DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VIRGINIA PLACE ASSISTED LIVING	8253 VIRGINIA ST MERRILLVILLE, IN 46410

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: February 14 and 15, 2024 Facility number: 010887 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/22/24.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber R Hepworth	Executive Director	03/03/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR certificate scheduled for 10 of 21 shifts, and current first aid certificate scheduled for 14 of 21 shifts reviewed. This had the potential to affect all 34 residents residing in the facility. Finding includes: Facility staffing schedules for 2/4/24 through 2/10/24 were reviewed on 2/15/24 at 10:00 a.m. The schedules indicated there were no staff members who were CPR or first aid certified on the following dates and shifts: No CPR certification: -Evening shift: 2/5/24, 2/9/24, and 2/10/24 -Midnight shift: 2/4/24, 2/5/24, 2/6/24, 2/7/24, 2/8/24, 2/9/24, and 2/10/24. No first aid certification: -Evening and Midnight shifts: 2/4/24, 2/5/24, 2/6/24, 2/7/24, 2/8/24, 2/9/24, and 2/10/24. During an interview on 2/15/24 at 12:47 p.m., the Administrator indicated they had no additional staff CPR or first aide certifications to provide.	R 0117	**R 117 410 IAC 16.2-5-1.4(b) Personnel Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Upon review, we found that there were not deficiencies with CPR, only First Aid certifications. The schedule was misread, as all nurses (whom all have active CPR certifications) regardless of shift were listed at the top of the schedule, and we have nurse coverage 24/7. However not everyone had first aid certification, an online class will be procured to ensure everyone on staff 24 hours a day are both CPR and First Aid Certified. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:**	03/15/2024

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			All residents had the potential to be affected by this deficient practice. DON and ED will review schedule and ensure any staff deficient in CPR and or First Aid training will be scheduled to complete the certification, as well as ensure 24/7 CPR/First Aid coverage until all staff missing the certification are up to date by March 15, 2024. **3 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:** Current staff who are not both CPR and First Aid certified will be scheduled for future classes. New staff will be screened upon hire to ensure their certifications are up to date. An up to date list will be kept with all staff names who are current with their certifications to ensure 24-hour CPR and first aid coverage. DON/Designee will review the staffing schedule to ensure there is CPR and first aid coverage 24 hours a day. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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			The Executive Director is responsible for sustained compliance. The ED/Designee will complete audits by reviewing staffing schedule weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly to ensure staff are current with CPR and first aid certification. The audit will be discussed monthly at our leadership meetings. The leadership team will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents			

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	shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure staff completed the required annual inservices for 3 of 5 employee records reviewed. (QMA1, Resident Assistant 1, and Resident Assistant 2) Findings include: The employee records were reviewed on 2/15/24 at 9:43 a.m. 1. QMA 1 had not completed annual training for 2023 for resident rights and had only 1.5 hours of dementia training. 2. Resident Assistant 1 had not completed annual training for 2023 for resident rights and had only 1.5 hours of dementia training. 3. Resident Assistant 2 had not completed annual training for 2023 for resident rights and had only 2 hours of dementia training.	R 0120	**R 120 410 IAC 16.2-5-1.4(e) (1-3) Personnel Noncompliance** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Those staff members who identified as not being current with their yearly education were informed and will receive the needed education. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:** All residents had the potential to be affected by this deficient	03/25/2024

