	R MEDICARE & MEDI		-			AB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		/	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155448	A. BUILDING B. WING	00		leted)/2023
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD CHIGAN ST		
LOWELL	HEALTHCARE			LL, IN 46356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
F 0000						
Bldg. 00						
		Recertification and State	F 0000	Please accept the followi	-	
	Licensure Survey.			the facility's credible alle of compliance. This plan	•	
	Survey dates: Febr	uary 6, 7, 8, 9, and 10, 2023.		correction does not cons an admission of guilt or l	stitute	
	Facility number: 0	0361		by the facility and is sub	-	
	Provider number:	155448		only in response to the		
	AIM number: 1002	266340		regulatory requirement.	Ne	
	Census Bed Type:			respectfully request consideration for paper		
	SNF/NF: 78			compliance.		
	Total: 78					
	Census Payor Typ	۰ د				
	Medicare: 4					
	Medicaid: 60					
	Other: 14					
	Total: 78					
	These deficiencies accordance with 4	reflect State Findings cited in 10 IAC 16.2-3.1.				
	Quality review cor	npleted on 2/14/23.				
F 0638	483.20(c)					
SS=A		t at Least Every 3 Months				
Bldg. 00	•	erly Review Assessment				
U U	,	sess a resident using the				
	quarterly review i	nstrument specified by the				
	State and approv	ed by CMS not less				
		nce every 3 months.				
		view and interview, the facility	F 0638	What corrective action(s)		02/28/2023
		Quarterly Minimum Data Set		be accomplished for the		
		sive assessment was submitted MDS assessments reviewed.		residents found to have I	been	
	(Resident 67)	will's assessments reviewed.		affected by the deficient practice:		
				· Resident 67 MDS		

