STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155715	A. BUILDING 00 B. WING	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 18, 19, 20, 21, 24, and 25, 2023. Facility number: 000347 Provider number: 155715 AIM number: 100275440 Census Bed Type: SNF/NF: 77 Residential: 29 Total: 106 Census Payor Type: Medicare: 6 Medicaid: 47 Other: 24 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 31, 2023.	F 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karyn Fleetwood	Executive Director	08/07/2023

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	§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure the proper application of an orthotic device for a resident with a contracture (Resident 16) and failed to provide restorative nursing services for residents with limited range of motion (Residents 60 and 64) for 3 of 4 residents reviewed for limited range of motion. Findings include: 1. Resident 16 was observed on 07/18/23 at 11:31 A.M. The resident was in her wheelchair in front of the television. A neck pillow was in place. The resident's right hand was closed as though it was contracted. There was no splint or brace device in use. The resident was observed in her room in bed on 07/18/23 at 2:10 P.M. The resident was awake and moving her thumb and fingers on her left hand. The resident's right hand was closed and there was no splint device in place. The resident was observed in the common area in front of the television on 07/20/23 at 10:30 A.M. A neck pillow was in place. The resident's right hand was closed. The index and middle fingers of the resident's left hand were extended. There was no	F 0688	F 688 Increase/Prevent Decrease in ROM/Mobility It is the policy of this facility to ensure the proper application of orthotic devices for residents with contractures and to provide restorative nursing services for residents with limited range of motion. Corrective Action For Residents Affected: Resident 16 - All staff who work on Birchwood Lane were educated on the proper placement and location of the orthotic ordered for this resident. (Attachment titled Orthotic Education Birchwood Lane Staff). Resident 64 - The therapy department evaluated this resident's restorative program to ensure that it was still appropriate for the resident and his restorative care plan was updated. (Attachment titled Resident 64 Restorative Program/Care Plan). Resident 60 - The therapy department evaluated this	08/23/2023

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	splint device in place. A nursing staff member approached the resident on 07/20/23 at 10:32 A.M. and applied a splint device to the resident's left hand. The resident was observed in the common area near the television on 07/25/23 at 10:30 A.M. The resident was wearing a splint device in their left hand. CNA (Certified Nurse Aide) 11 approached the resident and offered her a drink. The resident did not take the drink. The resident's record was reviewed on 07/20/23 at 2:59 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/02/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, cerebral palsy, malnutrition, and severe intellectual disabilities. The resident's range of motion was impaired in their arms and legs, and they required extensive staff assistance for all ADLs (Activities of Daily Living). The assessment indicated the resident did not participate in therapy or restorative programs, including splint or brace assistance during the assessment review period. An Occupational Therapy Plan of Treatment for the certification period of 04/24/23 through 07/22/23 was provided by the DON (Director of Nursing) on 07/25/23 at 2:41 P.M. The treatment plan indicated the resident was left handed. The resident used sign language and managed her drinking cup with her left hand. The resident's guardian reported the resident only used her left hand to do most things. The assessment summary indicated that skilled occupational therapy was indicated to reduce the risk of skin breakdown and contracture in the resident's right palm and to develop a restorative nursing program for		resident's restorative program to ensure that it was still appropriate for the resident and her restorative care plan was updated. (Attachment titled Resident 60 Restorative Program/Care Plan). Other Residents Having The Potential To Be Affected: All residents with an orthotic or restorative program have the potential to be affected. A log of residents requiring use of splints, in accordance with care plan review, was created by the Restorative Nurse and will be updated monthly. (Attachment titled Orthotic Log). An observation was completed on all residents requiring orthotics and no other issues were identified. A log was also developed of residents with restorative programs and will be updated monthly. (Attachment titled Restorative Program Log). An audit was performed of all programs to ensure that the care provided is documented. (Attachment titled Restorative Documentation Audit). Systemic Changes And Steps To Assure Deficient Practice Doe Not Recur: Education will be completed with the Nursing Staff the week of August 14, 2023 regarding the proper placement of orthotics and the restorative program and	

