STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155331	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Valparaiso	3405 N Campbell Rd Valparaiso, IN 46385

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents were assessed for self-administration of medications and had a physician's order to self-administer medications, for 1 of 1 resident reviewed for self-administration of medication. (Resident 55)Finding includes:On 12/30/25 at 10:45 a.m., Resident 55 was observed sitting in her wheelchair in her room. A plastic bag with the Facility's Pharmacy label was on her overbed table. The bag contained two bottles of nystatin powder (an antifungal medication). The resident indicated the powder was used for a rash under her right breast that she would get from time to time. Staff was responsible for storing and administering all of the resident's medications.The resident's record was reviewed on 1/2/26 at 10:47 a.m. Diagnoses included, but were not limited to, type two diabetes mellitus, hypertension, and hyperlipidemia.The admission Minimum Data Set (MDS) assessment, dated 12/1/25, indicated the resident was cognitively intact.A Physician's Order, dated 11/29/25, indicated nystatin powder, apply to groin and folds topically every day and evening shift. There was no Physician's Order to indicate the resident could self-administer the medication.There was a lack of any self-administration of medication assessments.During an interview on 1/5/26 at 10:36 a.m., the Director of Nursing (DON) was made aware of the medications at the resident's bedside. No further information was provided.A facility policy, titled, Self-Administration of Medications, indicated, .2. Facility, in conjunction with the interdisciplinary care team, should assess and determine, with respect to each resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition.5. Facility should ensure that orders for self-administration list the specific medications the resident may self-administer.3.1-11(a)

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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review and interview, the facility failed to ensure oral suctioning was completed and documented as ordered for 1 of 4 residents reviewed for respiratory care (Resident 4), medications were administered as ordered for 1 of 4 residents reviewed for accidents (Resident 1), wound assessments were completed and skin discolorations were monitored for 2 of 6 residents reviewed for non-pressure skin conditions. (Residents 24 and 67)Findings include:1.On 12/29/25 at 9:22 a.m., Resident 4 was observed in his bed. There was an oral suction machine on the nightstand next to his bed and the suction catheter was resting on his bed. The resident indicated he wanted the suction machine turned on. The Infection Control Nurse entered the room and turned the machine on for him; she indicated the resident suctioned himself. The resident picked up the suction catheter and put it in his mouth. The suction machine was observed to be on in the resident's room with no staff present on 12/30/25 at 8:30 a.m. and 1:00 p.m., and 12/31/25 at 8:23 a.m., 10:25 a.m. 1:13 p.m. and 2:33 p.m. The resident's record was reviewed on 12/31/25 at 8:45 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, dysphagia (difficulty swallowing) and congestive heart failure. The Quarterly Minimum Data Set assessment, dated 11/20/25, indicated the resident was cognitively intact and was dependent for toileting and transfers. A Physician's Order, dated 6/12/25, indicated may suction resident orally every four hours prn (as needed) for increased secretions. Resident may suction himself. The November and December 2025 Treatment Administration Record did not have any prn oral suctioning documented by staff or resident self-suctioning. During an interview on 12/31/25 at 3:10 p.m., the Director of Nursing indicated the resident needed to be assessed for self-suctioning. She was made aware there was nothing documented in the treatment record related to suctioning as needed. No additional information was provided. 2. Resident 1's record was reviewed on 12/31/25 at 10:11 a.m. Diagnoses included, but were not limited to, hypertension. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 11/19/25, indicated the resident was severely cognitively impaired. A Physician's Order, dated 2/14/25, indicated clonidine HCl oral tablet 0.1 milligram (mg), 1 tablet by mouth two times a day, hold if systolic blood pressure (first number) is below 110. The November and December 2025 Medication Administration Record indicated the resident's clonidine was not administered and there was no documented blood pressure on the following dates and times: at 8:00 p.m. on 11/15/25, 11/18/25, 11/19/25, 12/9/25, 12/15/25, 12/16/25, and 12/22/25. The November and December 2025 Medication Administration Record indicated the resident's clonidine was administered outside of the physician-ordered parameters on the following dates and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/3/25 at 8:00 p.m., blood pressure 100/50 11/22/25 at 8:00 a.m., blood pressure 108/63 11/22/25 at 8:00 p.m., blood pressure 109/66 12/7/25 at 8:00 p.m., blood pressure 105/66 12/29/25 at 8:00 p.m., blood pressure 100/65 During an interview on 1/5/26 at 11:24 a.m., the Director of Nursing indicated she had no further information to provide. 