STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155386	A. BUILDING 00 B. WING	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN 46721

(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. Survey dates: August 21, 22, 23, 24, and 25, 2023. Facility number: 000574 Provider number: 155386 AIM number: 100266430 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 2 Medicaid: 47 Other: 29 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 29, 2023	F 0000	=”” p=””> The Laurels of DeKalb wishes to have this submitted plan of correction stand as our written allegation of compliance. Preparation and/or execution of this plan does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our date of compliance is September 18,2023.The facility is requesting a desk review in lieu of a facility revisit. =”” p=”>	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review the facility failed to ensure supervision of self-administration of medication for 1 of 6 residents reviewed. (Resident 18)	F 0554	IDOH alleges that the facility failed to ensure supervision of self-administration of medication for 1 of 16 residents reviewed. **What corrective action(s) will be accomplished for those**	09/18/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Nelson	Administrator	09/11/2023

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	Findings include: During an observation 8/21/23 at 10:28 AM Resident 18 was sitting in a wheelchair in their room while RN 4 administered medications to Resident 18's roommate. A medication bottle was viewed on Resident 18's bedside table. In an interview on 8/21/23 at 3:00 PM, Resident 18 indicated the medication bottle contained eye drops. Resident 18 indicated they had experienced redness and dryness to both eyes for approximately 1 week. Resident 18 indicated they had made staff aware of the eye discomfort. Resident 18's record was reviewed on 8/22/23 at 10:07 AM. Diagnoses included diabetes mellitus, heart problems, major depressive disorder and chronic pain related to osteoarthritis and spinal stenosis. Resident 18's current comprehensive Minimum Data Set (MDS)dated 8/2/23 indicated their Basic Interview for Mental Status (BIMS) was 15 (no cognitive deficit). The MDS indicated the resident had adequate vision and wore glasses. Resident 18's current care plan initiated on 8/4/23 indicated the resident was at risk for side effects and adverse reactions related to medications with a goal date of 11/16/23. Interventions included administration of medications as ordered, observance for side effects such as dry eyes and reporting abnormal findings to the physician. In an interview on 8/22/23 at 3:16 PM, Resident 18 indicated facility staff had instructed the resident to hide the eye drops due to the government being in the building. The resident removed the eye drops from a plastic storage box. Resident 18		**residents found to have been affected by the deficient practice:** On 8/24/23, a licensed nurse received an order from the nurse practitioner for the medication the Resident #18 wished to self-administer. Resident # 18 was assessed for self-determination of the medication by the DON on 8/24/23. The assessment outcome revealed the resident was unable to sufficiently self-administer the medication. The resident was informed of the assessment outcome and voiced understanding that the licensed nurse will administer the medication. **How other residents have potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All Resident room/bedside tables were audited for medications by the Unit Managers on 9/06/23. · DON/designee reviewed residents for self-administration to ensure appropriate evaluations/interventions were in place on 9/06/23. · One call to all family members that all medications must be brought to the nurse for order and evaluation by the Administrator completed on 9/08/23. · All residents were notified	

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	indicated a staff member had stated the resident's eyes were red due bearing down to have a bowel movement. In an interview on 8/24/23 at 9:50 AM, Resident 18 indicated their eyes remained uncomfortable due to dryness and redness. Resident indicated they had made facility staff aware of their eye symptoms and had requested an appointment with their eye doctor. Resident 18 indicated the eye drops were put out of sight due to the facility staff's report of government investigators being in the facility. In an interview on 8/24/23 at 11:45 AM, the Director of Nursing (DON) indicated they had spoken with Resident 18 about the resident having had red and dry eyes. The DON could not recall when the conversation had occurred. The DON indicated Resident 18 had reported their eyes were red due to bearing down to have a bowel movement. The DON indicated they were unaware of Resident 18 having the eye drops at the bedside. The DON indicated Resident 18 was unable to pass a medication self-administration evaluation. A current policy dated 10/14/22 provided by the Administrator indicated residents may administer their own medications after a self-administration evaluation was completed and authorization was granted by the physician. 3.1-11		in the September Resident Newsletter that all medications must be brought to the nurse prior to being taken to the room for evaluation on 9/01/23. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** · Self-administration of medication form was added to admission packet to be reviewed and signed by resident and/or family with re-evaluation as needed on 9/07/23. · The DON/designee will educate nursing staff on self-administering medications policy and procedures by 9/18/23. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** · DON/Designee will review all new admissions for self-administration of medication and follow policy per assessment every week x 4 weeks, then 2 times monthly x 1 month, then monthly for a total of 6 months to ensure compliance. · All audits will be reviewed monthly by QAPI x 6 months.	
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI			

