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	08/09/2024

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on observation and interview, the facility failed to provide privacy related to a shared bathroom for 1 of 1 resident reviewed for privacy. (Resident 57) Finding includes: During an interview on 8/6/24 at 9:23 a.m., Resident 57 indicated she felt she lacked privacy in the bathroom because she had to share the bathroom with the two men residing in the room next door. She no longer utilized the toilet due to her continence status, but felt she should be able to go in the bathroom to wash her hands or face without a man opening the door or worrying a man could be coming in the bathroom while she was in there. On 8/6/24 at 9:44 a.m., Resident 57's bathroom was observed. The shared bathroom was located in between her room (room [ROOM NUMBER]) and the room next door (room [ROOM NUMBER]). There were doors on each side of the bathroom leading to the resident rooms. There were 2 male residents currently residing in room [ROOM NUMBER]. The record for Resident 57 was reviewed on 8/8/24 at 4:19 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, and hypertension. The Significant Change Minimum Data Set assessment, dated 6/21/24, indicated the resident was cognitively intact. During an interview on 8/9/24 at 10:33 a.m., the Director of Nursing indicated the resident had never voiced any concerns regarding privacy in the bathroom. The resident did not use the toilet, but the bathroom was shared with the room next door where two men currently resided. The resident was currently out at dialysis, but she would follow up with her when she returned. 3.1-3(p)(1)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 32664 Based on observation, record review, and interview, the facility failed to ensure care plans were reviewed and revised to include changes related to resident infections and dialysis access points for 2 of 29 resident care plans reviewed. (Residents 69 and 57) Findings include: 1. On 8/6/24 at 9:17 a.m., Resident 69 was observed in his room. The resident indicated he had a surgical wound to the top of his right foot. He had been under precautions at one time for having an infection. He no longer had the infection and was not on precautions any longer. There were no signs posted for any TBP (Transmission Based Precautions) or any PPE (Personal Protective Equipment) bins located inside or outside of the room. Record review for Resident 69 was completed on 8/9/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus and a history of MRSA (Methicillin-resistant Staphylococcus aureus - bacterial infection). The Significant Change Minimum Data Set (MDS) assessment, dated 7/5/24, indicated the resident was cognitively intact. The resident had a surgical wound and was not taking an antibiotic. A Care Plan, dated 4/29/24 and revised 6/29/24, indicated the resident had a need for Contact Isolation related to active infectious disease MRSA. Interventions included, but were not limited to, educate visitors on necessary precautions needed for the specific type of infection and to have adequate PPE available for staff and visitors. A Physician's Order, dated 3/1/24 and discontinued 6/6/24, indicated the resident was on isolation due to having an active infection related to MRSA in the right foot. During an interview on 8/9/24 at 10:48 a.m., the Wound Nurse indicated the resident did not currently have MRSA and did not require contact precautions. The care plan should have been updated to include a history of MRSA. 32788 2. The record for Resident 57 was reviewed on 8/8/24 at 4:19 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, and hypertension. The Significant Change Minimum Data Set assessment, dated 6/21/24, indicated the resident was cognitively intact and received hemodialysis. A care plan, updated 7/17/24, indicated the resident received hemodialysis and had a right chest permacath (dialysis catheter) for dialysis access. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/24 at 9:23 a.m., Resident 57 indicated she went to dialysis on Mondays, Wednesdays and Fridays. She had a right upper arm graft for her current dialysis access. She also had an old right arm fistula, but it was not working any longer. During an interview on 8/9/24 at 10:33 a.m., the Director of Nursing (DON) indicated she had called the dialysis center to confirm, and the resident had a right upper arm graft dialysis access site. They would update the care plan. 3.1-35(b)(1)

