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	01/29/2024

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00421911. Complaint IN00421911 - No deficiencies related to the allegations are cited. Survey dates: January 23, 24, 25, 26, and 29, 2024 Facility number: 000361 Provider number: 155448 AIM number: 233611 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 5 Medicaid: 62 Other: 9 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/1/24.	F 0000	Facility is requesting paper IDR for F 880, as facility disagrees with the scope and severity assigned. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.	
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			

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

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the lack of monitoring and assessments of a skin discoloration for 1 of 2 residents reviewed for non-pressure skin conditions. (Resident 47) Finding includes: On 1/23/24 at 11:28 a.m., Resident 47 was observed with a reddened area noted on her nose. The resident indicated it was from her BiPAP (bilevel positive airway pressure) mask that she wore at night. On 1/24/24 at 9:19 a.m., Resident 47 was observed sitting in a chair. She had a reddened area noted on the bridge of her nose. On 1/25/24 at 2:28 p.m., Resident 47 was observed sitting up in a chair. She had a reddened area with a small scab present, along with an indentation on the bridge of her nose. Resident 47's record was reviewed on 1/24/24 at 9:00 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, obstructive sleep apnea, and chronic obstructive pulmonary disease. The State Optional Minimum Data Set (MDS) assessment, dated 11/9/23, indicated the resident was cognitively intact for daily decision making and was a 1 person assist for ADLs (activities of daily living).	F 0684	**F684- Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 47 had new foam added to nose of mask. Lincare came out and refitted straps. New mask requested due to redness on bridge of nose still showing. No skin break down at this time. **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 the alleged deficient practice. House audited was completed on all residents who wear a Cpap or BiPap who are in house. Lincare came in and refit all residents in house to ensure proper fitting mask to prevent skin break down. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** In-service was conducted on 02/14/2024 with nursing staff on skin monitoring, change in skin condition documentation and communication with wound team for continuous monitoring.	02/14/2024

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	A current Care Plan, indicated the resident was at risk for decreased skin integrity, pressure ulcers, and skin tears, with a risk factor including, but not limited to, using BiPAP. The January 2024 Physician's Order Summary indicated, BiPAP at night with fraction of inspired oxygen (FiO2) 32%, inspiratory pressure 14, expiratory pressure 7, and oxygen at 3 liters. Change the mask & tubing as needed. There was no documentation in the clinical record related to the reddened scabbed area on Resident 47's nose. During an interview on 1/25/24 at 2:32 p.m., the Director of Nursing indicated she was not aware the resident had any marks on her nose. They will re-evaluate the mask fit and contact respiratory services if needed. 3.1-37(a)		DNS/Designee to conduct rounds to ensure Bipap and Cpap are fitting properly for those residents receiving Bipap and Cpap. Lincare has scheduled for new mask to be delivered every 90 days for those who wear a Cpap or BiPap. **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; and by what date the systemic changes for each deficiency will be completed;** Ongoing compliance with this corrective action will be monitored through the facility QAPI tool. The DNS/designee will be responsible for completing the QAPI Audit tool weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed: 02/14/2024**	
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;			

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	Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 5 residents observed during medication pass. Two errors were observed during 30 opportunities for errors during medication administration. This resulted in a medication error rate of 6.67%. (Resident 282) Finding includes: On 1/24/24 at 11:11 a.m., RN 1 was observed preparing Resident 282's medications to be administered via a gastrostomy tube (g-tube, a tube inserted through the belly that brings nutrition to the stomach). The nurse crushed 2 different medications, which included 1 Nephro Vite (vitamin) tablet and 1 Carafate (anti-ulcer medication) tablet. She poured the crushed medications together into a plastic cup and added an unmeasured amount of water. The RN indicated she added approximately 30 ml (milliliters of water to the medications). She then proceeded to check for placement of the g-tube by auscultation. She flushed the g-tube with 30 ml of water and then administered the cup with the 2 medications into the tube. The nurse then administered another 30 ml of water into the tube. She indicated she always administered the crushed medications all at once through the tube. A "Nursing Skills Competency for Enteral Tube-Medication Administration", dated 1/2010 and updated 5/2023, given by the Director of Nursing (DON) indicated, "...2. Dissolve each crushed medication in at least 10 cc-30 cc of water..." "...12. Flush tubing with at least 15 cc of water between each medication..." During an interview on 1/24/24 at 11:55 a.m., the DON indicated they did not have a policy that	F 0759	**F759- Free of Medication Error Rts 5% or More** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 282 showed no adverse effects from the alleged deficient practice. Resident is receiving crushed medications individually via g-tube. **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 the alleged deficient practice. 1:1 in-service was held for the nurse who administered the medication. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DNS or Designee will in-service all nursing management on importance of enteral medication administration and complete skills validations for all nurses on enteral medication administration. DNS/Designee will observe nurses administering the crushed medication via g-tube to ensure proper protocol is followed. **How the corrective action(s) will be monitored to ensure the**	02/14/2024

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	would indicate medications could not be crushed and administered via g-tube at the same time. She would expect nursing to use nursing judgment, and if there were only 2 medications, she would administer them together. The State Operations Manual (SOM) Appendix PP, revised 2/3/2023 indicated, "...The standard of practice is that crushed medications should not be combined and given all at once via feeding tube. Crushing and combining medications may result in physical and chemical incompatibilities leading to an altered therapeutic response, or cause feeding tube occlusions when the crushed medications are combined and administered via feeding tube. Flushing the feeding tube between each medication is also standard of practice..." 3.1-48(c)(1)		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Ongoing compliance with this corrective action will be monitored through the facility QAPI tool. The DNS/designee will be responsible for completing the QAPI Audit tool daily five times a week for 4 weeks, Once a week monthly for 6 months and once a month quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed: 02/14/2024**	