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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKDALE VALPARAISO	2601 VALPARAISO ST VALPARAISO, IN 46383

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 12 and 13, 2024 Facility number: 010757 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/20/24.	R 0000	The following is the Plan of Correction for Brookdale Valparaiso regarding the Statement of Deficiencies dated 3/13/24. 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 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Sipich	Executive Director	04/04/2024

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	discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves			

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	sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone			

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	number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure discharge/ transfer papers were completed for a resident transferred to the hospital, for 1 of 10 records reviewed. (Resident 8) Finding includes: The record for Resident 8 was reviewed on 3/12/24 at 10:10 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus, edema and peripheral vascular disease. The resident had a stage 3 pressure ulcer to her right heel. A Progress Note, dated 12/26/24, indicated the pressure ulcer on the right heel was showing signs of infection and not improving. The Nurse Practitioner indicated the resident should go to the Emergency Room in the morning for evaluation and treatment of the wound. The family was notified. A Progress Note, dated 12/27/24, indicated a family member had arrived that morning and transported the resident to the ER. The resident was admitted to the hospital that day for treatment of the wound. There was no documentation that discharge/ transfer papers had been completed and sent with the resident and family member to the hospital. During an interview with the Health and Wellness Director, on 3/12/24 at 3:16 p.m., he indicated they	R 0045	R045 - Resident 8 was not negatively impacted. All residents had the potential to be impacted. The Health & Wellness Director or designee will audit charts to make sure discharge/transfer papers are in them. The Health & Wellness Director or designee will re-inservice assisted living nurses & QMA's (Qualified Medication Aide) on documenting when transfer papers are completed and sent with resident or family member when resident is sent to the hospital. Health & Wellness Director and/or designee will monitor transfers/discharges weekly for 4 weeks. Then, the Health & Wellness Director and/or designee will monitor transfers/discharges bi-weekly for 2 months, then monthly for 3 months.	04/15/2024

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	normally completed those papers, but did not think it was necessary because a family member transported the resident.		Any non-compliance will be addressed with individual associate responsible for the transfer/ discharge and during daily stand up meetings, Mondays through Fridays.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted each shift per quarter, and failed to invite the fire department to participate in fire drills every six	R 0092	R - 092 - No residents were negatively impacted.	04/30/2024

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	months as required. This had the potential to affect all 57 residents residing in the facility. Findings include: 1. The annual fire drills were reviewed on 3/13/23. On Memory Care, there was no fire drill conducted on the third shift during the second quarter (April, May and June) of 2023. On Assisted Living, there was no fire drill conducted on the second shift of the second quarter, or the third shift of the third quarter (July, August and September) of 2023. 2. Review of the fire drills lacked documentation the fire department had attended or was invited to attend. During an interview with the Maintenance Director, on 3/13/24 at 10:50 a.m., he indicated he had not invited the fire department to participate in fire drills last year. He had no additional information related to the fire drills not conducted each shift per quarter.		All residents had the potential of being impacted. Fire drills will be reviewed monthly at the Safety Committee meetings to insure they are being completed and that the Fire Department is invited every 6 months. Tasks have been added in the community's Building Management System (TELS) to invite the Fire Department every 6 months to participate in a fire drill. Any non-compliance will be brought up at the daily stand up meetings, Monday through Fridays and discussed at the monthly Safety Committee meetings	
R 0096 Bldg. 00	410 IAC 16.2-5-1.3(m)(1-2)(A-B)(i-iii) Administration and Management - Deficiency (m) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training;			

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	(ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. Based on record review and interview, the facility staff failed to keep personal medications secure on a dementia care unit, resulting in a resident with dementia gaining access. (CNA 4 and Resident 6) This had the potential to affect all 34 residents who resided on the dementia care unit. Finding includes: On 3/12/24 at 10:10 a.m., Resident 6 was observed working on a puzzle in the library. On 3/12/24 at 10:36 a.m., the resident was observed in the dining room opening drawers. The resident was redirected by the staff. On 3/13/24 at 1:44 p.m., Resident 6 was observed working on a puzzle at the activity table. An Indiana Department of Health Reportable incident, dated 3/9/24 at 11:45 a.m., indicated CNA 6 was toileting Resident 6 and found medication bottles containing Flexeril, Tylenol extended release, and weight management pills in the resident's pants pockets. A small plastic caddy was also found by CNA 2 and CNA 6 with 7 loose pills inside the caddy near the dining room sink. The medication bottles were immediately given to LPN 1. CNA 4 indicated she was missing medications from her purse and identified all medications were accounted for. The record for Resident 6 was reviewed on 8/9/23 at 8:49 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, Type 2 diabetes, Chronic kidney disease stage 3 and	R 0096	R - 096 Resident 6 had no adverse affect related to this incident All residents had the potential of being impacted. The Executive Director or designee will re-inservice associates regarding keeping their personal items secured and out of reach from residents. The Health & Wellness Director or designee will complete weekly rounds for 2 months to insure associate personal items are secured and out of reach from residents. Then, the Health & Wellness Director or designee will complete bi-weekly rounds for 2 months, followed by bi-monthly rounds for 2 months to insure associate personal items are secured and out of reach from residents. Any non-compliance will be brought up during daily stand up meetings, Mondays through Fridays, and reviewed at the monthly Safety	04/15/2024