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	contracture prevention. The resident's current MD orders included, but were not limited to, an open ended order, with a start date of 05/04/23, that indicated a Soft Orthosis Roylan Palm Guard with finger separators was to be worn on the resident's right hand during daytime waking hours. Instructions for wear were posted in resident's room and in the therapy book at nurses' station. Instructions for the resident's orthotic device were provided by RN 10 on 07/25/23 at 10:45 A.M. The document, dated 05/01/23, and titled "[Resident 16's] Orthosis Wear and Schedule" indicated the resident was to wear the palm guard during daytime waking hours. Staff were to clean and dry the resident's right hand/palm prior to application of the device then perform PROM (Passive Range of Motion) to the right digits as tolerated then place palm protector onto the resident's right hand. During an interview on 07/25/23 at 10:33 A.M., CNA 11 indicated the restorative nursing aides documented the application of orthotic devices in the residents' EHR (Electronic Health Record), regular CNAs did not. During an observation and interview on 07/25/23 at 10:41 A.M., CNA 11 indicated the resident's device was currently on the resident's left hand and it was supposed to be on the right hand. The resident used her left hand to hold her drink cup. The resident's right hand was more contracted than the left. The device should have been on the resident's right hand. During an interview on 07/25/23 at 10:45 A.M., RN 10 indicated she hadn't worked on the resident's		documentation. (Attachment titled Mandatory Staff Education - Plan of Correction 2023). The Restorative Nurse or designee will visualize residents with orthotics daily for one week to ensure proper and consistent use. (Attachment titled Orthotic Observation). This will be followed by weekly observations for a total of six months. The Restorative Nurse will review restorative program documentation on 25% of the residents with restorative programs weekly to evaluate the effectiveness and the documentation of the programs. This will ensure that each resident is reviewed monthly. Referrals will be made to the Therapy Department if any declines are noted. (Attachment titled Restorative Program Review). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the weekly observations and audit for six months. If appropriate practice is occurring 100% of the time, weekly monitoring will stop.	

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	hall for very long and was not sure which hand the orthotic device was supposed to be in. The current facility policy, titled "NURSING POLICY ASSISTIVE DEVICES POLICY", updated January 2021, was provided by the DON on 07/25/23 at 11:47 A.M. The policy indicated, "...The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices...to maintain or improve function...direct care staff will be trained on the use of the devices as needed...A nurse with responsibility for the resident will monitor for the consistent use of the device..." 2. The clinical record for Resident 64 was reviewed on 07/20/23 at 10:25 A.M. A Quarterly MDS assessment, dated 06/07/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, obstructive uropathy, Alzheimer's disease, depression. A suggested program, dated 06/13/23, indicated Resident 64 was to participate in a transfer and an active range of motion restorative program with staff. His goal was to pull up to a standing position using the handrail with limited assistance three to five times and to participate in active range of motion exercises to the bilateral upper and lower extremities, completing two sets for 10 to 15 repetitions The programs were added to the restorative list. The Point of Care for "Transfers", dated July 2023 lacked documenting for the following dates: - 07/01/23, - 07/04/23, - 07/08/23, - 07/15/23,			

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	- 07/16/23, and - 07/20/23. The Point of Care for "Active Range of Motion", dated June and July 2023 lacked documentation for the following dates: - 06/23/23, - 06/27/23, - 07/01/23, - 07/04/23, - 07/08/23, - 07/15/23, - 07/16/23, - 07/20/23, - 07/21/23, and - 07/22/23. 3. The clinical record for Resident 60 was reviewed on 07/20/23 at 10:42 A.M. A Quarterly MDS assessment, dated 05/30/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension and dementia. A suggested program, dated 04/25/23, indicated Resident 60 was to participate in an eating and a passive range of motion restorative program with staff. Her goal was to self-feed with supervision with 25% to 50% verbal cues and participate in passive range of motion to the bilateral upper extremities with extensive assistance for two sets with 10 repetitions each. The programs were added to the restorative list. The Point of Care for "Eating", dated July 2023 lacked documentation the following dates: - 07/02/23, and - 07/16/23.			