Emily Bailey	Executive Director	03/03/2023

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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/10/2023	
	PROVIDER OR SUPPLIE	ËR	710 MI	ADDRESS, CITY, STATE, ZIP COD CHIGAN ST LL, IN 46356		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C Finding includes: Resident 67's reco 1:05 p.m. Diagnos to, cerebral vascul The Quarterly MD was incomplete an previous MDS ass 11/4/22. Telephone intervie Assessment Instru	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION and was reviewed on 2/8/23 at these included, but were not limited ar accident and aphasia. OS assessment, dated 1/25/23, and had not been submitted. The essment was completed on ew with the RAI (Resident ment) Specialist on 2/9/23 at and they were behind schedule t was late.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Assessment has been complet and submitted. How other residents having for potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: • All residents requiring a MDS Assessment have the potential to be affected by this finding. All current residents he been reviewed to ensure completion of a Quarterly MDS Assessment in the past 3 mon What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: • RAI Support Specialist	DATE	
			in-service MDSC and other relevant MDS staff on timeline MDS scheduling and completi on or before 02/28/2023. MDS will ensure that all assessmen are completed timely per CMS regulations. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place: • Ongoing compliance wit this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). MDSC or designee will complete the QA	ut		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155448	B. WING		02/10/	2023
NAME OF I	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP COD		
	. HEALTHCARE			ICHIGAN ST LL, IN 46356		
LOWELL				LL, IN 40300		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		anal	DATE
				tool labeled MDS Scheduling Timeliness weekly for 4 week		
				and then monthly for 6 month		
				threshold of 95% is not met, a		
				action plan will be developed.		
				Findings will be submitted to		
				QAPI Committee for review a		
				follow up.		
0641 SS=A	483.20(g) Accuracy of Asse	assments				
Bldg. 00		racy of Assessments.				
Jidg. 00	• (•)	must accurately reflect the				
	resident's status.	must accurately reliect the				
		view and interview, the facility	F 0641	What corrective action(s) wi		02/28/2023
		e Minimum Data Set (MDS)	1 0041	be accomplished for those		02/28/202.
		essment was accurately		residents found to have bee	n	
	-	to hypnotic medication use and		affected by the deficient		
	-	injury for 2 of 18 MDS		practice:		
	-	ved. (Residents 56 and 72)		· Resident 56 MDS		
		(110)1001000000000000000000000000000000		Assessment has been modifie	be	
	Findings include:			and resubmitted.	54	
	1 mangs meraat			· Resident 72 MDS		
	1. Resident 56's re	cord was reviewed on 2/9/23 at		Assessment has been modifie	ed	
	9:24 a.m. Diagnos	es included, but were not limited		and resubmitted.		
	to, cerebral infarct			How other residents having	the	
	, ,			potential to be affected by the		
	The Quarterly MD	S assessment, dated 11/23/22,		same deficient practice will		
	section N Medicat	ions, indicated the resident had		identified and what corrective	/e	
		in the past seven days, and		action(s) will be taken:		
		ety medications in the past		All residents requiring a	an	
	seven days.	_		MDS Assessment have the		
				potential to be affected by this	6	
	The current Physic	ian Order Summary (POS)		finding. All MDS Assessment	s	
	indicated the reside	ent took eszopiclone (a		within the last 30 days were		
	sedative/hypnotic	medication) 3 milligrams at		audited to ensure the residen	ts	
		nia. There were no anti-anxiety		assessment was coded		
	medications in the	current or previous months		accurately for antianxiety and		
	POS.			sedative/hypnotic medication	as	
			1	well as any resident with rece		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COM	PLETED
		155448	B. WIN	IG		02/1	0/2023
	PROVIDER OR SUPPLIE	P	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
		ĸ			CHIGAN ST		
LOWELI	L HEALTHCARE			LOWEL	L, IN 46356		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		cord was reviewed on 2/7/23 at			falls. Any inaccurate coding		
		es included, but were not limited			identified will be modified a		
	to, Diabetes Mellit	us and epilepsy.			resubmitted to ensure accu	-	
					What measures will be pu	t into	
	-	lated 9/16/22, indicated the			place or what systemic		
		in the shower and was			changes will be made to		
		in to her right ankle. The Nurse			ensure that the deficient		
		otified and ordered a portable			practice does not recur:		
	X-ray.				RAI Support Special		
	T1 X 1				in-service MDSC and other		
	-	on 9/16/22, indicated an acute			relevant MDS staff on accu	racy of	
	-	n metatarsal neck fracture			assessments on or before		
	(fractured small to	e).			02/28/2023. MDSC will ens		
	The Questerly MD	S, dated 10/11/22, section J			that coding of medications falls are completed accurat		
		, indicated the resident had one			before completing and sub	•	
		injury since the last assessment.			the MDS Assessment.	mung	
	-	o falls with a major injury			How the corrective action	(c)	
	(fractures) since th			will be monitored to ensu	. ,		
	(nucluies) since un	e lust ussessment.			deficient practice will not	ethe	
	Telephone intervie	w with RAI (Resident			recur, i.e., what quality		
		ment) Specialist on $2/9/23$ at			assurance program will be	- nut	
		d the eszopiclone had been			into place:	, put	
	-	as an anti-anxiety medication for			· Ongoing compliance	with	
	-	e fall should have been coded			this corrective action will be		
	as major injury du	e to a fracture for Resident 72.			monitored through the facil		
					Quality Assurance and	-	
	3.1-31(i)				Performance Improvement		
					Program (QAPI). MDSC or		
					designee will complete the	QA	
					tool labeled MDS Coding a	nd	
					Accuracy weekly for 4 wee	ks and	
					then monthly for 6 months.	lf	
					threshold of 95% is not me	t, an	
					action plan will be develope		
					Findings will be submitted t		
					QAPI Committee for review	and	
					follow up.		
							1

