STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00364472 and IN00365636. Complaint IN00364472 - Unsubstantiated due to lack of evidence. Complaint IN00365636 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: October 24, 25, 26, 27, and 28, 2021. Facility number: 000361 Provider number: 155448 AIM number: 100266340 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 4 Medicaid: 64 Other: 8 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/2/21.	F 0000	The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. Lowell Healthcare respectfully requests paper compliance due to the low scope and severity of citations.	
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing			

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

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	requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review.			

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	(vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to transmit Minimum Data Set (MDS) assessments in the required time frame for 6 of 24 MDS assessments reviewed. (Residents 1, 2, 3, 4, 5, and 7) Findings include: Record review for the MDS assessments was completed on 10/26/21 at 12:48 p.m. 1. Resident 1's Quarterly MDS assessment, dated 9/2/21, was not signed and transmitted until 10/26/21. 2. Resident 2's Annual MDS assessment, dated 8/26/21, was not signed and transmitted until 10/18/21. 3. Resident 3's Quarterly MDS assessment, dated 9/15/21, was not signed and transmitted until 10/26/21. 4. Resident 4's Quarterly MDS assessment, dated 9/7/21, was not signed and transmitted until 10/26/21. 5. Resident 5's Quarterly MDS assessment, dated	F 0640	It is the intent of this provider to encode and transmit resident assessments timely. **What corrective action(s) will be accomplished for the resident assessments identified by the deficient practice:** MDS assessment transmittal dates for residents #1, #2, #3, #4, #5, and #7 were reviewed to ensure had been transmitted according to the format specified by the State and approved by CMS and all had been transmitted. MDS Coordinator was in-serviced by the MDS Consultant regarding timely completion and transmittal of MDS assessments according to the format as specified by State and approved by CMS. **How other resident MDS assessment transmittals have the potential to be affected by**	11/13/2021

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	9/17/21, was not signed and transmitted until 10/26/21. 6. Resident 7's Annual MDS assessment, dated 9/20/21, was not signed and transmitted until 10/26/21. Interview with the MDS Coordinator on 10/27/21 at 9:22 a.m., indicated the assessments should have been signed and submitted within 14 days after they were completed. The assessments had not been submitted within the required timeframe.		**the same deficient practice will be identified and what correction action(s) will be taken:** All resident assessments have the potential to be affected by this finding. A facility audit was completed by the MDS Coordinator/Designee to ensure timely completion and submission. All assessments have been completed and transmitted according to the format specified by State and approved by CMS. **Measures put in place to ensure the deficient practice does not recur:** MDS Coordinator was in-serviced by the MDS Consultant regarding timely completion and transmittal of MDS assessments according to the format as specified by State and approved by CMS. MDS Coordinator will report to the Executive Director weekly the timeliness of MDS submissions to QUIS via validation reports. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:**	

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			Review of the completed QAPI MDS tool will occur in IDT Clinical morning meeting weekly for 4 weeks, then monthly for 6 weeks. Finding will be reviewed in monthly QAPI committee. Of a threshold of 100% is not met, an action plan will be implemented.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed related to a medication for 1 of 24 MDS assessments reviewed. (Resident 6) Finding includes: Record review for Resident 6 was completed on 10/26/21 at 12:48 p.m. The Quarterly Minimum Data Set (MDS) assessment, dated 6/18/21, indicated the resident had received an anticoagulant medication during the assessment look back period. The Medication Administration Record (MAR), dated 6/2021, indicated the resident had not received any anticoagulant medication. Interview with the MDS Coordinator on 10/26/21 at 1:29 p.m., indicated the resident had not received an anticoagulant medication, but rather an antiplatelet medication, during the assessment period.	F 0641	It is the intent of this Provider that each assessment accurately reflects the resident's status. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 6's MDS has been modified to accurately reflect the resident's medication receipt status. This resident experienced no negative outcome related to this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents have the potential to	11/13/2021