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	The Point of Care for "Passive Range of Motion", dated June and July 2023 lacked documentation the following dates: - 06/03/23, - 06/04/23, - 07/02/23, and - 07/16/23. During an interview on 07/25/23 at 9:57 A.M., the MDS Coordinator indicated she would receive a therapy recommendation for a restorative program and then she would add the resident to the restorative list. The residents' restorative programs were completed daily and documented in the point of care. The current facility policy titled, "Restorative Nursing Programs" and updated January 2021, was provided by the DON on 07/25/23 at 11:49 A.M. The policy indicated, "...It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level...The Restorative Nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented...Restorative aides will implement the plan for a designated length of time, performing the activities, and document the plan...The Restorative Nurse, or designated licensed nurse, will provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly..." 3.1-42(a)(2)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, interview, and observation, the facility failed to follow Care Plan interventions related to falls for 2 of 5 residents reviewed for accidents. (Residents 66 and 64) Findings include: 1. The clinical record for Resident 66 was reviewed on 07/21/23 at 11:16 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 07/07/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Neurocognitive disorder with Lewy bodies, hypertension, depression, and insomnia. The resident received scheduled and as needed pain medications. He had no falls since the last assessment. A Quarterly MDS assessment, dated 06/01/23, indicated the resident had 2 or more falls since the previous assessment, dated 03/01/23, one with an injury that was not major. The Care Plan for falls was provided by the DON (Director of Nursing) on 07/21/23 at 3:13 P.M. The record indicated the resident was at risk for falls related to a Neurocognitive disorder with Lewy Bodies. An intervention, with a start date of 04/11/2023, indicated the resident was to have	F 0689	F 689 Free of Accident Hazards/Supervision/Devices It is the policy of this facility to follow care plan interventions related to falls. Corrective Action For Residents Affected: Resident 64 - His care plan was reviewed by the Inter-Disciplinary Team and was updated to include the removal of the non-skid strips. (Attachment titled Resident 64 Falls Care Plan). Resident 66 - A maintenance order was put in to place the non-skid strips once they were identified as missing. (Attachment titled Resident 66 Completed Maintenance Work Order). Other Residents Having The Potential To Be Affected: Any resident who has non-skid strips as a fall intervention has the potential to be affected. An audit of fall care plans was completed to	08/23/2023

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	non-skid strips placed in front of the resident's toilet. A Fall Event report, dated 04/08/23, indicated the resident had a fall in his bathroom, the resident had had three or more falls in the last three months and was disoriented with diminished safety awareness. The IDT (Interdisciplinary Team) note indicated the resident was to have non-skid strips placed in front of the toilet. During an interview, record review, and observation, on 07/21/23 at 1:57 P.M., LPN (Licensed Practical Nurse) 7 indicated staff knew what the Care Plan interventions were by using the paper pocket sheets that were printed off for each staff at the beginning of each shift. A copy of the current pocket sheet was provided at that time and lacked the intervention of having non-skid strips in front of the resident's toilet. The resident's bathroom was observed with LPN 7 and non-skid strips were not in place in front of the resident's toilet. 2. The clinical record for Resident 64 was reviewed on 07/20/23 at 10:25 A.M. A Quarterly MDS assessment, dated 06/07/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, obstructive uropathy, Alzheimer's disease, depression. A Fall Event, dated 06/06/23, indicated the resident had an unwitnessed fall in his room. The resident was sitting on the side of his bed with his breakfast. The resident's legs were wrapped in his blanket, and he was sitting on the floor with his back against the bed. He denied hitting his head and was able to move all extremities. No injuries were noted.		determine if any other residents had this as a fall intervention and to determine if they were in place. (Attachment titled Non-Skid Strip Fall Intervention Audit). Systemic Changes And Steps Top Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff the week of August 14, 2023 regarding the need to notify Nursing Leadership and Maintenance if the non-skid strips become loose or need to be removed so the care plan can be updated. (Attachment title Mandatory Staff Education - Plan of Correction 2023). The Director of Nursing or designee will complete a weekly observation of all residents with non-skid strips as a fall intervention to ensure that they are in place or if the care plan needs to be updated if the non-skid strips are removed. (Attachment titled Non-Skid Strips Observation). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will review the results of the weekly observations for six months to ensure that the deficient practice does not recur. If the appropriate intervention is in place 100% of the time, the weekly monitoring will stop. The prevention of falls is a high priority	