0VQM11 Facility ID: 000361

0361 If contin

If continuation sheet F

Page 4 of 16

PRINTED: 03/17/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155448	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G <u>00</u>	(X3) DATE SURVEY COMPLETED 02/10/2023
	PROVIDER OR SUPPLIEF	2	710	et address, city, state, zip cod MICHIGAN ST VELL, IN 46356	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
0677	483.24(a)(2)				
SS=D	ADL Care Provide	ed for Dependent Residents			
Bldg. 00	§483.24(a)(2) A re	esident who is unable to			
	carry out activities	s of daily living receives the			
	necessary service	es to maintain good			
	nutrition, groomin	g, and personal and oral			
	hygiene;				
		on, record review, and	F 0677	What corrective action(s) wil	02/28/2023
		ty failed to ensure ADL		be accomplished for those	
		living) care was provided		residents found to have been	n
		ing a dependent resident with		affected by the deficient	
	e e	esidents reviewed for ADL		practice;	
	care. (Resident 56)			 Resident 56 was shave 	n
				per preference on the date of	
	Finding includes:			observation (2/8/2023).	
				How other residents having	the
	On 2/7/23 at 11:22	a.m. and 2/8/23 at 8:51 a.m.,		potential to be affected by th	e
	Resident 56 was ob	served in his bed, he was		same deficient practice will b	be
	unshaven. On 2/9/2	23 at 1:20 p.m., the resident was		identified and what correctiv	e
	in bed and unshave	n. At that time, he indicated he		action(s) will be taken;	
	preferred to be clea	n shaved.		 All residents have the 	
				potential to be affected by the	
		rd was reviewed on 2/9/23 at		alleged deficient practice.	
	e	es included, but were not limited		DNS/Designee conducted an	audit
	to, cerebral infarction	on and dementia.		to ensure all residents are	
				appropriately groomed per	
		imum Data Set assessment,		preferences. No concerns not	ed
		icated he had moderate		from audit.	
		ent and required extensive		What measures will be put in	nto
	assistance of one fo	or personal hygiene.		place and what systemic	
				changes will be made to	
		ndicated the resident received		ensure that the deficient	
		kly on Wednesday and		practice does not recur;	
		sheets for the past 30 days		• DNS or Designee will	
		nt had only been shaved on		in-service all staff on providing	
	1/10/23 and 1/25/2.	3. There were no refusals noted.		care per preference as well as	\$
				accurately documenting	
		A 3 on 2/9/23 at 11:45 a.m.,		completion or refusal.	
		ld give him a shower twice		How the corrective action(s)	
	weekly and he need	led assistance with shaving.		will be monitored to ensure t	the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0VQM11 Facility ID: 000361

