STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013733	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA MERRILLVILLE	7900 RHODE ISLAND STREET MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: March 12 and 13, 2024 Facility number: 013733 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/19/24.	R 000		
R 029	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. This RULE is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained, related to not placing a dignity bag over a foley (urinary) catheter drainage bag, for 1 of 2 residents reviewed for urinary catheters. (Resident 3) Finding includes: On 3/13/24 at 11:07 a.m., Resident 3 was observed in a wheelchair in the common area participating in activities. The foley catheter bag was attached under the wheelchair and uncovered. On 3/13/24 at 2:31 p.m., Resident 3 was observed in a wheelchair in the common area	R 029		

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R 029	Continued From page 1 watching the television. The foley catheter bag was attached under the wheelchair and uncovered. Resident 3's record was reviewed on 3/12/24 at 12:47 p.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, and high blood pressure. The Service Plan, dated 12/5/23, indicated the resident was moderately cognitively impaired for daily decision making. During an interview, on 3/13/24 at 2:45 p.m., the Director of Nursing indicated the resident usually had a leg bag so it had never been a problem in the past. The catheter bag should have been covered.	R 029		
R 246	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. 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 RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure as needed (PRN) medications were authorized by a licensed nurse prior to administration with documentation noting the time of contact, for 1 of 4 residents reviewed for PRN medications. (Resident 7)	R 246		

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R 246	Continued From page 2 Finding includes: Resident 7's record was reviewed on 3/13/24 at 12:06 p.m. Diagnoses included, but were not limited to, dementia and high blood pressure. The Service Plan, dated 2/1/24, indicated the resident was severely cognitively impaired. Physician's Orders, dated 2/2/24, indicated the resident was to receive morphine sulfate solution 100 milligram (mg)/5 milliliter (ml) (a pain medication), 0.25 ml by mouth or sublingual (under the tongue) as needed every 4 hours. The February 2024 Medication Administration Record (MAR), indicated the morphine was signed out as administered on 2/3/24 at 6:36 a.m. by QMA 1. Physician's Orders, dated 2/4/24, indicated the resident was to receive morphine sulfate solution 100 mg/5 ml, 0.5 ml by mouth or sublingual as needed every 2 hours. The February 2024 Medication Administration Record (MAR), indicated the morphine was signed out as administered on 2/5/24 at 6:14 a.m. by QMA 1. The record lacked documentation of the QMA receiving authorization from a licensed nurse to administer the PRN medication. During an interview, on 3/13/24 at 2:55 p.m., the Director of Nursing indicated she was unable to provide further information regarding administration of PRN medications without prior licensed nurse authorization.	R 246		

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R 301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. This RULE is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a medication was accurately labeled, for 1 of 5 residents observed during medication pass. (Resident 3) Finding includes: On 3/13/24 at 11:45 a.m., LPN 1 was observed preparing Resident 3's medication. LPN 1 placed one 10 milligram (mg) buspirone tablet (an anti-anxiety medication) into a medication cup. The label on the prescription bottle indicated to give two 10 mg tablets of buspirone, three times a day. LPN 1 administered the medication to the resident. Resident 3's record was reviewed on 3/13/24 at 10:52 a.m. A Physician's Order, dated 7/22/21, indicated	R 301		

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R 301	Continued From page 4 buspirone 10 mg oral tablet, take 1 tablet by mouth three times a day. During an interview, on 3/13/24 at 11:48 a.m., LPN 1 indicated she knew the medication label was incorrect. She had reviewed the Medication Administration Record (MAR) before administering the medication, which indicated the resident should receive one 10 mg buspirone tablet. The pharmacy was supposed to apply the correct label, and she had complained several times regarding wrong instructions found on medication bottles. During an interview, on 3/13/24 at 12:35 p.m., the Director of Nursing indicated the pharmacy continued to put the same order labels from the past on the medication, even after being told several times to change the labels to match the current facility orders.	R 301		