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	An IDT Note, dated 06/06/23 at 4:55 P.M., indicated the resident had a fall on 06/06/23 at 8:30 A.M. An intervention to prevent further falls was to place non-skid strips to the floor of the right side of the bed. The Complete Care Plan was provided by the DON on 07/21/23 at 3:13 P.M. The care plan included, but was not limited to, falls with a start date of 10/24/22. The intervention, with a start date of 06/06/23, indicated the resident was to have non-skid strips on the floor of the right side of the bed. During an observation on 07/21/23 at 2:15 P.M., the resident's room was observed and there were no non-skid strips by the bed. During an observation and interview on 07/21/23 at 2:17 P.M., the resident's room did not have non-skid strips present. CNA 15 indicated the resident had frequent falls. The resident had been in the same room for a while. The resident used to have non-skid strips by his bed, but they were coming up and no longer there. She wasn't sure how long the strips had been gone. The clinical record lacked any indication the non-skid strips had been removed or discontinued. The current facility policy titled, "Fall Prevention Program", with a revised date of 01/01/23 was provided by the DON on 07/21/23 at 3:13 P.M. The policy indicated, "...Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls...Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's		for the organization and is a standing agenda item for this committee and will be reviewed on an ongoing basis.	

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	comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed..." The current, undated, facility policy titled, "Care Plans- Comprehensive", was provided by the DON on 07/21/23 at 3:13 P.M. The policy indicated, "...An individualized comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. The care plan is based on the understanding of the resident's strength, goals, life history, and preferences...The care plan is accessible to any person involved in the implementation of the care plan..." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §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			

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	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, interview, and record review, the facility failed to follow appropriate infection control guidelines related to indwelling urinary catheter care for 2 of 3 residents reviewed for urinary catheters and Urinary Tract Infections. (Residents 64 and 76) Findings include: 1. During an observation on 07/19/23 at 10:12 A.M., Resident 64 was at the end of a hallway, sitting in his wheelchair. His indwelling urinary catheter tubing was dragging the floor. During an observation on 07/19/23 at 1:38 P.M., the resident was sitting at the dining room table. The resident's indwelling urinary catheter tubing was resting on the floor. During an observation on 07/20/23 at 1:57 P.M., QMA (Qualified Medication Aide) 12 propelled the resident from the dining room to the common area in front of the TV. The indwelling urinary catheter tubing was dragging the floor.	F 0690	F 690 Bowel/Bladder Incontinence, Catheter, UTI It is the policy of this facility to follow appropriate infection control guidelines related to indwelling catheter care. Corrective Action For Residents Affected: Observations during the annual survey on Resident 64 and Resident 76 were in the past and could not be corrected. Other Residents Having The Potential To Be Affected: Any resident who has a catheter has the potential to be affected. An audit was completed on all residents to develop a list of all residents with foley catheters so that observations could be completed. (Attachment titled Residents With Foley Catheters	08/23/2023

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	155715	A. BUILDING 00 B. WING	07/25/2023