If continuation sheet Page 5 of 16

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155448	<u> </u>	ILTIPLE CONSTRUCTION ILDING <u>00</u> NG	СОМ	ate survey DMPLETED 2/10/2023	
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, Z 710 MICHIGAN ST LOWELL, IN 46356	IP COD		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION then the resident had been	I	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO T TAG DEFICIENCY deficient practice v	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	shaved last. 3.1-38(a)(3)			recur, i.e., what qua assurance program into place; and by the systemic chang deficiency will be of Ongoing com this corrective action monitored through the QAPI tool for five (5 residents. The DNS be responsible for co QAPI Audit tool for the residents weekly for monthly for 6 monthe quarterly thereafter quarters. If threshold met, an action plan developed. Findings submitted to the QA for review and follow	ality n will be put what date ges for each completed; apliance with n will be the facility b) random S/designee will completing the five (5) random r 4 weeks, as and for at least 2 d of 90% is not will be s will be s will be s will be		
F 0684 SS=D Bldg. 00	applies to all treat facility residents. comprehensive a facility must ensu- treatment and ca professional stan comprehensive p and the residents Based on observat interview, the facili (elastic compression	a fundamental principle that tment and care provided to Based on the ssessment of a resident, the re that residents receive re in accordance with dards of practice, the erson-centered care plan,	F 06	be accomplished for residents found to affected by the def practice;	or those have been	02/28/202	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/10/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD		
LOWELI	_ HEALTHCARE			/ICHIGAN ST ELL, IN 46356		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Finding includes:			Grip (elastic compression		
				bandages) were reviewed with	NP	
	On 2/7/23 at 9:55	a.m., Resident 225 was observed		on her next visit on 02/11/2023		
	seated in her whee	elchair in her room. She had		New order to d/c it due to		
	white crew socks	and shoes in place to both feet.		residents refusal to wear them.		
	Her ankles appear	ed to be slightly swollen.		How other residents having the	ne	
				potential to be affected by the		
	On 2/8/23 at 2:18	p.m., Resident 225 was observed		same deficient practice will be	e	
	seated in her whee	clchair in the first floor lounge		identified and what corrective)	
	area watching tele	vision. She had white crew		action(s) will be taken;		
	socks and shoes in	place to both feet. Her ankles		All residents have the		
	appeared to be slig	shtly swollen.		potential to be affected by the		
				alleged deficient practice.		
	On 2/9/23 at 2:05	p.m., Resident 225 was observed		DNS/Designee will conduct an		
		clohair in the first floor lounge		audit to identify anyone who ma	av	
		te crew socks and shoes in place		wear preventative/adaptive dev	-	
		then escorted resident out of		to ensure they are in place or		
	the lounge area to			documented accurately for refu	Isal	
				No further concerns from audit.		
	The resident's reco	ord was reviewed on $2/10/23$ at		What measures will be put int		
		oses included, but were not		place and what systemic	•	
	-	ension, dementia, and pulmonary		changes will be made to		
	hypertension.	nision, demonta, and pullionary		ensure that the deficient		
	nypertension.			practice does not recur;		
	The Admission M	inimum Data Set (MDS)		· DNS or Designee will		
		11/28/22, indicated the resident		in-service all nursing staff		
		npaired. She required extensive		regarding applying		
	· ·	nce for bed mobility and		adaptive/preventative devices p	ber	
	-	son assistance for transfers.		order and accurately document		
	extensive two pers	son assistance for transfers.		refusals.	ing	
	A Physician's Ord	er, dated 1/25/23, indicated tubi		How the corrective action(s)		
		ower extremities for edema, may		will be monitored to ensure th		
	e .	e and to be removed before bed.				
	Temove for hygien			deficient practice will not		
	The Treatment A	ministration Bosond (TAB)		recur, i.e., what quality		
		lministration Record (TAR),		assurance program will be pu	i L	
		cated the tubi grips were signed		into place; and by what date	ь	
	-	the day shift (7 a.m. through 3 $\frac{1}{2}$		the systemic changes for each		
	p.m.) on 2/7/23, 2	(8/23, and 2/9/23.		deficiency will be completed;		
	T, · · · · · · · ·			• Ongoing compliance with	ו ו	
	Interview with the	Director of Nursing (DON) on		this corrective action will be		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	A. I	MULTIPLE CO BUILDING WING	DNSTRUCTION 00	COMI	e survey pleted D/2023
	PROVIDER OR SUPPLIE	R		710 MI	address, city, state, zip coi CHIGAN ST .L, IN 46356)	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O 2/9/23 at 2:30 p.m. wearing regular so in place. She was	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION , indicated the resident was cks and the tubi grips were not going to ask the Nurse		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY) monitored through the fa QAPI tool for five (5) rand residents. The DNS/des	ild BE ROPRIATE cility dom ignee will	(X5) COMPLETION DATE
	Practitioner if they the resident's edem 3.1-37(a)	could discontinue them since a had decreased.			be responsible for compl QAPI Audit tool for five (residents weekly for 4 we monthly for 6 months and quarterly thereafter for at quarters. If threshold of 9 met, an action plan will b developed. Findings will submitted to the QAPI Co for review and follow up.	5) random beeks, d least 2 00% is not e be	
- 0690 SS=D Bldg. 00	§483.25(e) Incon §483.25(e)(1) Th resident who is co bowel on admissi assistance to ma or her clinical cor that continence is §483.25(e)(2)For incontinence, bas comprehensive a ensure that- (i) A resident who an indwelling cath unless the reside demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed to as soon as possil clinical condition catheterization is	e facility must ensure that ontinent of bladder and on receives services and intain continence unless his idition is or becomes such a not possible to maintain. a resident with urinary sed on the resident's ssessment, the facility must o enters the facility without neter is not catheterized nt's clinical condition it catheterization was o enters the facility with an er or subsequently receives for removal of the catheter ole unless the resident's demonstrates that					

03/17/2023 PRINTED: FORM APPROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/10/2023 155448 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and F 0690 02/28/2023 What corrective action(s) will interview, the facility failed to ensure a resident be accomplished for those with a urinary catheter, who was awaiting results residents found to have been of a urine Culture and Sensitivity (C&S) for a affected by the deficient possible Urinary Tract Infection (UTI), received practice: the proper care and services related to improper Resident 14's foley was catheter positioning for 1 of 2 residents reviewed changed as well as adaptive for catheters. (Resident 14) straps to help with placement to keep off the ground. Dignity bag Finding includes: also adjusted to ensure bag remains covered. On 2/7/23 at 12:54 p.m., Resident 14 was observed How other residents having the sitting in a wheelchair in her room. The resident's potential to be affected by the catheter bag was hanging from underneath the same deficient practice will be wheelchair, out of the dignity bag and resting identified and what corrective directly on the floor. action(s) will be taken: All residents have the On 2/8/23 at 9:13 a.m., Resident 14 was observed potential to be affected by the sitting in a wheelchair in her room. The resident's alleged deficient practice. A house catheter bag was hanging from underneath the audit was completed for anyone wheelchair. The bag was touching up against the who has a foley catheter to ensure legs of the wheelchair and the inner tire. The dignity bags were in place and not dignity bag was on the floor underneath the touching the ground. No concerns wheelchair. were identified by the audit. What measures will be put into Record review for Resident 14 was completed on place and what systemic 2/8/23 at 9:06 a.m. Diagnoses included, but were changes will be made to not limited to, neurogenic bladder, and dementia. ensure that the deficient practice does not recur; 0VQM11 Facility ID: 000361 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