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32582 Based on observation, record review and interview, the facility failed to ensure a resident with edema was monitored or treated for 1 of 1 resident reviewed for edema (Resident 18), medications were given as scheduled and accuchecks were documented for 2 of 5 residents reviewed for unnecessary medications. (Residents 91 and 120) Findings include: 1. On 8/6/24 at 1:41 p.m., Resident 18 was observed seated in her room in a wheelchair. Her legs were elevated with the footrests and she indicated they were swollen. On 8/7/24 at 1:19 p.m. the resident was seated in her room in a wheelchair, her call light was on. She indicated she wanted someone to put the footrests on her wheelchair so she could elevate her legs because they were swollen. On 8/9/24 at 1:12 p.m., the resident was seated in her room in a wheelchair. She indicated her legs had been swollen for about a month and she had told the nurses about it, but did not know what they were doing about it. The resident's record was reviewed on 8/7/24 at 2:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus, heart disease and chronic obstructive pulmonary disease. The Significant Change Minimum Data Set (MDS) assessment, dated 6/13/24, indicated the resident was cognitively intact and required substantial assistance for bed mobility and transfers. The Weekly Skin and Vitals Assessments, dated 7/26/24, 8/2/24 and 8/9/24, indicated there was no edema. The Daily Shift Report, dated 8/4/24, indicated the resident had bilateral lower extremity edema. There was no documentation in the resident's progress notes or documentation the physician had been notified of the edema. During an interview on 8/9/24 at 1:14 p.m., LPN 1 indicated he had completed the Weekly Skin and Vitals Assessment that day. He asked the East Unit Manager if she knew anything about the resident having edema. The East Unit Manager indicated yes and the Nurse Practitioner (NP) was aware of it. The East Unit Manager indicated there was no documentation because it was a telehealth visit and not in the electronic record. During an interview on 8/9/24 at 1:30 p.m., the Director of Nursing (DON) indicated the NP thought the edema may be related to recent intravenous fluids given. A Care Plan, dated 4/9/24, indicated adequate tissue perfusion would be maintained as evidence by blood pressure within normal limits, no change in mental status, no complaints of dizziness and no edema. Interventions included, but were not limited to, elevate lower extremities, observe and document pallor, dizziness, variations in blood pressure, edema and notify MD. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 91's record was reviewed on 8/7/24 at 9:08 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, chronic pain and anxiety. The Quarterly MDS assessment, dated 7/10/24, indicated the resident had significant cognitive impairment and received anti-anxiety medications and opioids. A Physician's Order, dated 8/16/23, indicated to give hydrocodone-acetaminophen (opioid pain medication) 10 milligrams (mgs)/325 mgs every 6 hours for chronic pain. The July and August 2024 Medication Administration Records indicated the medication was not signed out as given or refused on the following dates and times: 7/5/24 2:00 a.m. 7/13/24 2:00 a.m. 7/16/24 2:00 a.m. 7/17/24 2:00 a.m. 7/18/24 8:00 p.m. 7/27/24 2:00 a.m. 7/29/24 2:00 a.m. 8/5/24 2:00 a.m. During an interview on 8/8/24 at 3:05 p.m., LPN 1 indicated if a medication was not given or was refused, it should be documented. The resident did not normally refuse medications. During an interview on 8/8/24 at 3:18 p.m., the DON indicated the missing doses were likely because the resident was sleeping at 2:00 a.m., and the schedule should be revisited. The current policy, General Dose Preparation and Medication Administration, indicated, .6. After medication administration, .Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application site) on appropriate forms 45666 3. Resident 120's record was reviewed on 8/7/24 at 8:32 a.m. Diagnoses included, but were not limited to type 2 diabetes mellitus, dementia, and Parkinson's disease. The Significant Change Minimum Data Set (MDS) assessment, dated 5/22/24, indicated the resident was severely cognitively impaired for daily decision making. She received insulin injections. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 3/2/24, indicated the resident was at risk for adverse effects related to the use of glucose lowering medications and/or the diagnoses of diabetes mellitus. Interventions included, but were not limited to, monitor blood sugars as ordered, administer medications as ordered, and provide diet as ordered. The July 2024 Physician's Order Summary indicated a daily blood sugar check at 6:00 a.m. and Lantus Solostar U-100 (a diabetic medication) insulin pen 100 unit/milliliter 10 units subcutaneous at bedtime. The July 2024 Medication Administration Record (MAR) indicated the blood sugar check at 6:00 a.m. was blank on 7/7, 7/19, 7/22, 7/27, and 7/30/24. The Lantus Solostar medication was blank at 9:00 p.m. on 7/25/24. During an interview on 8/8/24 at 4:13 p.m., the Director of Nursing indicated the nurse who was working those days had not documented on the MAR, however the blood sugar checks and Lantus medication were administered. She was unable to provide any further documentation. 