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	During an interview on 2/15/24 at 12:47 p.m., the Administrator indicated the above employees did not complete their annual inservices for 2023.		practice. An audit took place on 2/19/24 of the staff files to identify all staff members that are not in compliance with their yearly education including but not limited to dementia education, resident rights, prevention and control of infection, fire prevention, ect. The staff members that were identified as being noncompliant with annual education will be placed on the schedule to specifically complete the annual education on a computer in the community to ensure everyone is up to compliance. **3 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:** The ED/Designee will review each file before a new staff member starts on the floor, and ensure that the first days scheduled are to complete initial trainings. As well, the ED/Designee will complete a monthly audit of staff's continued education, and schedule those in need to come to the community to complete annual trainings. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place: The Executive Director is responsible for sustained compliance. The ED/Designee will complete audits of annual training to ensure completion bi-weekly for 4 weeks, then monthly to ensure staff are current with all trainings/inservices. The audit will be discussed monthly at our leadership meetings. The leadership team will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. **5 By what date will the systemic changes be completed?** March 25, 2024	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the kitchen was clean and in good repair, related to dirty walls and floors, build up on pipes, and a dirty window, for 1 of 1 kitchen observed. (Main Kitchen). Findings include: During the initial tour with the Dietary Food Manager on 2/14/24 at 9:03 a.m., the following was	R 0144	**R 144 410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards-Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	02/27/2024

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	observed: a. The walls had food splashed on them and were dirty throughout the kitchen. b. There was lime build up on the pipes behind the sink. c. The floors and baseboards were dirty throughout the kitchen, and there was an unidentified liquid spilled under the plate warmer. d. The window sill and blinds in the kitchen were dirty and had an accumulation of dust. e. The pipes under the 3-compartment sink had an accumulation of dirt and lime build up on them. The Dietary Food Manager indicated at that time the kitchen needed to be deep cleaned in all of the noted areas.		Deep cleaning in all areas of the kitchen including but not limited to window, walls, floors, baseboards, sinks, and pipes has been completed as of February 27, 2024 by DSD, ESD, and cook. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. The DSD (Dining Services Director) will keep a record of deep cleaning schedule/check list for these areas, and ensure it is being completed. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The DSD will provide ED with copies of completed deep cleaning log to ensure all deep cleaning is completed per schedule. DSD/ED will review and maintain these logs together monthly. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: The Executive Director is responsible for continued compliance. The DSD/Designee will complete audits by ensuring completion of cleaning tasks through visual inspection along with the cleaning logs completed by dining or environmental staff signing off on each assigned task. This will be done on a weekly basis for 4 weeks, then bi-weekly for 4 weeks, then monthly for 1 month. The audit will be discussed at monthly leadership meetings. The leadership team will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.			
	Based on observation, interview, and record review, the facility failed to ensure safe hot water temperatures were maintained for 3 of 5 rooms observed during the Environmental Tour. (Rooms 108, 204, and 302) Finding includes:	R 0187	**R 187 410 IAC 16.2-5-1.6(k) Physical Plant Standards-Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/16/2024

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	During the Environmental Tour on 2/15/24 at 11:27 a.m., with the Environmental Services Director (ESD), the following was observed: - Room 108's kitchen hot water temperature was 121 degrees Fahrenheit (F). There was one resident who resided in this room. - Room 204's kitchen hot water temperature was 122 degrees F. There was one resident who resided in this room. - Room 302's kitchen hot water temperature was 121 degrees F. There was one resident who resided in this room. During interview after the water temperatures were taken, the ESD indicated he thought the water temperatures were supposed to be between 118-123 F. Every day, he would check a random room's water temperature and log the temperature. He had not had any complaints from any residents or staff that the hot water was too hot. Review of the February 2024 facility water temperature logs indicated: - 2/1/24; Room 601 was 121 F. - 2/5/24: Room 604 was 121 F. - 2/6/24: Room 605 was 122 F. - 2/7/24: Room 606 was 123 F. - 2/8/24: Room 607 was 122 F. - 2/12/24: Main Dining Room in facility was 123 F. During a follow up interview on 2/15/24 at 11:45 a.m., the ESD indicated he was unaware the hot water temperature range was supposed to be under 120 F. He was in the process of turning the hot water down to be below 120 F.		**practice:** The Environmental Services Director was immediately educated by an ISDH employee on proper water temperatures for residents' rooms on 2/14. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. The ESD corrected all water heaters to be under 120° immediately after his education. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** ESD/Designee will complete an audit three times per week on a random sample of resident rooms and common areas such as but not limited to the dining room sink, and public restrooms to ensure the water temperature is between 100°-120°. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: The Executive Director is responsible for continued compliance. The ESD/Designee will complete audits on temperature logs weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly for 1 month. The audit will be discussed at monthly leadership meetings. The leadership team will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the			