Event ID:

Page 9 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDI- NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 02/10/2023
	PROVIDER OR SUPPLIE	ËR	710 MI	address, city, state, zip cod CHIGAN ST LL, IN 46356	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
0692 SS=D 3ldg. 00	The Significant Cl assessment, dated was cognitively in extensive 1 person indwelling Foley of A Care Plan, dated indicated the resid supra-pubic urinar neuromuscular dys Interventions inclu part of the drainag to store the collect dignity pouch. A Progress Note, of indicated urine was collection bag to b The urine was darl sediment were not A Progress Note, of indicated the urine the laboratory at th Interview with LP indicated the resid The results were re received the C&S bag should always floor or touching a being uncovered. 3.1-41(a)(2) 483.25(g)(1)-(3) Nutrition/Hydratio §483.25(g) Assis (Includes naso-g	d 10/21/22 and revised 1/4/23, tent required an indwelling y catheter due to: sfunction of the bladder. uded to not allow tubing or any te system to touch the floor and cion bag inside a protective dated 2/5/23 at 2:15 p.m., ts collected from the catheter be picked up by the laboratory. k amber, slight foul odor and ted. dated 2/10/23 at 6:27 a.m., the C&S test remained pending at	TAG	 DEFICIENCY) DNS or Designee will in-service all nursing staff on importance of providing dignit coverings for those with a catheter. Also, that it should n touch the ground. Facility also ordered new catheter bags th come with an attached dignity cover. How the corrective action(s) will be monitored to ensure a deficient practice will not recur, i.e., what quality assurance program will be p into place; and by what date the systemic changes for ea deficiency will be completed Ongoing compliance wit this corrective action will be monitored through the facility QAPI tool for five (5) random residents. The DNS/designee be responsible for completing QAPI Audit tool weekly for 4 weeks, monthly for 6 months quarterly thereafter for at leas quarters. If threshold of 90% i met, an action plan will be submitted to the QAPI Comm for review and follow up. 	ever at the ut ch l; th s will the and t 2 s not

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0VQM11 Facility ID: 000361

If continuation sheet Page 10 of 16

PRINTED: 03/17/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/10/2023 155448 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 710 MICHIGAN ST LOWELL HEALTHCARE LOWELL. IN 46356 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and F 0692 02/28/2023 What corrective action(s) will interview, the facility failed to ensure food be accomplished for those consumption logs were completed for residents residents found to have been with a history of weight loss for 2 of 3 residents affected by the deficient reviewed for nutrition. (Residents 18 and 36) practice; Resident 18 and 36 was Findings include: reviewed in Nutrition At Risk (NAR) meeting by IDT team and 1. The record for Resident 18 was reviewed on RD. Resident 18 is on hospice 2/9/23 at 10:34 a.m. Diagnoses included, but were and resident 36 is on palliative not limited to, hypertension, dementia, and care. IDT and RD did not have any cerebral infarction. The resident was hospitalized further recommendations for on 1/16/23 and returned to the facility on 1/20/23. supplements and both residents' weights have since stabilized. The Significant Change Minimum Data Set (MDS) How other residents having the assessment, dated 1/7/23, indicated the resident potential to be affected by the was cognitively impaired and required an same deficient practice will be extensive assistance of one with eating. identified and what corrective action(s) will be taken: The resident weighed 230 pounds on 1/4/23 and All residents have the 209 pounds on 2/6/23. potential to be affected by the 0VQM11 Facility ID: 000361