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Bldg. 00	§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder 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 interview the facility failed to ensure a resident catheter drainage bag did not touch the floor for 1 of 2 residents reviewed for catheter care. (Resident 82).	F 0690	IDOH alleges that the facility failed to ensure a resident catheter drainage bag did not touch the floor for 1 of 2 residents reviewed for catheter care.	09/18/2023

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	Findings include: During an observation on 08/21/23 at 2:37 pm Resident 82's catheter drainage bag was obersved laying on the floor. During an observation on 08/22/23 at 10:19 am Resident 82's catheter drainage bag was observed laying on the floor. Resident 82's record was reviewed on 08/24/23 at 12:18 pm. Diagnoses included malignant neoplasm of prostate, neuromuscular dysfunction of Bladder, and quadriplegia. A review of Resident 82's current significant change Minimum Data Set (MDS) assessment, dated 6/30/23, indicated his Basic Interview for Mental Status (BIMS) score was 10 (moderately impaired). The MDS indicated the resident had an indwelling catheter (including suprapubic catheter and nephrostomy tube) and was on hospice. A review of Resident 82's current Care plan indicated the resident was at risk for urinary tract infections, catheter-related trauma and had a foley catheter related to a neurogenic bladder, with a goal he would show no signs or symptoms of urinary infection. Intervention included to ensure the drainage bag was secured properly. A Medication Review Report, dated 8/13/23, indicated the physician ordered an 18 French foley catheter with a 10mm balloon for Resident 82'd diagnosis of neurogenic bladder. In an interview on 8/24/23 at 11:07 AM, CNA 2 indicated a catheter bag should not be on or touching the floor due to contamination.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident # 82's catheter bag was secured off the floor by a licensed nurse on 8/24/23. **How other residents have potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents with indwelling catheters were audited by the Unit Managers on 8/24/23 to ensure they were secured properly and not on the floor with no concerns noted. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** · The DON/designee will educate nursing staff on appropriate catheter drainage bag placement by 9/18/23. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** · DON/Designee will review all new admissions/current guests for catheter bag placement and follow policy every week x 4 weeks, then 2 times monthly x 1 month, then monthly for a total of 6 months to ensure compliance. · All audits will be reviewed	

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	In an interview on 8/24/23 at 11:07 AM, RN 3 indicated a indicated the catheter bag should not be on the floor or touching the floor due to infection risk. In an interview on 8/24/23 at 11:07 AM, The Director of Nursing (DON) indicated a indicated the catheter bag should not be on the floor or touching the floor due to infection risk. A current procedure titled "Indwelling urinary catheter (Foley) care and management Critical Notes!", reviewed 12/2/22, provided by the DON on 8/24/23 at 11:15 AM indicated the catheter drainage bag should not be on the floor to reduce the risk of contamination and subsequent catheter-associated urinary tract infections (CAUTI). 3.1-41(a)(1)		monthly by QAPI x 6 months.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic 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;			