3.1-37(a)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 45666 Based on observation, record review, and interview, the facility failed to care for a PICC (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) line in accordance with professional standards of practice, related to flushing the PICC line for 1 of 5 residents observed during medication pass. (Resident 3) Finding includes: During medication pass, the Infection Preventionist (IP) was observed preparing an intravenous medication for Resident 3 on 8/8/24 at 2:13 p.m. The IP prepared meropenem (an antibiotic) reconstituted solution 1 gram per 100 cc of normal saline. She washed her hands and donned clean gloves. She bent the connection between the 100 cc normal saline bag and the vial of meropenem, squeezed the normal saline into the vial, and then shook the vial to dissolve the meropenem powder medication. She held the vial above the bag and squeezed air from the bag into the vial to force the liquid back into the bag. She spiked the normal saline bag with new tubing and primed the tubing. She connected the tubing thru the pump and set it to run at 100 cc's per hour. She reached into her scrub top pocket with her gloved hands, pulled out an alcohol swab, opened the package, cleaned off the PICC connection port, and then attached a 10 cc normal saline syringe. She injected 6 cc's of normal saline thru the PICC line, unattached the normal saline syringe, reached into her pocket with the same gloved hands, and pulled out a new alcohol swab. She opened the alcohol swab, cleaned the PICC connection port, and attached the primed tubing. She then started the medication pump and the infusion of meropenem began. Resident 3's record was reviewed on 8/8/24 at 2:30 p.m. The August 2024 Physician Order Summary indicated a normal saline 10 cc syringe injection, flush PICC line before and after antibiotic administration to maintain patency every 8 hours. During an interview on 8/8/24 at 2:33 p.m., the IP indicated she should have flushed with a total of 10 cc of normal saline prior to administering the antibiotics thru the PICC line. A facility policy, titled Vascular Access Device Flush Ordered, received as current, indicated, .Peripherally Inserted Central Catheter (PICC) valved catheters, flush with normal saline-10 ml before and after IV medication administration . 3.1-47(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 32582 Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary care and treatment related to incorrect oxygen flow rate and a humidity bottle not changed for 1 of 4 residents reviewed for respiratory care. (Resident 70) Finding includes: On 8/5/24 at 1:29 p.m., Resident 70 was observed in a wheelchair. He had a nasal cannula in place and attached to a portable oxygen tank on the back of the wheelchair. The flow rate was set at 4 liters per minute (lpm). On 8/6/24 at 9:08 a.m., the resident was observed lying in bed with a nasal cannula in place attached to the portable oxygen tank. The tank was set to a flow rate of 4 lpm. The oxygen concentrator was also on and set at 4 lpm. The water bottle on the concentrator was dated 7/29/24. The resident's record was reviewed on 8/7/24 at 1:22 p.m. Diagnoses included, but were not limited to, Parkinson's disease and chronic obstructive pulmonary disease. The Quarterly Minimum Data Set assessment, dated 7/31/24, indicated the resident had moderate cognitive impairment and required substantial/maximum assistance for bed mobility and transfers. A Physician's Order, dated 2/27/24, indicated the resident was to be on oxygen at 2 lpm continuously. A Physician's Order, dated 7/18/23, indicated the oxygen tubing and water bottle was to be changed weekly on Sunday. The August 2024 Medication Administration Record indicated the water bottle had been changed on 8/4/24. During an observation and interview on 8/6/24 at 9:15 a.m., the Cottage Unit Manager observed the oxygen and indicated it was set at 4 lpm and the water bottle was dated 7/29/24. 3.1-47(a)(6)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 32788 Based on observation, record review, and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis, related to not monitoring the dialysis access site, for 1 of 1 resident reviewed for dialysis. (Resident 57) Finding includes: During an interview on 8/6/24 at 9:23 a.m., Resident 57 indicated she went to dialysis on Mondays, Wednesdays and Fridays. She had a right upper arm graft for her current dialysis access. She also had an old right arm fistula, but it was not working any longer. The record for Resident 57 was reviewed on 8/8/24 at 4:19 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, and hypertension. The Significant Change Minimum Data Set assessment, dated 6/21/24, indicated the resident was cognitively intact and received hemodialysis. A care plan, updated 7/17/24, indicated the resident received hemodialysis. Interventions included, .assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warmth, bruit/thrill. Document findings . The Physician's Order Summary, dated 8/2024, indicated the resident had dialysis on Mondays, Wednesdays, and Fridays at 11:00 a.m. and to check for bruit and thrill every shift. There was no location specified on the order for the bruit and thrill. There were no orders related to monitoring the dialysis access site for excessive bleeding, drainage, swelling, redness or warmth. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 8/2024, lacked any monitoring of the right arm graft site for excessive bleeding, drainage, swelling, redness or warmth. There were Dialysis Appointment Assessments completed on the resident's dialysis days which included monitoring of the dialysis access site on those days. During an interview on 8/9/24 at 10:33 a.m., the Director of Nursing (DON) indicated she would clarify the orders to include where the dialysis access site was and to monitor for excessive bleeding, drainage, swelling, redness or warmth along with the bruit and thrill. A Facility Policy, titled Dialysis Care, received as current, indicated, .1. Physician orders will be received at time of admission specific to the resident: dialysis access care .9. It is recommended that peritoneal and hemodialysis residents be kept on hot charting to monitor for complications [access sites, change in condition, pain, signs of fluid overload, etc.] . 