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

If continuation sheet

Page 11 of 16

03/17/2023

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD ICHIGAN ST		
LOWELI	- HEALTHCARE			LL, IN 46356		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION	TE	COMPLETI
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				alleged deficient practice. An a		
	-	dated 2/8/23, indicated the		was completed on all residents		
	10.7% weight loss	% weight loss in 90 days and a		being reviewed by NAR team t		
	10.7% weight loss	s in 180 days.		significant weight loss to ensur		
	The Meal Consum	ption Log for February 2023		charting was completed to ens proper intake. No concerns no		
				for those residents.		
	lacked documentation of the following meals: - Breakfast on 2/1/23, 2/6/23, and 2/8/23			What measures will be put in	to	
		, 2/6/23, and 2/8/23		place and what systemic		
				changes will be made to		
	The Meal Consumption Log for January 2023 lacked documentation of the following meals:			ensure that the deficient		
				practice does not recur;		
	- Breakfast on 1/2	0/23		· DNS or Designee will		
	- Lunch on 1/3/23	, 1/6/23, 1/8/23, 1/13/23, 1/15/23,		in-service all nursing on		
	1/20/23, and 1/30/			importance of documentation f	for	
	- Dinner on 1/2/23	6, 1/4/23, 1/5/23, and 1/6/23		food and fluids to accurately to		
				ensure of any significant weigh		
		Director of Nursing (DON) on		loss. Facility also implemented		
		n., indicated the food		back up paper charting in case	eof	
		were incomplete and they had le with their electronic charting		power outage or technical		
	Ũ	She was unable to provide any		difficulties.		
	further documenta			How the corrective action(s) will be monitored to ensure t	ha	
				deficient practice will not		
	2. The record for	Resident 36 was reviewed on		recur, i.e., what quality		
		. Diagnoses included, but were		assurance program will be p	ut	
		nentia, hypertension, and adult		into place; and by what date		
	failure to thrive.			the systemic changes for eac	ch	
				deficiency will be completed;		
	e	hange Minimum Data Set (MDS)		Ongoing compliance wit	th	
		1/11/23, indicated the resident		this corrective action will be		
	was cognitively in	npaired and had weight loss.		monitored through the facility		
				QAPI tool for five (5) random		
	-	hed 130 pounds on 8/6/22 and		residents who are currently be	-	
	117 pounds on 2/6	0/23.		monitored for significant weigh		
				loss. The DNS/designee will b		
	-	dated 2/8/23, indicated the		responsible for completing the		
	resident had a 10%	6 weight loss in 180 days.		QAPI Audit tool weekly for 4		
	The Meel Comment	untion Log for Echnology 2022		weeks, monthly for 6 months a		
	The Meal Consum	ption Log for February 2023	1	quarterly thereafter for at least	. ∠	