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	During an observation and interview on 07/24/23 at 11:36 A.M., the resident was sitting in the common area with his indwelling urinary catheter tubing resting on the floor under the resident's foot. QMA 8 indicated the resident's indwelling urinary catheter tubing should not touch the floor. The clinical record was reviewed on 07/20/23 at 10:25 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/07/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, obstructive uropathy, Alzheimer's disease, and depression. A Progress Note, dated 05/04/23, indicated the resident had received a 1 gram Rocephin (an antibiotic) IM (intramuscular) injection in the buttock, for a UTI (Urinary Tract Infection). 2. On 07/18/23 at 1:54 P.M., an isolation cart was observed sitting in the hallway outside of Resident 76's room. A passing staff member indicated the resident had ESBL (Extended Spectrum Beta-Lactamase, an enzyme found in some strains of bacteria) in his urine. During an observation and interview on 07/18/23 at 1:41 P.M., Resident 76 indicated he had an indwelling urinary catheter because he had an infection. He had been on an antibiotic for the infection. During an observation on 07/20/23 at 1:29 P.M., the resident was sitting in his wheelchair in his room. One to two inches of his indwelling urinary catheter tubing was touching the floor. An isolation cart was still sitting in the hall outside the resident's room door.		Log). Observations were then completed to ensure that the catheter bag and tubing were not touching the floor or attached to a trash can. (Attachment titled Foley Catheter Observation). Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff the week of Augst 14, 2023 regarding the proper placement of catheter bags and tubing to prevent infections. (Attachment titled Mandatory Staff Education - Plan of Correction 2023). The Director of Nursing or designee will complete weekly observations of all residents with foley catheters to ensure the deficient practice does not recur. (Attachment titled Foley Catheter Observation). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the weekly observations monthly for six months. If proper practice is occurring 100% of the time, weekly audits will stop although infections, including urinary tract infections, are a standing agenda item for this committee to review and discuss.	

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	During an observation on 07/20/23 at 2:32 P.M., the resident was sitting in his wheelchair in his room. His indwelling urinary catheter tubing was touching the floor. A facility staff member was sitting in the room reviewing the meal menus with the resident. During an observation on 07/20/23 at 2:59 P.M., the resident was sitting in his wheelchair in his room. Over an inch of his indwelling urinary catheter tubing was touching the floor. Two staff members, RN 5 and CNA (Certified Nurse Aide) 4, donned PPE (Personal Protective Equipment) before assisting the resident to bed using a mechanical lift. While the CNA pushed the wheelchair into place, the tubing was dragging on the floor making a scraping sound. The staff attached the resident's harness to the lift, moved the resident over the recliner, and lowered the resident into the seat. The nurse pulled a small trash can up next to the resident's recliner, hung the indwelling urinary catheter bag to the side of the trash can, then picked a piece of trash up off the floor and tossed it in the trash can. During an observation on 07/24/23 at 11:22 A.M., the resident was sitting in his recliner in his room. His indwelling urinary catheter bag was covered with a dignity bag with two to three inches of the bag laying on the floor at the side of his recliner. The floor was wet in the immediate area. During an observation and interview with RN 5 on 07/24/23 at 11:28 A.M., the resident was still sitting in his recliner with his indwelling urinary catheter bag laying on the floor. RN 5 indicated staff had hooked the catheter bag to the side of the resident's recliner. They normally hung it on the trash can. The facility policy did not say anything about where they should hang the			

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	catheter bags, they just needed to be off the floor. The resident was still in isolation for ESBL in his urine. During an interview on 07/24/23 at 12:33 P.M., LPN 7 indicated indwelling urinary catheters should be kept off the floor and hanging below the bladder. Urinary catheters should not be hung on a trash can. The clinical record was reviewed on 07/20/23 11:24 AM. An Admission MDS assessment, dated 07/06/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fracture of left fibula, renal insufficiency, obstructive uropathy, and UTI in the last 30 days. The resident had an indwelling urinary catheter in place and was frequently incontinent of bowel. The Progress Notes for June and July 2023 were provided by the Administrator on 07/24/23 at 12:36 P.M., and included, but were not limited to, the following: - A note, dated 06/29/23 at 8:40 P.M., indicated the resident was on IV (Intravenous) antibiotics for a UTI with ESBL. The physician's orders were provided by the Administrator on 07/24/23 at 1:54 P.M., and included, but were not limited to, the following: - The resident received Meropenem (an antibiotic) one gram intravenous, every 12 hours with a start date of 06/29/23, and a discontinued date of 07/03/23, and - a current open-ended order to keep catheter and tubing as free of kinks as possible. Maintain			