3. Resident 24 was observed during wound care on 1/6/26 at 9:44 a.m. with the Director of Nursing (DON). The resident had two round-shaped open wounds that had a pink-red color wound bed observed to the right shin. Resident 24's record was reviewed on 1/2/26 at 8:32 a.m. Diagnoses included, but were not limited to, hypertension and stage 3 pressure ulcer of the left heel. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 10/6/25, indicated the resident was cognitively intact. She required substantial assistance from staff for toileting hygiene and showering, and moderate assistance with bed mobility, and was dependent for transfers. A Care Plan, dated 9/17/25, indicated the resident had a pressure ulcer to the left lateral heel and a right lower leg skin tear and was at risk for poor healing. Interventions included, but were not limited to, administer treatments as ordered, and assess for pain and administer medications as ordered. A Physician's Order, dated 9/17/25, indicated wound care to the right shin every day shift, cleanse area with wound wash, apply Hydrogel (a wound gel), and cover with a dry dressing daily and as needed for soiled or dislodged dressings. A Progress Note, dated 9/17/25 at 10:41 a.m., indicated the resident had open areas to the distal lower right shin measuring 2.5 centimeters (cm) long by 3.8 cm wide by 0.1 cm deep. The wound bed had exposed dermis with tissue that was pink. There was a scant amount of serosanguinous drainage (mix of clear/serous drainage and bloody drainage). The surrounding skin was pink with normal skin tone. The proximal wound measured 1.0 cm long by 1.5 cm wide by 0.1 cm deep with a pink/red wound bed that had a scant amount of serosanguinous drainage. The resident denied pain and stated that it was an old wound that had opened. She stated that it rubs on the lift when they transfer me. The resident used a princess lift (mechanical lift) for transfers. A treatment was put in place and the physician, family, and therapy were aware. The Weekly Skin Integrity Data Collection assessments, dated 10/7/25 at 12:21 a.m. and 10/14/25 at 12:16 a.m., both indicated the resident had a skin tear to the right lower leg. The Weekly Skin Integrity Data Collection assessments, dated 10/21/25 at 12:37 a.m., 10/27/25 at 1:51 a.m., 11/4/25 at 1:37 a.m., and 11/11/25 at 12:54 a.m., indicated the resident had open areas to the right and left heel. There was no documentation of the area to the right shin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Weekly Skin Integrity Data Collection assessments, dated 11/18/25 at 12:22 a.m., 11/25/25 at 12:13 a.m., 12/2/25 a 12:25 a.m., 12/9/25 at 12:18 a.m., 12/16/25 at 12:12 a.m., 12/23/25 at 12:10 a.m., 12/30/25 at 12:24 a.m., and 1/6/26 at 2:19 a.m., indicated the resident had open areas to the right shin and left heel. There were no updated measurements available in the resident's record. During an interview on 1/6/26 at 11:54 a.m., the Director of Nursing indicated in the past, the resident had edema and open blisters in that area. They had healed at one time and now were reopened again. There were no updated measurements, and the physician would not usually address those kinds of skin conditions unless there was a major change or there were no improvements occurring with the wound. There should have been assessments completed with measurements to determine if the wound had any improvement. 4. Resident 67 was observed on 12/29/25 at 1:35 p.m. She was sitting in bed in her room. Her left hand had scattered discolorations around the thumb up to the wrist and on the forearm that were purplish blue in color. There was also a bandage in place. On 1/3/26 at 10:41 a.m., Resident 67 was observed sitting in her wheelchair. Her left hand and forearm remained with the scattered discolorations. There was no bandage in place at the time. Resident 67's record was reviewed on 1/2/26 at 10:43 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure and chronic obstructive pulmonary disease. A Care Plan, dated 12/3/25, indicated the resident was at risk for alterations in skin integrity due to generalized weakness. Interventions included, but were not limited to, weekly skin checks. A Weekly Skin Integrity Data Collection assessment, dated 12/31/25 at 1:48 p.m., indicated the resident had no skin integrity concerns identified. During an interview on 1/5/26 at 11:24 a.m., the Director of Nursing indicated the bandage was from a blood draw on 12/29/25. She had no further information to provide. A facility policy titled, Skin Integrity & Pressure Ulcer/Injury Prevention, indicated, .3. A skin assessment/inspection should be performed weekly by a nurse. A. Skin observations also occur throughout points of care provided by CNAs during ADL care. Any changes or open areas are reported to the Nurse.Nurse will complete further inspection/assessment and provide treatment if needed. 3.1-37(a)