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	3.1-31(d)(3)		be affected by this finding. A facility audit was completed by MDS Coordinator/Designee for all MDS assessments completed in the past 90 days to ensure accuracy for residents receiving antiplatelet and anticoagulant medication. There were no identified concerns related to the audit. **Measures put in place to ensure the deficient practice does not recur:** MDS Coordinator was in-serviced by the MDS Consultant regarding accuracy of MDS assessment completion for antiplatelet and anticoagulant medication. MDS Coordinator/Designee will review with MDS Consultant/Designee any MDS anticoagulant coding to ensure accuracy of anticoagulant medication MDS coding. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** Review of the completed QAPI audit tool will be completed in IDT Clinical Morning Meeting weekly for 4 weeks, then monthly for 6 months. If a threshold of 100% is	

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			not met, an action plan will be implemented. Findings will be reviewed in monthly QAPI committee.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to develop a comprehensive care plan for a resident with identified dental concerns for 1 of 1 residents reviewed for dental. (Resident 37) Finding includes: During an interview with the resident on 10/24/21 at 10:30 a.m., she indicated she had bad teeth, that included a chipped or cracked tooth, a painful area on her right side and a cavity. She indicated someone had looked at her teeth a couple months ago, but nothing had been done yet. Resident 37's record was reviewed on 10/25/21 at 3:00 p.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease and morbid obesity. The Annual Minimum Data Set (MDS) assessment, dated 7/29/21, indicated the resident was cognitively intact, and required extensive two person assist for transfers using a mechanical lift. The oral/ dental section indicated there were no problems. A dental assessment, dated 7/22/21, completed by	F 0656	It is the intent of this provider to develop comprehensive person-centered care plans for each resident, consistent with resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A dental care plan was implemented immediately for resident # 37, reflecting medical and nursing needs as identified on the comprehensive assessment. **How other residents having the potential to be affected by the**	11/13/2021

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	a contracted dental hygienist, indicated the resident was very concerned about an area on her lower right side. The note indicated, "...It appears that food, plaque is being packed in the cusp tip of number 27 and is causing a suspicious lesion. Number 10 has a suspicious lesion that can be seen from the lingual surface..." The assessment also indicated the resident had gingivitis and suspected area of broken teeth. The record lacked an oral/dental care plan.. Interview with Social Service Director on 10/26/21 at 10:00 a.m., indicated she was aware the resident needed to see a dentist but was having difficulty making arrangements due to family and transportation issues. During a follow up interview at 11:55 a.m., she indicated there should have been a dental care plan. 3.1-35(a)		**same deficient practice will be identified and what correction action(s) will be taken:** All other residents have the potential to be affected by this finding. Dental care plans for all residents have been reviewed by the IDT team to ensure that dental care plans have been developed and implemented to meet the resident's medical, nursing, and mental and psychosocial needs according to the comprehensive assessment. Any identified dental care plan concerns were addressed. Nursing staff and Social Service Director were in-serviced by the DNS/Designee and reviewed the facility policy related to the creation of comprehensive care plans with healthcare information necessary to properly care for the resident's dental needs. **Measures put in place to ensure the deficient practice does not recur:** IDT will review dental care plans during weekly clinical meeting to ensure comprehensive care plans have been developed that meet the resident's dental needs according to the comprehensive assessment. DNS/Designee will	

