STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155696	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEPOINTE HEALTH CAMPUS	1900 COLLEGE AVE VINCENNES, IN 47591

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00423574. Complaint IN00423574: Federal/State deficiencies related to the allegations are cited at F635. Unrelated deficiency is cited. Survey dates: January 2 & 3, 2024 Facility number: 003237 Provider number: 155696 AIM number: 200374360 Census bed type: SNF: 20 SNF/NF: 43 Residential: 22 Total: 85 Census payor type: Medicare: 24 Medicaid: 29 Other: 10 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 9,2024 .	F 0000	The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Bridgepointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted January 2-3, 2024. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0635 SS=D Bldg. 00	483.20(a) Admission Physician Orders for Immediate Care §483.20(a) Admission orders At the time each resident is admitted, the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Weber	Executive Director	01/21/2024

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.

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	facility must have physician orders for the resident's immediate care. Based on record review and interview, the facility failed to ensure physician orders were obtained and implemented following admission for 1 of 3 diabetic resident's reviewed. A resident with a diagnoses of type II diabetes did not have a physician's order to monitor their blood sugar levels for 7 days following their admission to the facility. (Resident F) Finding includes: During record review on 1/2/24 at 11:15 A.M., Resident F's diagnoses included, but was not limited to, type II diabetes mellitus with diabetic chronic kidney disease and type II diabetes mellitus with hyperglycemia. Resident F's admission MDS (minimum data set) dated, 11/29/23, indicated that the resident had diabetes mellitus and did not receive insulin. Resident F's physician orders included, but were not limited to, Trulicity Pen Injector 1.5 mg (milligrams) per ml (milliliter) for diabetes mellitus type II once a day on Mondays (started 11/22/23 on admission) Accucheck 4 times daily (started 11/29/23). A hospital discharge summary, dated 11/22/23, provided discharge medications which included glucose blood test strips with instructions to test 4 times daily before meals and at bedtime. Resident F's blood sugar levels were not documented from the admission date of 11/22/23 thru 11/29/23, nor was an order obtained for monitoring the resident's blood sugar until 11/29/23.	F 0635	The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Bridgepointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted January 2-3, 2024. The facility respectfully requests from the department a desk review for substantial compliance. F635 D Admission Physician Orders for Immediate Care This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure physician orders were obtained and implemented	01/29/2024

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	During an interview on 1/3/24 at 1:05 P.M., LPN 10 indicated that any resident with a diagnosis of type II diabetes should have a physician's order to monitor their blood sugar levels routinely. On 1/3/24 at 2:15 P.M., the DON (Director of Nursing) supplied a facility policy titled, Glucometer SOP (Standard Operating Procedure), dated 12/31/22. The policy included, "...1. Blood glucose monitoring shall be completed for the resident per the physician's order..." This citation relates to complaint IN00423574. 3.1-30(a)		following admission for 1 of 3 diabetic residents reviewed. A resident with a diagnosis of type II diabetes did not have a physician's order to monitor their blood sugar levels for 7 days following their admission to the facility. (Resident F) Plan of Correction: 1. Resident F was not affected by the alleged deficient practice. Resident assessed with no findings. Transfer/admission orders reviewed, reconciled, and verified with MD. Orders for blood glucose monitoring for Resident F have remained in place since 11/29/23 and documented appropriately with no adverse effects. Staff were immediately educated on following physicians admission orders and blood glucose monitoring for all diabetic residents. 2. All residents admitted and residents with a diagnosis of diabetes have the potential to be affected. Audit completed on all resident admissions within last 30 days to ensure transfer/admission order compliance and for all diabetic residents to ensure blood glucose monitoring in place per physicians' orders. Orders reconciled and updated as indicated. RN's/LPN's educated regarding admission physician orders verification process and blood glucose monitoring for	

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			diabetic residents. 3. As a measure of ongoing compliance, DHS or designee will audit transfer/admission orders for 3 new admissions/readmissions per week for 4 weeks, then 2 new admissions/readmissions per week x 4 weeks then 1 new admission/readmission per week x 4 weeks then 3 admissions/readmissions per month x 3 months. DHS or designee will also audit 3 diabetic residents to ensure blood sugar monitoring orders in place per physician's orders 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks, then monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Completion Date: 1/29/24	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program			

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	designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and			

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	(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during 1 of 2 observations of care. Staff failed to complete hand hygiene after removing their gloves during care, a resident's oxygen tubing and nasal cannula were allowed to fall to the floor and were repeatedly stepped on during care, and a resident's catheter drainage bag was not kept below the resident's bladder, was clipped to the side of a waste bin, and was resting on the floor. (Resident D) Finding includes:	F 0880	The submission of this plan of correction does not indicate an admission by Bridgepointe Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of Bridgepointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an	01/29/2024

