STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valparaiso Care & Rehabilitation	606 Wall Street Valparaiso, IN 46383

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure residents were administered medications and accuchecks (blood sugar testing) as ordered, for 3 of 4 residents reviewed for medications and accuchecks. (Residents B, K, and D)Findings include:1. During an interview on 4/15/26 at 9:53 a.m., Resident B indicated she did not always get her medications as ordered by the physician. Resident B's record was reviewed on 4/15/26 at 11:27 a.m. The diagnoses included, but were not limited to, diabetes mellitus and neuropathy. Physician's Orders, dated 1/29/26, indicated gabapentin (for nerve pain) 400 milligrams (mg) to be given four times a day, scheduled for 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., and hydroxyzine HCL (antihistamine) 25 mg to be given every six hours, scheduled at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. The Medication Administration Record (MAR), dated 3/15/26 to 4/14/26, indicated the gabapentin had not been administered on 3/20/26 at 4:00 p.m. and 4/4/26 at 8:00 a.m. The hydroxyzine HCL had not been administered on 3/18/26 at 12:00 a.m. and 3/23/26 at 6:00 p.m. There was no documentation on the MAR nor the Nurses' Progress Notes that indicated why the medications were not given. The Director of Nursing (DON) was notified on 4/15/26 at 5:30 p.m., no further information was provided. 2. Resident K's record was reviewed on 4/16/26 at 2:27 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Physician's Order, dated 12/15/25, indicated lantus insulin 15 units was to be administered every day at 9:00 a.m. The Medicaton Administration Record (MAR), dated 3/17/26 through 4/16/26, indicated the lantus insulin had not been administered on 3/21/26 and 4/4/26. There was no documentation on the MAR nor the Nurses' Progress Notes why the lantus had not been administered. A Physician's Order, dated 3/27/26, indicated novolog insulin four units was to be administered at 8:00 a.m. daily. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR, dated 3/17/26 through 4/16/26, indicated the novolog insulin had not been administered on 3/21/26 and 4/4/26. There was no documentation on the MAR nor the Nurses' Progress Notes why the novolog had not been administered. A Physician's Order, dated 2/10/26, indicated an accucheck was to be completed twice a day at 6:00 a.m. and 4:00 p.m. The MAR, dated 3/17/26 through 4/16/26, indicated the 4:00 p.m. accucheck had not been completed on 3/24/26 and 3/28/26. There was no documentation on the MAR nor the Nurses' Progress Notes why the accucheck had not been completed. During an interview on 4/16/26 at 3:00 p.m., the DON was unable to find any further information. 3. During an interview on 4/15/26 at 10:12 a.m., Resident D indicated she had not received her levothyroxine (a thyroid medication) medication at times. The record for Resident D was reviewed on 4/15/26 at 9:41 a.m. Diagnoses included, but were not limited to, hypothyroidism. A Physician's Order, dated 4/21/25, indicated levothyroxine 50 micrograms (mcg) every morning. The Quarterly Minimum Data Set (MDS) assessment, dated 1/2/26, indicated the resident was cognitively intact. The Medication Administration Record (MAR), dated 2/2026, indicated the levothyroxine medication was not signed off as given on 2/12/26 and 2/23/26. The Medication Administration Record (MAR), dated 3/2026, indicated the levothyroxine medication was not signed off as given on 3/23/26. The Medication Administration Record (MAR), dated 4/2026, indicated the levothyroxine medication was not signed off as given on 4/7/26. During an interview on 4/15/26 at 3:45 p.m., the Director of Nursing was made aware of the blanks on the MARs. No further information was provided. A facility medication administration policy/procedure, dated 4/2025 and received from the DON as current, indicated medications would be administered with the right resident, right medication, right dose, right time, right route. This citation relates to Intakes 2970538, 2976557, and 2977293. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during medication pass. Three errors were observed during 27 opportunities for errors during medication administration. This resulted in a medication error rate of 11.1%. (Residents M and N)Findings include:1. During an observation on 4/15/26 at 4:39 p.m., LPN 4 prepared Resident M's 4:00 p.m. medication of metoclopramide (stomach medication) 10 milligrams (mg). She placed one tablet in the plastic cup and indicated there was one tablet in the cup and she was ready to administer the medication. LPN 4 was stopped prior to entry of the room. She indicated the label on the medication card was metoclopramide 10 mg, administer 20 mg and indicated he should have two tablets of the medication.Resident M's record was reviewed on 4/16/26 at 8:40 a.m. The diagnoses included, but were not limited to, type one diabetes.A Physician's Order, dated 2/10/25, indicated metoclopramide 20 mg was to be administered four times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. 2. During an observation on 4/16/26 at 8:12 a.m., LPN 3 prepared Resident N's morning medication which included Fiberlax (fiber laxative) 625 mg, administer 1250 mg, and acetaminophen 325 mg, administer 650 mg. LPN 3 placed one tablet of Fiberlax and one tablet of acetaminophen in the plastic cup with the other medications and then indicated the medications were ready to be administered.LPN 3 was stopped prior to the administration. She indicated there should have been two tablets of the Fiberlax and two tablets of the acetaminophen in the medications cup.Resident N's record was reviewed on 4/16/26 at 8:40 a.m. The diagnoses included, but were not limited to, dementia and osteomylelitis.A Physician's Order, dated 1/17/25, indicated Fibercon (Fiberlax) 625 mg tablet, 1250 mg to be administered twice a day.A Physician's Order, dated 5/5/25, indicated acetaminophen 325 mg tablet, 650 mg to be administered twice a day.A facility medication administration policy, dated 4/2025, indicated the five rights of medication was to be performed, right resident, right medication, right dose, right route, and right time.This citation relates to Intakes 2970538, 2976557, and 2977293.410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to behavior documentation for 1 of 12 records reviewed. (Resident B)Finding includes:An Indiana Department of Health reported incident, dated 3/28/26 at 8:01 a.m., indicated Resident B voiced an allegation of abuse against staff at the facility.The undated investigation of the incident indicated undated interviews were completed with CNA 1, CNA 2, LPN 1, and LPN 2. The staff indicated the resident had been yelling and calling staff vulgar names.There was no documentation in the progress notes that indicated the allegation had been voiced nor the behaviors of the resident.During an interview on 4/15/26 at 3:41 p.m., LPN 1 indicated she thought LPN 2 was taking care of the documentation.During an interview on 4/16/26 at 4:11 a.m., LPN 2 indicated she had not charted the incident since she had not witnessed the incident.This citation relates to Intake 2970538.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)410 IAC 16.2-3.1-50(a)(2)