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			interview/access each resident's oral status at time of admission or change in dental condition to identify/validate dental status. Dental referrals will be completed as needed. Care plan will be updated as necessary. Social Service will follow up on dental referrals to ensure dental needs are met. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** Results of the audit will be reviewed in IDT Clinical Morning Meetings weekly for 4 weeks, then monthly for 6 months. If a threshold of 100% is not met, an action plan will be implemented. Ongoing compliance with this corrective action will be monitored through the monthly QAPI Committee.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to monitor and treat skin conditions for 1 of 6 residents reviewed for non-pressure related skin issues. (Resident C) Finding includes: On 10/27/21 at 2:45 p.m., Resident C was observed in bed. She was positioned to her right side by a family member and a CNA. There were diffuse, scattered red spots over both buttocks, scratch marks on the abdomen and thighs, and an open abrasion, approximately 1 cm x 1 cm on her outer left thigh. The resident indicated her skin itched and she frequently scratched at it. The CNA indicated she had applied A & D ointment to buttocks prior to the observation. The resident's record was reviewed on 10/27/21 at 8:30 a.m. Diagnoses included, but were not limited to, multiple sclerosis and immobility syndrome. The Quarterly Minimum Data Set assessment, dated 7/21/21, indicated the resident needed extensive assistance of two for bed mobility and transfers. A CNA Shower and Skin sheet, dated 3/9/21, indicated, "...redness under side skin fold, breasts and groin. Redness and open area to bottom and back/ scabs from scratching...." The shower sheet had been signed off by RN 3. The Nursing Progress Note, completed that day by RN 3, indicated the resident was on isolation and had no symptoms related to COVID-19. The note did not indicate any skin concerns had been identified.	F 0684	It is the intent of this provider to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choice. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** A comprehensive skin assessment was completed for resident C and a treatment and monitoring plan was implemented. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All other residents have the potential to be affected by this finding. 100 percent skin sweep was completed for all residents. There were no other identified concerns. Nursing staff received education regarding skin policy and protocol by Clinical Educator. **Measures put in place to ensure the deficient practice does not recur:** Shower sheets will be reviewed by	11/13/2021

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	There was not a wound note or new order related to the observed skin issues. Weekly skin assessments were completed on 3/4/21, 3/11/21 and 3/18/21, which indicated there were no skin issues. On 3/18/21, the resident was admitted to the hospital for unrelated concerns. She returned to the facility on 3/28/21. A Physician's order, dated 3/29/21, indicated to apply A & D ointment to buttocks every shift. A Physician's order, dated 9/13/21, indicated to apply Sarna lotion, to the buttocks and legs every shift for itching. A weekly skin assessment, dated 10/4/21, indicated Sarna for itching, no skin issues. A weekly skin assessment, dated 10/11/21, indicated old superficial scratches to buttocks. The weekly skin assessment, dated 10/18/21, indicated no skin issues. A Nursing Note, dated 10/27/21, indicated the resident had returned and family voiced concerns about skin. The Nursing Note indicated, "...resident has several abrasions on left lower buttock and right hip. Abrasions consistent with scratching...res also has multiple scarred areas and red blanching dots on buttocks...." Interview with the resident's family member, on 10/27/21 at 2:25 p.m., indicated he had been notified of the skin issues by the hospital staff on the day she was admitted to the hospital, 3/18/21. It had been an ongoing issue since. The resident had recently been home for a five day visit and		DNS/Designee daily to ensure proper skin conditions are identified and treated per physician order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** Results of the Skin Assessment audit tool and resident shower sheet review will be reviewed in IDT Clinical Morning Meetings 5 days weekly for 4 weeks, then weekly for 6 months. If a threshold of 100% is not met, an action plan will be implemented. Ongoing compliance for this corrective action will be monitored through the QAPI monthly meeting.	

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	had returned to the facility on 10/27/21. He indicated when she was home, the skin issues were still present. He had spoken to the Director of Nursing (DON) by phone on 10/26/21. Interview with the DON on 10/27/21 at 3:10 p.m., indicated she had spoke to the family member the previous day and he voiced concerns about the resident's skin. She indicated she had not been aware of it, but had notified the physician. The physician was to come see the resident that day. She indicated there were no nursing notes or new orders when the skin issues were first identified on 3/9/21. This Federal deficiency relates to Complaint IN00365636. 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure a resident received proper respiratory care and treatment related to incorrect oxygen flow rate for 1 of 4 residents reviewed for respiratory care. (Resident 37)	F 0695	It is the intent of this provider to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the	11/13/2021