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	During an observation on 1/3/24 at 10:15 A.M., CNA 4 and CNA 5 were performing incontinence care for Resident D. Resident D was receiving supplemental oxygen via nasal cannula with oxygen tubing extending from the resident to the oxygen concentrator located on the floor near the resident's bed. While providing care, staff removed Resident D's supplemental oxygen and allowed the nasal cannula and tubing to fall to the floor next to the resident's bed. Throughout the incontinence care, CNA 5 stood on and stepped on the resident's oxygen tubing. Resident D also had a urinary catheter with a catheter drainage bag clipped to the side of his bed. CNA 4 provided catheter care and perineal care to Resident D, then assisted the resident to turn towards CNA 5 to remove a small amount of BM (bowel movement) from the resident's buttocks. Following care, both CNA 4 and CNA 5 removed their gloves and did not perform hand hygiene. CNA 4 briefly exited the resident's room to retrieve a Hoyer lift from the hallway just outside Resident D's room. CNA 4 proceeded to lift Resident D from his bed while the catheter drainage bag was given to Resident D to hold during the transfer to his recliner. While hanging in the Hoyer lift, Resident D's hands were in front of his face and holding on to the drainage bag, positioned above the resident's bladder. As CNA 4 lowered Resident D into his recliner, CNA 5 placed her hand on Resident D's forehead. Staff then clipped Resident D's catheter drainage bag to the side of a waste bin located next to the recliner. Staff then reinserted the resident's nasal cannula without cleaning the cannula or wiping the tubing. During an interview on 1/3/24 at 11:00 A.M., QMA 8 indicated that resident's nasal cannula and oxygen tubing should be wrapped up and placed		economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted January 2-3, 2024. The facility respectfully requests from the department a desk review for substantial compliance. F880 D Infection Prevention & Control This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during 1 of 2 observations of care. Staff failed to complete hand hygiene after removing their gloves during care, a resident's oxygen tubing and nasal cannula were allowed to fall to the floor and were repeatedly stepped on during care, and a resident's catheter drainage bag was not kept below the resident's bladder, was clipped to the side of a waste bin, and was resting on the floor. (Resident D) Plan of Correction: 1. Resident D was not affected	

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	in bag on a table or night stand when not in use. QMA 8 indicated catheter drainage bags should stay below the level of the bladder and should not be resting on the floor, and that staff should perform hand hygiene prior to donning gloves and after removing gloves. On 1/3/24 at 2:05 P.M., the DON (Director of Nursing) supplied a facility policy titled, Hand Hygiene, dated 1/18/23. The policy included, "Purpose: Effective hand hygiene reduces the incidence of healthcare-associated infections... 3. Handwashing may also be used for routinely decontaminating hands in the following clinical situations: ...After removing gloves..." The DON also provided a policy titled Urinary Catheter Care, dated 12/31/22. The policy included, "To prevent infection of the resident's urinary tract... 4. The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder... 11. Be sure the catheter tubing and drainage bag are kept off the floor." 3.1-18(b) 3.1-18(l)		by the alleged deficient practice. Resident assessed with no findings or adverse effects noted. Resident D's oxygen tubing was immediately discarded and replaced with new tubing and cannula. Resident D's foley catheter bag was immediately removed from the side of the trash can. The catheter bag was replaced with a new bag and positioned below the level of bladder, ensuring the tubing was not touching the floor. CNA #4 and CNA #5 immediately educated related to hand hygiene, oxygen tubing care and maintenance, and catheter bag placement and care. Resident D monitored for any signs or symptoms of infection with no findings. 2. All residents have the potential to be affected. All residents with oxygen audited for appropriate placement of oxygen tubing and all residents with catheters audited to ensure appropriate placement of catheter bag. Oxygen tubing and catheters bags replaced and placed properly if indicated. Nursing staff educated on infection control including hand hygiene, oxygen tubing care and maintenance, and urinary catheter bag placement and care. 3. As a measure of ongoing compliance, the DHS or designee will 1) monitor 5 staff members	

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			hand hygiene 5 times per week for 4 weeks, 3 times per week for 4 weeks, weekly for 4 weeks, then monthly for 3 months; 2) audit 5 residents with oxygen for proper placement of tubing 5 times per week for 4 weeks, 3 times per week for 4 weeks, weekly for 4 weeks, then monthly x 3 months; 3) audit 3 residents with urinary catheters for proper placement of catheter bag 5 times per week for 4 weeks, 3 times per week for 4 weeks, weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Completion Date: 1/29/24	