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	§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, interview, and record review the facility failed to ensure nutritional risk factors were assessed and intervened upon for 1 of 24 residents reviewed (Resident 6). Findings include: During an observation on 8/21/23 at 10:24 AM Resident 6 was observed seated in her wheelchair in her room. She had about 2+ edema of both feet and her abdomen and extremities were consistent with being above ideal body weight. Resident 6's record was reviewed on 8/21/23 at 11:11 AM. Diagnoses included heart failure, type 2 diabetes mellitus without complications, and unspecified intellectual disabilities. A review of Resident 6's current Medicare 5-day Minimum Data Set (MDS) dated 7/20/23 indicated her Basic Interview for Mental Status (BIMS) score was 8 (cognitively impaired). The MDS indicated the resident had a significant weight gain. A review of Resident 6's current care plan titled Resident is at risk for nutritional decline indicated Resident 6 had a problem of risk for nutritional decline, with a goal, dated 10/19/23, of maintaining current weight. Interventions included notifying the Registered Dietician (RD), family and physician of significant weight changes, and	F 0692	IDOH alleges that the facility failed to ensure nutritional risk factors were assessed and intervened upon 1 of 24 residents reviewed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #6 ‘s care plan was reviewed and updated by the Registered Dietician/Dietary Manager on 9/6/23. **How other residents have potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All resident’s care plans were reviewed to ensure that the care plans were appropriate for their nutrition levels by IDT by 9/08/23. · Plan of care updated as appropriate with interventions as needed by Dietary Manager by 9/15/23. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** · Weight Exemption Report will be reviewed weekly for weight	09/18/2023

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	observing and evaluating weight and weight changes. A review of a weight summary document indicated on 2/3/23 Resident 6 weighed 138 lbs. On 8/3/23, Resident 6 weighed 170.2 lbs. This is a 23.33 % gain in six months. A review of a height summary indicated on 7/13/23 Resident 6 was 60 inches tall. A progress note dated 3/13/23 indicated Resident 6 had a weight gain of 8% in 30 days, the Nurse Practitioner (NP) and Power of Attorney (POA) were aware. There was not an indication the Registered Dietician had been notified to review her nutritional status, A progress note dated 4/7/23 indicated Resident 6 had a weight gain of 12% in 3 months and 15% in 6 months. The note indicated the NP and POA were aware. There was not an indication the Registered Dietician had been notified to review her nutritional status, A progress note dated 5/11/23 indicated Resident 6 had a weight gain of 14% in 3 months and the NP and POA were aware. There was not an indication the Registered Dietician had been notified to review her nutritional status, A progress note dated 6/16/23 indicated Resident 6 had a weight gain of 17% in 6 months and the NP and POA were aware. There was not an indication the Registered Dietician had been notified to review her nutritional status, A progress note dated 8/11/23 indicated Resident 6 had a 32.2 lb. weight gain since February and the NP and POA were aware. There was not an		fluctuations by IDT in Clin-ops. IDT to update plan of care and interventions as needed. · Registered Dietician will be updated weekly by Unit Managers on new admissions/hospitalizations and significant weight changes. Unit Managers will then follow through with any recommendations. · The Registered Dietician/Designee will review new patients/re-admission within 14 days for dietary/nutritional status and recommendations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** · Dietary manager will review new admissions/current guests to ensure nutritional risk factors were assessed and interventions in place per facility policy every week x 4 weeks, then 2 times monthly x 1 month, then monthly for a total of 6 months to ensure compliance. · All audits will be reviewed monthly by QAPI x 6 months.	

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	indication the Registered Dietician had been notified to review her nutritional status, A review of RD weight reviews dated 11/30/22 indicated Resident 6 weighed 134 lbs. with a BMI of 26.2 indicative of overweight status. No Registered Dietician evaluations after 11/30/22 were available for review. No documentation of Registered Dietician notification of weight changes after 11/30/22 was available for review. In an interview on 8/24/23 at 2:05 PM, the Dietary Manager indicated the RD came in every other week and reviewed all weights, making recommendations as needed. In an interview on 8/23/23 at 1:35 PM the Director of Nursing indicated she was not aware of a policy for Registered Dietician notification of weight changes. 3.1-46(a)(1)			