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	catheter bag below level of the bladder but do not allow to rest on the floor, every shift, with a start date of 06/29/23. The Care Plan indicating the resident had an indwelling urinary catheter for a diagnosis of obstructive uropathy, with a start date of 06/29/23, was provided by the Administrator on 07/24/23 at 12:36 P.M. The interventions included, but were not limited to, "...Keep catheter and tubing as free of kinks as possible. Maintain catheter bag below level of the bladder but do not allow to rest on the floor..." The current Catheters - Catheter Care policy, updated in January 2021, was provided by the Administrator on 07/24/23 at 12:36 P.M. The policy indicated, "...It is the policy of this facility to provide catheter care to all residents that have an indwelling catheter to assist in reducing bladder and kidney infections..." 3.1-41(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and			

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	permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately related following manufacturer's guidelines, labeling medication, and having unsecured loose tablets in the medication carts for 4 of 5 medication carts reviewed. (Medication Carts One and Two on the 100 Hall, and Medication Carts One and Two on the 200 Hall) Findings include: 1. The 100 Hall Medication Carts were observed on 07/18/23 at 10:20 A.M., with RN 2. Cart One contained the following items and loose pills laying in the bottom of drawers: - an Albuterol inhaler with a spacer attached, laying on its side in the bottom drawer for Resident 11, - three small white oval tablets, - one medium white oval tablet, - one small white round tablet, and - one medium pink round tablet. Cart Two contained the following items and loose pills laying in the bottom of drawers:	F 0761	F 761 Label/Store Drugs and Biologicals It is the policy of this facility to store medications appropriately related to following manufacturer's guidelines, labeling medication, and having unsecured loose tablets in the medication carts. Corrective Action For Residents Affected: All inhalers were stored upright and loose pills were discarded. Staff were educated on the need to keep the box of corn starch closed and to use a new spoon each time. The resident name was added to the Nystatin and the eye ointment was replaced with a new one and the date opened was added. Other Residents Having The Potential To Be Affected: All residents who receive medication have the potential to be affected. A medication cart	08/23/2023

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	- a Fluticasone inhaler laying on its side in a box for Resident 65, - a box of cornstarch with the top of the box open, the powder cornstarch visible, with a plastic spoon sticking up out of the cornstarch powder that RN 2 indicated was for Resident 18 who used it under her breasts, - one small white oval tablet, - one medium white oval tablet, - two medium white round tablets, and - one large white round tablet. RN 2 indicated inhalers were normally kept upright. Flonase had to be stored upright. 2. The 200 Hall Medication carts were observed on 07/18/23 at 10:37 A.M., with QMA (Qualified Medication Aided) 3. Cart One contained the following items and loose pills laying in the bottom of drawers: - one opened tube of Nystatin ointment with no resident name or label, - one small tube of Erythromycin eye ointment for Resident 16 with no open date, - a Symbicort inhaler for Resident 21 laying on its side in the third drawer, - four small white oval tablet halves, - one small white rectangular tablet, and - one small pink oval tablet half. Cart two contained the following loose pills laying in the bottom of drawers: - one medium orange round tablet, - one small white oval tablet half, and - one large red round tablet was laying on the floor under the cart.		audit was completed on all medication carts the week of August 7, 2023. Every medication cart in the facility was audited for storage of inhalers, loose pills, and proper labeling of medications with the resident's name and open dates. (Attachment titled Medication Storage Audit). Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff the week of August 14, 2023 regarding the need to store inhalers upright in the cart, to discard any loose pills, to label tubes of ointments with the resident's name, and to label with the date when opened. (Attachment titled Mandatory Staff Education - Plan of Correction 2023). The Director of Nursing or designee will complete a medication audit weekly of all medication carts to ensure that the deficient practice does not recur. (Attachment titled Medication Storage Review). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the weekly audits monthly for three months. If appropriate practice is occurring 100% of the time, weekly monitoring will stop, and monthly audits will occur for	