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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. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to following physician's orders for oxygen administration for 1 of 4 residents reviewed for respiratory care. (Resident 67) Finding includes:Resident 67 was observed on 12/29/25 at 1:35 p.m. She was sitting in bed in her room with a nasal cannula connected to a concentrator running at 6 liters per minute. The humidifier container was empty at the time. On 1/2/26 at 10:41 a.m., Resident 67 was sitting in her wheelchair. She had a nasal cannula that was only placed in one nostril. It was connected to a portable concentrator running at 5 liters per minute. Resident 67's record was reviewed on 1/2/26 at 10:43 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure and chronic obstructive pulmonary disease. A Physician's Order, dated 7/15/25, indicated oxygen at 5 liters per minute continuously per nasal cannula every shift and change oxygen tubing, nebulizer circuit and humidifier bottle every night shift every Sunday and as needed. A Care Plan, dated 7/17/25, indicated the resident had oxygen therapy. Interventions included, but were not limited to, give medications and oxygen per the physician's orders. During an interview on 1/5/26 at 10:41 a.m., the Director of Nursing was notified of the concern and had no further information to provide. A facility policy titled, Oxygen Administration, indicated, .2. Residents receiving oxygen at 4 L/min or greater, via concentrator, should be connected to a humidifier.Infection Control.2. Humidifier bottles should be dated and replaced every 7 days regardless of H2O level.b. If reusable humidifier is used, refill using sterile water only. i. Sterile water is to be emptied and replaced daily. 3.1-47(a)(6)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure medications were given with adequate indication for use related to lack of non-pharmacological interventions prior to giving pain medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 93)Finding includes:Resident 93's record was reviewed on 12/30/25 at 1:08 p.m. Diagnoses included, but were not limited to, displaced fracture of right femur neck, history of falling and dementia. The Quarterly Minimum Data Set assessment, dated 12/5/25, indicated the resident had moderate cognitive impairment and used opioid pain medications. A Physician's Order, dated 6/29/25, indicated to give hydrocodone 5 milligrams (mgs)/ acetaminophen 325 mgs (an opioid pain medication) every 6 hours as needed for pain. A Physician's Order, dated 10/17/25, indicated to document two non-medication interventions prior to giving as needed pain medication. Interventions included heat, music, cold, gentle range of motion, positioning, TENS, massage, support group, meditation or other rest. The November 2025 Medication Administration Record (MAR) indicated the resident was given hydrocodone/acetaminophen 21 times, the December 2025 MAR indicated he was given the medication nine times. There was only one day that non-medication interventions were documented prior to giving the medication in November and December. During an interview on 1/5/26 at 10:31 a.m., the Director of Nursing (DON) indicated non-pharmacological interventions should be documented and there were none documented in December, she had not looked at November's MAR. The Pain Management Policy, revised 9/23/25, was received from the DON on 1/5/26 indicated, .2. The facility will address/treat the underlying causes of the pain, to the extent possible, a. Developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management, depending on factors such as whether pain is episodic, continuous or both 3.1-48(a)(6)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff not wearing personal protective equipment (PPE) correctly when entering an isolation room for 2 of 2 residents reviewed for COVID-19. (Residents 88 and 55) The facility also failed to ensure infection control practices and standards were maintained related to medication administration for 1 of 7 residents observed during the medication administration observation. (Resident 53)Findings include:1. On 12/30/25 at 10:45 a.m. RN 1 was observed in room [ROOM NUMBER] providing care to Resident 88. She was wearing a gown, gloves, and N95 mask. She was not wearing any eye protection. There were signs on the door that indicated the residents in room [ROOM NUMBER] were in droplet/contact isolation.Record review for Resident 88, who resided in room [ROOM NUMBER], was completed on 1/2/26 at 10:15 a.m. Resident 88 had been sent out to the hospital on [DATE], she tested positive for COVID-19 at the hospital and returned to the facility the same day.Record review for Resident 55, who resided in room [ROOM NUMBER], was completed on 1/2/26 at 10:15 a.m. The resident tested positive for COVID-19 at the facility on 12/26/25.During an interview on 12/30/26 at 4:26 p.m., the Infection Preventionist was made aware RN 1 had not worn eye protection in the contact/droplet isolation room. She indicated eye protection should have been used, and she would provide further education.A facility policy, titled, Personal Protective Equipment PPE for SARS-CoV-2, indicated, .HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH approved N95 or equivalent or higher level respirator, gown, gloves, and eye protection. 2. The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: a. Respirator .b. eye protection .c. gloves .d. gowns .2. During a medication administration observation on 1/2/26 at 9:31 a.m., LPN 1 was observed preparing Resident 53's medications which included Tums (an antacid medication) and atenolol (a blood pressure medication). She poured two Tums tablets out of the medication bottle into her hand and then placed them in a medication cup. She popped the atenolol tablet out of the pill card, and it landed on top of the medication cart. She picked up the medication with her bare hands and placed it in the medication cup. She then took the medications into the resident's room to administer.During an interview on 1/2/26 at 1:48 p.m., the Director of Nursing (DON) was made aware of LPN 1 touching the medications with her bare hands. No further information was provided.3.1-18(b)