for Resident 28 was reviewed on 10/23/23 at 9:27 a.m. Diagnoses included, but were not limited to, hypertension, heart failure, and Alzheimer's disease. The Significant Change Minimum Data Set (MDS) assessment, dated 9/21/23, indicated the resident was cognitively impaired. A Progress Note, dated 9/28/23 at 5:10 p.m., indicated the Physician had been in to see the resident and reviewed her blood work. Her white blood cell count was elevated so they completed a urine dip test, and it had abnormal results. The Physician then ordered for the urine to be sent to the lab for a urinalysis (UA) with culture and sensitivity (C&S). He ordered Keflex (an antibiotic) 500 mg (milligrams) twice daily for 3 days. The urine specimen was placed in the refrigerator for lab to pick up in the morning. The UA report indicated the urine sample was collected on 9/28/23. The urine was turbid, positive for nitrates, leukocytes and many bacteria were present. The urine culture and sensitivity report indicated 10-50,000 citrobacter freundii complex (under 100,000 not usually considered significant per McGreer's criteria). The organism was resistant to ceftriaxone.		1. Resident # 28 was no longer receiving antibiotic therapy at the time of discovery of the concern. No negative outcomes were noted. 2. A listing of all current residents with antibiotic orders was developed on 11-9-23 and reviewed by the DON and the Infection Control Preventionist on 11-10-23 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. The DON provided education to the Infection Preventionist related to her responsibilities in ensuring the policy expectations are met and proper protocol followed. 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 by 11-14-23. 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	

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	A hand written note on the bottom of the UA report, indicated it had been reviewed by the Physician and due to ongoing behavior issues, aggression, and decreased appetite, he had given a new order for ceftriaxone IM (intramuscular). A Physician's Note, dated 10/20/23, indicated on 10/9/23 he had reviewed the previous urine culture. The resident was having a recurrence of urinary symptoms and agitation and IM ceftriaxone was ordered. There was lack of documentation as to why he had chosen a resistant antibiotic based on the urine culture results. A Physician's Order, dated 10/13/23, indicated ceftriaxone (an antibiotic) 1 gram IM (intramuscular injection) every evening for 7 days for UTI (urinary tract infection). The Medication Administration Records (MAR), dated 9/2023 and 10/2023, indicated the resident received the full courses of the Keflex and ceftriaxone antibiotics. Interview with the Assistant Director of Nursing (ADON) on 10/24/23 at 2:20 p.m., indicated the Physician had indicated in his progress note that he had reviewed the urine culture and had ordered the ceftriaxone. She was unsure why he had chosen a resistant antibiotic. Interview with the Director of Nursing (DON) on 10/25/23 at 12:00 p.m., indicated she had spoken with the Physician, and he had ordered the ceftriaxone because it was what had worked for the resident in the past. She was having decreased appetite and some behavior concerns even though she had not met the McGreer's		consisting of the physician champion, the nursing champion, the infection prevention champion 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 Certain: November 17, 2023	

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	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	criteria for a urinary tract infection. 3.1-18(b)(1)			
F 9999 Bldg. 00	3.1-25 Pharmacy services (b) The administration of drugs and treatments, including alcoholic beverages, nutrition concentrates, and therapeutic supplements, shall be as ordered by the attending physician and shall be supervised by a licensed nurse as follows: (8) Per required need (PRN) medications may be administered only upon authorization of a licensed nurse or physician. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. This State rule was not met as evidenced by: Based on record review and interview the facility failed to ensure a QMA (Qualified Medication Aide) received prior authorization from a licensed nurse before administering a PRN (when necessary) medication to a resident for 1 out of 5 residents reviewed for unnecessary medications. (Resident 58) Finding includes: Resident 58's record was reviewed on 10/23/23 at 11:03 a.m. Diagnoses included, but were not limited to, polyneuropathy, hemiparesis/hemiplegia following a cerebral infarction, and unspecified dementia.	F 9999	F9999 1. Resident #58 had no negative outcomes. The Q.M.A. received verbal education immediately upon identification by the DON and the physician was notified. 2. An in house audit will be completed by date of compliance by nursing management on residents who received medications by a Q.M.A. to ensure the appropriate practice and documentation were in place. Any issues will be addressed by date of compliance. 3. Education will be completed for licensed nursing staff and Q.M.A.'s regarding their scope of practice and what the nurse is responsible for when a Q.M.A. is on duty 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 audit	11/17/2023

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	10/25/2023

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	A Physician's Order, dated 8/21/23, indicated to give Morphine Sulfate solution 20 milligrams (mg)/milliliter (ml), 0.25 ml every two hours as needed for pain. A Physician's Order, dated 5/15/23, indicated to give Acetaminophen 325 mg, 2 tablets every 6 hours as needed for pain. The August 2023 Mediation Administration Record (MAR), indicated on 8/9/23 the resident was given acetaminophen by QMA 1. There was no documentation a nurse had assessed the resident or authorized the medication to be given . The October 2023 MAR, indicated on 10/19/23 the resident was given Morphine Sulfate by QMA 2. There was no documentation a nurse had assessed the resident or authorized the medication to be given. Interview with LPN 1 on 10/24/23 at 8:55 a.m., indicated QMAs could give PRN medications, but the nurse had to assess the resident and document in the notes. Interview with the Director of Nursing on 10/24/23 at 11:34 a.m., indicated there was no documentation related to the medications being administered and they would have to do staff education. No additional information was provided.		the MARS and clinical record utilizing a “PRN Medication Administration Tool” 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. Date Certain: November 17, 2023	