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	02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
JOURNEY SENIOR LIVING OF VALPARAISO	74 E JOURNEY WAY VALPARAISO, IN 46383

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: February 7 and 8, 2019. Facility number: 014081 Residential Census: 25 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/12/19.	R 0000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility is also requesting a desk review for compliance in these areas.	
R 0086 Bldg. 00	410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on record review and interview, the failed to have a CLIA (Clinical Laboratory Improvement Amendments) waiver for glucose meter testing (a blood test that reads the sugar level in the blood). This had the potential to affect 1 of 1 residents who had blood glucose testing. (Resident 5) Finding includes:	R 0086	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** On 2/7/19, Executive Director made aware of oversight on having the CLIA waiver and immediately filled out the application for the	03/08/2019

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

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	Resident 5's record was reviewed on 2/8/19 at 1:03 p.m. Diagnoses included, but were not limited to, diabetes mellitus. The current Physician Order Summary indicated blood sugar checks every p.m. The February Medication Administration Sheet indicated blood sugars checks were completed. The facility lacked a CLIA waiver for glucose meter testing. Interview with the Administrator on 2/8/19 at 8:02 a.m. indicated it was an oversight and had not applied for the facility's CLIA waiver for the Nurses to complete glucose meter testing.		CLIA waiver. Application was mailed out on 2/8/19 to the proper state agency office. State agency sent Executive Director the "Disclosure of Ownership" form on 2/12. Executive Director gathered required information and sent back to state agency on 2/18. **How will you identify other residents having potential to be affected by the same deficient practice?** Any resident who has an order for blood glucose checks has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make the ensure the deficient practice does not recur?** CLIA waiver paperwork sent out to state agency. Executive Director will ensure payments for the CLIA wavier are made timely in order to keep the CLIA waiver current at all times. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Executive Director will ensure every two years to make payment on time to keep CLIA waiver current and community in compliance with state regulation.	

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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 invite the local fire department to a fire drill at least every 6 months and complete fire drills quarterly on each shift. Finding includes: The 2018 fire drills were reviewed on 2/7/19 at 11:00 a.m. Fire drills were completed on 5/18/18 first shift and 7/17/18 3rd shift. There was lack of any other documentation fire drills were completed quarterly	R 0092	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** A fire drill will be conducted at the community on 2/22/19, including a transmission of a fire alarm signal and simulation of emergency fire conditions. One drill was conducted in January, we will conduct one more this quarter to be in compliance with State	03/15/2019

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	on each shift. There was lack of documentation to indicate the local fire department attended or was invited to any fire drills in 2018. Interview with the Administrator on 2/8/19 at 1:33 p.m., indicated the fire department had not been invited and the fire drills had not been completed as required.		regulations and to ensure that all three shifts have training on the community's fire drills. Maintenance Supervisor will invite the local fire department to come out to participate in a community fire drill procedure every 6 months. **How will you identify other residents having potential to be affected by the same deficient practice?** Any resident has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make the ensure the deficient practice does not recur?** Maintenance Director inserviced on ensuring to conduct three fire drills, one on each shift, per quarter and the requirement to call and invite local fire department every 6 months. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** An audit will be created to be placed in the Fire Drill binder to ensure that drills are done three times each quarter on all three shifts. The audit will also have notation on when the fire department is called to participate in community fire drills.	

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			Maintenance Director/ and or Designee will check this audit monthly to ensure drills are being done accurately and according to State regulations. Audit will be reviewed during the QA committee meeting. Any recommendations made by the committee will be followed up by the Maintenance Director/and or designee and results brought to next meeting. This will continue for 12 months.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to maintain the safety of residents related to access to chemical hazards for 12 residents who have dementia and resided in the building. (Locked Memory Care Unit) Finding includes:	R 0148	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents immediately affected. Items, such as air	03/08/2019