NTERS FO	R MEDICARE & MEDIC	AID SERVICES				0	MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00	_	PLETED
		155448	В.	WING		02/1	0/2023
NAME OF	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP	COD	
					CHIGAN ST		
LOWELL	- HEALTHCARE			LOWE	LL, IN 46356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETIO
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on of the following meals:			quarters. If threshold		
	- Breakfast on 2/4/2				met, an action plan wi		
	- Lunch on 2/7/23,	and 2/4/23			developed. Findings v		
	- Dinner on 2/6/23				submitted to the QAP		
					for review and follow u	up.	
	The Meal Consumption Log for January 2023						
	lacked documentation of the following meals:						
	- Lunch on 1/6/23, 1/7/23, 1/27/23, and 1/31/23 - Dinner on 1/3/23, 1/4/23, 1/15/23, 1/16/23, 1/21/23,						
	1/27/23, 1/28/23, an	lid 1/29/23					
	Interview with the l	Director of Nursing (DON) on					
		., indicated the food					
		vere incomplete and they had					
		e with their electronic charting					
	-	the was unable to provide any					
	further documentation						
	3.1-46(a)(1)						
	3.1-46(a)(2)						
0756	483.45(c)(1)(2)(4)	(5)					
SS=D	Drug Regimen Re	eview, Report Irregular, Act					
3ldg. 00	On						
	§483.45(c) Drug F	0					
		e drug regimen of each					
		reviewed at least once a					
	month by a licens	ed pharmacist.					
	§483.45(c)(2) This	s review must include a					
	review of the resid	dent's medical chart.					
	§483.45(c)(4) The	e pharmacist must report					
		o the attending physician					
		nedical director and director					
		ese reports must be acted					
	upon.						
	(i) Irregularities in	nclude, but are not limited					
		neets the criteria set forth					
	in paragraph (d) o				1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155448	(X2) MULTIPLE A. BUILDING B. WING	Сом 02/1	(X3) DATE SURVEY COMPLETED 02/10/2023	
	PROVIDER OR SUPPLIE	R	710 N	T ADDRESS, CITY, STATE, ZIP CO AICHIGAN ST ELL, IN 46356	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	during this review separate, written attending physici director and direc minimum, the res drug, and the irre- identified. (iii) The attending in the resident's fi identified irregula what, if any, action address it. If ther medication, the a document his or medical record. §483.45(c)(5) The maintain policies monthly drug reg are not limited to steps in the proc pharmacist must identifies an irreg action to protect Based on record re failed to ensure ea regimen was mana or maintain the res mental, physical, related to Pharmac follow up for 1 of unnecessary medio Finding includes: The record for Res 2/10/23 at 11:31 a	ties noted by the pharmacist v must be documented on a report that is sent to the an and the facility's medical ctor of nursing and lists, at a sident's name, the relevant egularity the pharmacist g physician must document medical record that the arity has been reviewed and on has been taken to e is to be no change in the attending physician should her rationale in the resident's e facility must develop and and procedures for the imen review that include, but , time frames for the different ess and steps the take when he or she gularity that requires urgent	F 0756	What corrective action be accomplished for the residents found to have affected by the deficient practice; • Resident 61 phater recommendation was at the NP on 02/10/2023 we concerns. How other residents her potential to be affected same deficient practice identified and what co action(s) will be taken	hose re been nt macy ccepted by with no aving the d by the e will be rrective	02/28/202

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155448	B. WING		02/10/2023	
NAME OF	PROVIDER OR SUPPLIE	7D	STREET	ADDRESS, CITY, STATE, ZIP COD		
				CHIGAN ST		
LOWELI	_ HEALTHCARE		LOWE	LL, IN 46356		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	dementia and a his	story of falls.		 All residents have the 		
				potential to be affected by the		
		cian's Order Summary indicated		alleged deficient practice. Facil	ity,	
		neclizine (a medication used to		as well as pharmacy completed	la	
		nausea) 12.5 milligrams (mg) in		whole house audit and found ne	0	
	the morning and 2	5 mg in the evening.		other pharmacy recommendation	ons	
				out of compliance or not		
		ew, dated 1/11/23, recommended		addressed in a timely manner.		
	-	clizine to 12.5 mg twice daily		What measures will be put int	o	
		l. The Pharmacy review had		place and what systemic		
	been signed by the	e Nurse Practitioner, but it was		changes will be made to		
	left blank as to wh	ether to accept or decline the		ensure that the deficient		
	recommendation.			practice does not recur;		
				 DNS or Designee will 		
	Interview with the	Director of Nursing on 2/10/23		in-service all nursing managem	ient	
	at 1:46 p.m., indic	ated she had contacted the		on importance of addressing		
		and they were going to accept		pharmacy recommendations		
		on to decrease the meclizine.		timely and accurately to ensure	; all	
	She was unsure w	hy it had not been completed		fields are filled out by physician	ı for	
	before.			either accepting or declining		
				recommendations.		
	3.1-48(a)(5)			How the corrective action(s)		
				will be monitored to ensure the	le	
				deficient practice will not		
				recur, i.e., what quality		
				assurance program will be pu	t	
				into place; and by what date		
				the systemic changes for eac		
				deficiency will be completed;		
				Ongoing compliance with	1	
				this corrective action will be		
				monitored through the facility		
				QAPI tool for five (5) random		
				residents. The DNS/designee		
				be responsible for completing the	he	
				QAPI Audit tool weekly for 4		
				weeks, monthly for 6 months ar		
				quarterly thereafter for at least		
				quarters. If threshold of 90% is	not	
				met, an action plan will be		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES						ОМ	B NO. 0938-039
STATEMEN	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155448	B. WI	NG	02/10		/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 710 MICHIGAN ST LOWELL, IN 46356				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					submitted to the QAPI Commi	ttee	
					for review and follow up.		

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0VQM11 Facility ID: 000361