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	During an interview on 07/18/23 at 11:02 A.M., QMA 3 indicated inhalers should be stored upright and at room temperature. During an interview on 07/25/23 at 10:30 A.M., the ADON (Assistant Director of Nursing) indicated they had had a staff member, QMA 13, doing the medication cart audits weekly but that staff member had gone back to working the floor. The current Medication Storage Policy, updated in January of 2021, was provided by the Administrator on 07/25/23 at 11:01 A.M. The policy indicated, "...It is the policy of this facility to ensure all medications housed on our premises will be stored...according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security..." 3.1-25j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)		the next three months. If after six months of audits, 100% compliance continues, auditing will stop although monthly pharmacy audits will continue.	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories			

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	specified in part 493 of this chapter. Based on record review and interview, the facility failed to follow a physician's recommendation related to a urinalysis for 1 of 19 residents reviewed for laboratory services. Findings include: The clinical record for Resident 64 was reviewed on 07/20/23 at 10:25 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 06/07/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, obstructive uropathy, Alzheimer's disease, and depression. A Psychiatry Progress Note, dated 06/06/23, indicated the resident was sitting in his room. Per the nursing staff, the resident had not displayed any sadness or tearfulness. He had decreased agitation but continued to to be restless and had multiple falls trying to get up unassisted. The resident had some nights where he was awake and not sleeping. His appetite seemed fair. He was having increased aggression and inappropriate sexual behaviors. The assessment and plan, included but was not limited to, "...Recent UTI (Urinary Tract Infection): Recommend rechecking a Urinalysis [UA] to make sure it is cleared. Reviewed recent UA and was positive with Proteus mirabilis and pseudomonas aeruginosa..." The resident laboratory results from May to current were provided by the DON (Director of Nursing) on 07/25/23 at 11:04 A.M. The results lacked a urinalysis. The clinical record lacked any indication that the recommendation was acknowledged.	F 0770	F 770 Laboratory Services It is the policy of this facility to follow physician recommendations related to a urinalysis. Corrective Action For Resident Affected: Resident 64 - The need for a urinalysis was discussed with the provider during the survey and it was determined that it was not necessary. The surveyors were notified of this prior to their departure. (Attachment titled Urinalysis Documentation From NP). Other Residents Having The Potential To Be Affected: Any resident who had a visit from the Psych Nurse Practitioner has the potential to be affected. Psych notes for the past three months were audited to determine that all recommendations for labs were followed up on. (Attachment titled Psych NP Notes Audit). A new Psych Nurse Practitioner is providing service in the facility and notes are coming in more timely than in the past. Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: Education will be completed with the Nursing Staff the week of August 14, 2023 of the need to ensure that any recommendation	08/23/2023

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	During an interview on 07/25/23 at 10:55 A.M., the DON indicated when the psychiatry physician came to the facility, she would make recommendations and the facility Nurse Practitioner would either agree or disagree with the recommendations. The Social Service Director would review the psychiatry notes that were available, see if there were any additional recommendations, and send them to the Nurse Practitioner. If the Nurse Practitioner agreed with the recommendation, she would input the orders or a nurse on the floor would input them. She believed the urinalysis wasn't put on the list for the Nurse Practitioners review. There should have been a note that the Nurse Practitioner agreed or disagreed with the recommendation. The current, undated, facility policy tilted, "Physician Orders" was provided by the DON on 07/25/23 at 11:49 A.M. The policy indicated, "...Physician orders must be given and managed in accordance with applicable laws and regulations..." 3.1-49(a)		for a lab is communicated to the provider. (Attachment titled Mandatory Staff Education - Plan of Correction 2023). Any recommendations will be forwarded to the provider for review. The Director of Social Service will complete an audit monthly on all Psych NP Notes for lab recommendations to ensure follow-up. (Attachment titled Psych NP Notes Audit). Monitoring of Corrective Action: The Quality Assurance Performance Improvement Committee will monitor the results of the audits monthly for six months. If appropriate practice is occurring 100% of the time, monthly audits will stop although the Director of Social Services will continue to monitor all recommendations for follow-up.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 18, 19, 20, 21, 24, and 25, 2023. Facility number: 000347 Residential Census: 29 Lutheran Community Home was found to be in	R 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible	

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	compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on July 31, 2023.		allegation of compliance.	