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	Finding includes: On 10/25/211 at 1:33 p.m., Resident 37 was observed in bed with her oxygen on. The flow rate was set at 3 liters. On 10/25/211 at 3:05 p.m., she was observed in bed with her oxygen on. The flow rate was set at 3 liters. On 10/26/21 at 9:29 a.m., she was observed in bed with her oxygen on. The flow rate was still on 3 liters. Resident 37's record was reviewed on 10/25/21 at 3:00 p.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease and morbid obesity. The Annual Minimum Data Set assessment, dated 7/29/21, indicated the resident was cognitively intact. A Physician's order, dated 9/12/21, indicated continuous oxygen at 2 liters. Interview with the Director of Nursing on 10/26/21 at 10:10 a.m., indicated nurses would turn her oxygen up at times if her oxygen saturation was low. She indicated there was not an order with parameters in place, but she would contact the provider to clarify. 3.1-47(a)(6)		comprehensive person-centered care plan, and resident's goals and preferences. **What corrective action will be accomplished for the resident found to be affected by the deficient practice:** Physician for resident # 37 was notified of the deficient practice. Resident # 37 received a new order to monitor saturation and titrate oxygen based on monitoring indications, which will be monitored every shift. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. An audit of all residents receiving oxygen therapy was completed with no additional findings. Nursing staff were in-serviced by Clinical Nurse regarding Physician orders and oxygen therapy. **Measures put in place to ensure the deficient practice does not recur:** DNS/Designee will conduct rounds each shift to ensure resident oxygen flow is per physician order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	10/28/2021

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place: Results of the QAPI audit tool related to Oxygen Therapy will be reviewed in IDT Clinical Morning Meetings weekly for 4 weeks, then monthly for 6 months, then quarterly. If a threshold of 100% is not met, an action plan will be implemented. Ongoing compliance with this corrective action will be monitored through QAPI. **Completion date:**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 4 residents observed during medication pass. Two errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 8%. (Resident 40) Finding includes: On 10/26/21 at 9:13 a.m., LPN 1 was observed preparing medications for Resident 40. The medications included gabapentin (anticonvulsant medication) 100 mg (milligrams) and vitamin D3 capsule 50 mcg (micrograms) 2000 units. The	F 0759	It is the intent of this provider that medication errors are not 5 percent or greater. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 40 received the correct medication dosage at the time of the medication pass. There was no negative result for resident # 40	11/13/2021

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	nurse had popped out only 1 pill of the gabapentin and the vitamin D3 from the medication cards into the medication cup. The medication card instructions indicated to administer 2 gabapentin pills to equal 200 mg and 2 vitamin D3 pills to equal 100 mcg, 4000 units. The nurse finished preparing the medications and indicated she was ready to administer the medications to the resident. The nurse was asked at the time to count the number of pills she had in her medication cup. She had counted 12 pills and indicated that was correct. She was then asked to recheck the medication cards with the Physician Orders. She rechecked them and then realized she should have had 14 pills in the cup. She did not realize the medication cards said to give 2 gabapentin and 2 vitamin D3 pills. The October 2021 Physician's Order Summary for Resident 40 indicated the following orders: - gabapentin 200 mg twice a day - Vitamin D3 (cholecalciferol (vitamin D3)) 100 mcg, 4000 units every day 3.1-48(c)(1)		related to this finding. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken: All residents have the potential to be affected by this finding. The staff Nurse that had the medication error was educated regarding this finding. All Nurses and QMA's were in-serviced by the DNS/Designee regarding medication administration and errors. **Measures put in to place to ensure the deficient practice does not recur:** The DNS/Designee will conduct rounds each shift to ensure medications administration is accurate per physician order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** Results of the QAPI Monitoring Tool will be reviewed in the Clinical Morning Meeting 5 times weekly for 4 weeks, then weekly for 6	

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			months If a threshold of 100% is not met, an action plan will be implemented. Findings will be submitted to the QAPI Committee for review.	