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664 Based on observation, record review, and interview, the facility failed to ensure medications were stored properly, with appropriate labeling and not expired, for 2 of 4 medication carts observed. (East Cart and Cottage Cart) Findings include: 1. On [DATE] at 1:28 p.m., the following was observed on the East Cart with LPN 1: - A Basaglar KwikPen (insulin) was dated with an open date on [DATE]. - A Rezvoglar KwikPen (insulin) was dated with an open date on [DATE]. - A Toujeo SoloStar (insulin) pen was opened with no open date written on the pen. - A Basaglar KwikPen was opened with no open date written on the pen. During an interview on [DATE] at 1:35 p.m., the East Unit Manager indicated the open insulins should have been dated and disposed of 30 days after opening. 2. On [DATE] at 1:41 p.m., the following was observed on the Cottage Cart with QMA 1: - An insulin lispro vial was dated with open date on [DATE]. - A Lantus (insulin) pen was opened with no open date written on the pen. - An insulin lispro pen was opened with no open date written on the pen. During an interview on [DATE] at 1:50 p.m., LPN 1 indicated the open insulins should have been dated and disposed of 30 days after opening. A policy titled, 5.3 Storage and Expiration Dating of Medications and Biologicals, and received as current from the Director of Nursing, indicated, .11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened .11.3 If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial . 3XXX,d+[DATE](j)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45666 Based on observation, record review, and interview, the facility failed to ensure a resident with a peripherally inserted central catheter (PICC) was placed in enhanced barrier precautions (EBP) for high contact resident care activities, and for improper glove use for 1 of 5 residents reviewed during medication administration. Finding includes: During medication pass, the Infection Preventionist (IP) was observed preparing an intravenous medication for Resident 3 on 8/8/24 at 2:13 p.m. Upon entrance to Resident 3's room, there was no signage noted in or around the doorway for EBP and no personal protective equipment bins. The IP prepared meropenem reconstituted solution (an antibiotic) 1 gram per 100 cc of normal saline. She washed her hands and donned clean gloves. She bent the connection between the 100 cc normal saline bag and the vial of meropenem, squeezed the normal saline into the vial, and then shook the vial to dissolve the meropenem powder medication. She held the vial above the bag and squeezed air from the bag into the vial to force the liquid back into the bag. She spiked the normal saline bag with new tubing and primed the tubing. She connected the tubing thru the pump and set it to run at 100 cc's per hour. She reached into her scrub top pocket with her gloved hands, pulled out an alcohol swab, opened the package, cleaned off the PICC connection port, and then attached a 10 cc normal saline syringe. She injected 6 cc's of normal saline thru the PICC line, unattached the normal saline syringe, reached into her pocket with the same gloved hands, and pulled out a new alcohol swab. She opened the alcohol swab, cleaned the PICC connection port, and attached the primed tubing. She then started the medication pump and the infusion of meropenem began. Resident 3's record was reviewed on 8/8/24 at 2:30 p.m. There were no Physician's Orders for EBP. During an interview on 8/8/24 at 2:33 p.m., the IP indicated any resident with a central line or PICC should have been placed in EBP and she would correct it immediately. During an interview on 8/9/24 at 8:57 a.m., the Director of Nursing indicated the resident should have been in EBP and the IP should have performed hand hygiene and changed her gloves after reaching into her pockets while administering a medication thru a PICC line. A facility policy, titled, Standard and Transmission-Based Precautions (Isolation) Policy, provided as current, indicated .Standard Precautions .The following infection prevention and control practices should be used during the delivery of care to all residents: Hand Hygiene . Perform hand hygiene: Before having direct contact with a resident, before performing clean/aseptic procedure, after contact with the resident, after contact with blood, body fluids, or visibly contaminated surfaces, after touching resident surroundings (objects and surfaces in the resident's environment) .Gloves .Change gloves during care and hand hygiene performed if hands will move from a contaminated site to a clean site .Enhanced Barrier Precautions . It is also used for any resident with any of the following: wounds and/or indwelling medical devices (e.g., central line) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-18(b)