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	resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure resident service plans were reviewed and signed by the resident or resident's representative for 2 of 7 service plans reviewed. The facility also failed to ensure service plans were accurate and/or complete related to not addressing urinary catheters and home health services. (Residents 2 and 6) Findings include: 1. Resident 2's record was reviewed on 2/14/24 at 1:29 p.m. Diagnoses included, but were not limited to, high blood pressure, diabetes mellitus, and osteoarthritis. A Physician's Order, dated 2/10/24, indicated the resident had a 16 french, 10 cc balloon foley catheter. Home health was to take care of the foley catheter. There was no updated service plan completed for the foley catheter or home health services. The Individualized Service Plan, dated 10/17/23, was not signed by the resident and/or responsible party. During an interview on 2/15/24 at 11:40 a.m., the Director of Nursing indicated she was currently	R 0217	**R 217 410 IAC 16.2-5-2(e) (1-5) Evaluation- Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Individualized Service Plans (ISP's) for all affected residents were reviewed and signed by the family or resident and staff on 2/15/24 and 2/16/24. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Complete chart audit performed February 16, 2024 to verify that ISPs have been signed by all parties. Any ISP found to have missing signatures were flagged for the DON or ED to reach out and have a care conference and responsible party to sign the ISP.	03/25/2024

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	updating the service plan to reflect the catheter, but was waiting until the resident had returned from a doctor appointment to see if she was keeping the foley catheter. The resident or representative should have signed the service plan. 2. Resident 6's record was reviewed on 2/15/24 at 8:44 a.m. The Individualized Service Plan, dated 1/19/24, was not signed by the resident and/or responsible party. During an interview on 2/15/24 at 11:40 a.m., the Director of Nursing indicated the service plan should have been signed by the resident or representative.		**3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** DON and ED will review charts bi-weekly to ensure all ISP's are up to date and signed by all responsible parties per policy. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director is responsible for sustained compliance. The ED/Designee will complete audits by reviewing 3 charts weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly for 1 month. The audit will be discussed at monthly leadership meetings. The leadership team will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling			

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	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VIRGINIA PLACE ASSISTED LIVING	8253 VIRGINIA ST MERRILLVILLE, IN 46410

(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
	standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to store, serve, and prepare food under sanitary conditions, related to dirty food equipment, food crumbs and debris on clean surfaces, unlabeled food in the refrigerator, serving dishes and pots stored improperly, and improper hand hygiene during food preparation, for 1 of 1 kitchen areas observed (Main Kitchen). This had the potential to affect the 34 out of 34 total residents who received food from the kitchen. Findings include: 1. During the Initial Kitchen Sanitation Tour with the Dietary Food Manager (DFM) on 2/14/24 at 9:03 a.m., the following was observed: a. The stove top had an accumulation of grease and food build up. b. The inside of the ice machine was dirty. c. There were eight juice pitchers and a 12 quart container filled with unknown liquids with no label or date in the reach in cooler. d. An open personal beverage was stored in the reach in cooler. e. There were pots, plates, and bowls stored upright on the storage shelves. f. The plate warmer had crumbs and debris on top of it. g. There was food and debris on a tray on the clean storage shelving.	R 0273	**R 273 410 IAC 16.2-5-5.1 (f) Food and Nutritional Services- Deficiency** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Deep cleaning in all areas of the kitchen including but not limited to stove top, ice machine, plate warmer clean storage shelving, utensil storage containers, ventilation hood, and dishwasher has been completed as of February 27, 2024. All food has been labeled and ensured none of which is expired. The Dining Services Director (DSD) and all other dietary staff has been educated as of February 16, 2024, on proper donning/doffing PPE as well as hand hygiene. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. DSD/Designee shall follow deep clean schedule, as well as perform audits to ensure	02/27/2024