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	Atherosclerotic heart disease of native coronary artery without angina pectoris. The Service Plan, dated 1/29/24, indicated the resident was cognitively impaired and required 1+ assist for toileting, dressing and bathing. During an interview, on 3/13/24 at 11:01 a.m., the Administrator indicated personal items should not be kept in the immediate work area. During an interview, on 3/13/24 at 11:15 a.m., the Health and Wellness Director indicated he had no written statements from the incident regarding the medications that were taken from CNA 4's purse. He indicated CNA 4's purse was found on the counter in the dining room, and the purse should not have been there accessible to residents. During an interview, on 3/12/24 at 11:16 a.m., the Memory Care Director indicated she usually arrived to work early to observe all shifts. She also indicated the resident was observed often on various shifts doing different activities and puzzles. During an interview, on 3/13/24 at 1:46 p.m., CNA 1 indicated if the resident was observed wandering, she would redirect him. Management had conducted a meeting and staff were to leave personal items in their cars. During an interview, on 3/13/24 at 2:01 p.m., CNA 2 indicated if the resident was observed wandering, she would redirect him. Management conducted a meeting and staff were to leave personal items in their cars. The policy, "Miscellaneous", was received from the Administrator on 3/13/24 at 11:01 a.m.,		Committee meetings	

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	indicated "...At certain Brookdale communities, personal items, such as overcoats, backpacks, purses, cell phones, or packages, may be not permitted in your immediate work area. Associate lockers may be provided to store your personal items...."			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, interview, and record review, the facility failed to ensure food was prepared in form to meet individual needs, related to incorrectly made pureed food. This had the potential to affect 7 residents who received a pureed diet. Finding includes: On 3/12/24 at 11:45 a.m., Cook 1 was observed making pureed peas. There was no recipe present. She placed several slices of bread into the mixer, then three slotted spoonfuls of cooked peas and a blue plastic cup of water. She indicated the spoonfuls were 4 ounces each, and the plastic container of water was more than a cup. She also indicated she used bread to thicken the mixture instead of food thickener. During an interview with the Executive Director (ED), on 3/12/24 at 2:35 p.m., she indicated there was food thickener present in the kitchen, she did not know why the Cook used bread.	R 0270	R 270 - No residents were negatively impacted. 7 residents had the potential of being impacted. The Executive Director, or designee, will re-inservice dietary staff on the importance of preparing pureed diets according to the recipe. The recipe for pureed diets will be posted in the kitchen for easy access during meal preparations. The Executive Director, or designee, will monitor pureed diets weekly for 4 weeks, followed by monitoring pureed diets bi-weekly for 2 months and then monitoring monthly for	04/15/2024

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	The policy, "How to Prepare Pureed Food", was provided by the ED and indicated, "...Vegetables and Salads:...Add 1/2-1 tablespoon to Thicken Right or NutraThik per recommended serving to thicken most vegetables to the desired "mashed potato" consistency...If liquid is needed when pureeing cooked vegetables, use the cooking liquid for more flavor and nutrients. No liquid will be needed for canned or very well cooked vegetables...." 410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.		the next 3 months. Any non-compliant issues to be discussed immediately with the dietary associate and will be discussed in the daily stand up meetings, Mondays through Fridays.	
R 0407 Bldg. 00	Based on record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to COVID-19 positive staff not restricted from work for the required quarantine period, for 3 of 3 staff reviewed. (CNAs 4, 5 and 6) Finding includes: The Infection Control program was reviewed on 3/13/24. The following staff members were reviewed for COVID-19 and had tested positive as follows:	R 0407	R 407 - No resident was negatively impacted All residents had the potential of being impacted Executive Director and Health & Wellness Directors will re-inservice associates and department managers on the ISDH LTC Infection Control policy which includes COVID 19+	04/30/2024

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	- CNA 4 tested positive on 8/22/23. She returned to work on 8/28/23, six days later. - CNA 5 tested positive on 8/22/23. She returned to work on 8/28/23, six days later. - CNA 6 tested positive on 8/31/23. She returned to work on 9/6/23, six days later. During an interview with the Memory Care Director, on 3/13/24 at 1:05 p.m., she indicated COVID-19 positive staff were restricted from work for five days, and if they had no fever, they could return and wear an N-95 mask for an additional five days. She indicated this was a corporate policy. The policies provided for review, "COVID-19 Playbook" and, "Skilled Nursing COVID-19 Testing Practice" did not include work restriction guidelines for COVID-19 positive staff. The Indiana Department of Health document, "COVID-19 LTC (long term care) Guidance Refresher", dated 8/23/23, indicated, "...Restrict from work for 10 days if asymptomatic, or mild to moderate illness. Return at that time if improving symptoms, and fever free without fever reducing meds for 24 hours. Mild to moderate cases (if improving and fever free without fever reducing meds), asymptomatic ones may return after 7 days with a negative test within 48 hours prior to return to work. If that test is positive, complete the ten-day period before returning to work....:"		quarantine time for associates Executive Director/designee will monitor COVID+ associates for 6 months to insure the correct quarantine time is being followed. Any non-compliance issues will be brought up at daily stand up meetings, Mondays through Fridays, and at monthly Safety Committee meetings.	