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	During the Environmental Tour with the Maintenance Director, on 2/8/19 at 8:51 a.m., the following resident's rooms had their doors open, and had easily accessible chemicals that indicated on the container "Keep out of reach of children," observed in the locked memory care unit: 1. In Room 112's bathroom, there was a large tube of toothpaste laying on the countertop by the sink. 2. In Room 124's bathroom, there was a large container of ACT mouthwash (containing alcohol) on the countertop by the sink. 3. In Room 105's bathroom, there was a solid air freshener placed on the countertop by the sink. 4. In Room 113's bathroom, there a "Sure Scent" air freshener beads in a container, on the countertop by the sink. Interview and observation with the Director of Nursing (DON) on 2/8/19 at 9:56 a.m., for the above rooms, indicated all chemicals are to be in a locked cabinet. A Policy titled, " Assessments and Service Plans Policy and Procedure," was provided by the DON on 2/8/19 at 11:00 a.m. This current policy indicated, "Residents that are transitioning to the facilities memory care unit will have a facility provided locked cabinet available to time of move-in. This furnished cabinet, is to ensure that all residents toiletries or any items that pose a health and safety risk, are secured by staff at all times in this cabinet...."		fresheners, were taken off the unit. Other items, such as toothpaste and mouthwash, were placed securely in the provided locked cabinets of each apartment. **How will you identify other residents having potential to be affected by the same deficient practice?** All residents on the Memory Care unit have the potential to be affected by the same alleged deficient practice. All 12 residents' vitals taken and head to toe assessment done to ensure no adverse effects if a resident came in contact with hazardous materials. **What measures will be put into place or what systematic changes will you make the ensure the deficient practice does not recur?** All staff re-educated on ensuring that any items that could be deemed hazardous to residents are to be secured in the provided locked cabinet of each resident's rooms when these items are not in use. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Nursing and/or designee will conduct twice daily	

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			audits on all resident occupied apartments to ensure that all hazardous chemical toiletries are locked away in their designated/facility provided locked cabinet. The Director of Nursing and/or designee will bring the results of audits to the QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and/or designee and results brought to next meeting. This will be done for 6 months.	
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, record review, and interview, the facility failed to ensure modified diets were prepared properly according to a recipe. (Main kitchen) This had the potential to affect 1 resident who resided in the facility and received a puree diet. Finding includes: On 2/7/19 at 2:12 p.m., Cook 1 was observed preparing a puree modified diet. He indicated he was making puree food for 1 resident. He started with vegetable soup. He took one ladle of soup and put it into the blender. He then added an	R 0270	**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Dietician Consultant conversed with ED on 2/15 about best practices, state regulations and sent in-services for dietary staff to review and get tested on. Dietary Consultant scheduled visit made for 2/18. Dietary Consultant arrived at community on 2/18 to go over modified diets, recipes and	03/08/2019

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	unmeasured amount of the broth from the soup into the blender and turned it on. He then turned the blender off and then added 3 pumps of thickener to the blender and turned it back on. He then put the blender through the dishwasher and started to puree a sandwich. The sandwich was turkey and cheese with 2 pieces of bread. He ripped apart the sandwich and added it to the blender. He poured an unmeasured amount of chicken broth into the blender and turned the blender on. He turned the blender off and then added more unmeasured amount of chicken broth into the blender and turned it on. He then turned the blender off and added 1 pump of thickener to the blender and continued to puree the sandwich. Interview with Cook 1 after the puree observation indicated he was unaware if there were any recipes to follow for the puree. He indicated he just "eyeballs" the food to see if he needs to add thickener or broth. Interview with the Dietary Director on 2/7/19 at 4:40 p.m., indicated she was unaware if the facility had a policy for puree diets. She was unaware if they had any recipes for puree diets. The cooks were supposed to add thickener if needed. On 2/8/19 at 9:44 a.m., the Dietary Director provided recipes for pureed vegetables and pureed meat. The recipes did not include how much thickener was supposed to be added.		best practices with Dietary Supervisor. Per dietician, when it comes to pureed recipes, there is no set amount of thickener noted on recipes to be added. Pureed diets are to be prepared to consistency of applesauce or mashed potatoes. Staff are trained to know when the food arrives to the correct consistency. **How will you identify other residents having potential to be affected by the same deficient practice?** Any resident who is on a modified diet has the potential to be affected by the alleged deficit. **What measures will be put into place or what systematic changes will you make the ensure the deficient practice does not recur?** Dietary Supervisor inserviced by Dietary Consultant in depth on textured modified diets & pureed food preparation and presentation. Dietary staff inserviced on texture modified diets, along with, pureed food preparation and presentation. Puree Recipe binder created and placed near blender area. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Dietary Supervisor and/or	

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			designee will monitor/audit, once a week, a pureed recipe being made by dietary staff. The Dietary Supervisor and/or designee will bring the results of audits to the QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and/or designee and results brought to next meeting. This will be done for 6 months.	