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	h. The storage container for the cooking utensils had debris and crumbs inside of it. i. There was a container of provolone cheese and another block of cheese opened in the reach in cooler with no label or date. j. A container of 1% low fat buttermilk was in the reach in cooler with an expiration date of 2/9/24. k. The ventilation hood had a build up of grease. l. The dishwasher had a build up of lime around the edges of the door. m. There was a box of cereal left open to air in the dry storage room. The DFM indicated at that time the kitchen was in need of a deep clean. 2. During an observation of the tray line on 2/14/24 at 12:03 p.m., the DFM was observed touching his hat and then donning clean gloves. He did not perform hand hygiene. He then grabbed a package of bread, opened the bag, reached in with the same gloved hands, and pulled out two slices of bread. With the same gloved hands, he served tuna salad onto one piece of bread and placed the other slice on top. He put the sandwich down, grabbed a knife, sliced the sandwich in half, and used the same gloved hands to place the sandwich on a plate to serve. The DFM grabbed a glass and filled it with ice with the ice scoop. He handed the glass to a staff member, took off his gloves, and donned a new pair of gloves without performing hand hygiene. The DFM indicated he should have performed hand hygiene in between glove use and needed to		all food is properly labeled and within expiration dates. DON/Designee shall also perform audits of proper food handling. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The DSD will provide ED with copies of completed deep cleaning log and fridge/freezer logs to ensure cleaning is being completed per schedule. DSD/ED will review and maintain these logs together monthly. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director is responsible for continued compliance. The DSD/Designee will complete audits by ensuring completion of cleaning tasks through visual inspection along with the cleaning logs completed by dining or environmental staff signing off on each assigned task. This will be done on a weekly basis for 4 weeks, then bi-weekly for 4 weeks, then monthly for 1 month. The audit will be discussed at monthly leadership meetings.	

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		A. BUILDING 00 B. WING	02/15/2024

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	change out his gloves after touching other items or surfaces other than food.		The leadership team will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff.			
	Based on observation, record review, and interview, the facility failed to ensure nursing staff administering medication followed the facility policy and manufacturer's instructions, regarding insulin injections from an insulin pen. (LPN 1, Resident 4) Finding includes: On 2/14/24 at 11:54 a.m., LPN 1 was observed preparing Resident 4's medications, which included Humalog (insulin) administered by insulin pen. The LPN indicated the resident's blood sugar read "HI". The Nurse Practitioner was notified and ordered the resident to have 20 units of insulin. The LPN turned the dial on the Humalog pen to 3 units and then turned it back to 0. She then proceeded to turn the dial to 20 units and administered the insulin into the resident's abdomen. During an interview with the LPN after administering the insulin, she indicated she thought she just had to turn the dial to 3 and then	R 0296	**R 296 410 IAC 16.2-5-6 (b) Pharmaceutical Services- Noncompliance** **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An in-service was completed on February 21, 2024 related to proper priming of insulin and general proper insulin pen handling, as well as where to find the guide that states how to use the different types of insulin pens. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents in need of insulin pens had the potential to be affected by this deficient practice.	02/21/2024

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		A. BUILDING 00 B. WING	02/15/2024

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VIRGINIA PLACE ASSISTED LIVING	8253 VIRGINIA ST MERRILLVILLE, IN 46410

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	back to 0 and then turn it to the ordered amount of insulin. She did not do an air shot, and thought just turning the dial was priming the insulin into the pen. Review of the facility "Insulin Pen Quick Reference Guide", indicated, "...Humalog KwikPen... Air Shot Before Each Use...2 units, hold dose knob for 5 secs [seconds] ...Dose button should be at "zero" after air shot and before dialing to dose..." During an interview on 2/14/24 at 12:20 p.m., the Director of Nursing indicated the nurses were to follow the Insulin Pen Quick Reference Guide that was located in the front of the Medication Administration Record. The LPN should have dialed the insulin pen to 2 units, completed an air shot, and then dialed the insulin up to the ordered amount before administering the insulin.		Inservice completed. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** Proficiency audits to be completed by DON/Designee on proper insulin pen handing. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Proficiency audits to be completed once per month for 3 months. As well as with all new hires that are required to handle insulin.	