STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155267	A. BUILDING 00 B. WING	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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 27, 28, 29, and 30, 2024 Facility number: 000168 Provider number: 155267 AIM number: 100267020 Census Bed Type: SNF/NF: 62 Total: 62 Census payor type: Medicare: 2 Medicaid: 42 Other: 18 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 4, 2024.	F 0000	***This Plan of Correction constitutes the written allegation of compliance for deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey re-visit on or after 09-30-2024***	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to catheter bag and tubing touching the floor for a resident with an indwelling urinary catheter for 1 of 5 residents reviewed for Urinary Tract Infections. (Resident 35) Findings include:	F 0690	It is the policy of this facility to ensure that each resident with indwelling catheters receive appropriate care and services that prevent infections. What corrective action will be done by the facility? All nursing staff were re-educated regarding appropriate care and services for residents who have	09/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richey Barton	Executive Director	09/17/2024

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	During the Resident Council Meeting observation, on 8/28/24 at 1:45 p.m., the Resident 35's indwelling urinary catheter tubing could be heard dragging the floor as the Activities Director was pushing the wheelchair the resident was in, to the table. One of the wheelchair wheels ran over the indwelling urinary catheter tubing. The record for Resident 35 was reviewed on 8/29/24 at 2:51 p.m. The resident's diagnoses included, but were not limited to, dementia, anemia, obstructive and reflux uropathy, stage 3 chronic kidney disease, anuria and oliguria, and urinary tract infection. The care plan, dated 5/2/23, indicated the resident required an indwelling urinary catheter due to obstructive uropathy. The interventions, dated 5/2/23, indicated to avoid obstructions in the drainage, and do not allow tubing or any part of the drainage system to touch the floor. The nurse's note, dated 12/20/23 at 5:16 a.m., indicated the resident's catheter bag was found leaking onto the floor. A new catheter bag was put in place. The nurse's note, dated 1/13/24 at 5:57 p.m., indicated a new indwelling urinary catheter was in place related to the resident's complaints of pain and pressure. Yellow urine was in the BSD (bedside drain). The resident indicated that it was starting to feel better. The IDT (Interdisciplinary team) note, dated 1/15/24 at 3:50 p.m., indicated the resident was admitted to a local hospital with diagnoses of hypoxia and acute UTI (urinary tract infection). The urine culture results from the urine collection,		indwelling catheters, including assurance that the resident's catheter bag and tubing do not touch the floor at any time. Resident 35 catheter tubing has been adjusted to ensure tubing does not touch the floor. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents having catheters have the potential to be affected. If any resident with an indwelling catheter is observed to have his/her catheter tubing and/or catheter drainage bag touching the floor, the DNS/designee will address the issue with the staff involved at that time. Once the staff reposition the bag and tubing are in the proper position, the DNS/designee will re-train the staff involved on the facility policy regarding how the drainage bag and tubing should be placed so that it does not touch the floor. Written counseling will be completed for continued noncompliance. What measures will be put into place to ensure that this practice does not recur? DNS will conduct rounds each shift to ensure catheter tubing is placed appropriately. How will corrective action be monitored to ensure the practice does not recur and what QA will	

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	on 1/15/24, reported results, dated 1/23/24, had greater than 2 organisms recovered. There was greater than 100,000 colony forming units. The Quarterly MDS (Minimum Data Set) assessment, dated 4/18/24, indicated the resident was cognitively intact. During an interview and tour with the DON (Director of Nursing) on 8/30/24 at 8:20 a.m., the catheter tubing should be secured with a clip device when residents were in their wheelchairs. The tubing should not be dragging the floor. Staff should check for the tubing location when a resident was in their wheelchair, to make sure the tubing wasn't dragging the floor and to make sure the clip device was holding the tubing. During an interview on 8/30/24 at 8:44 a.m., the IP (Infection Preventionist) indicated the indwelling urinary catheter tubing and bag should be kept off the floor to prevent pinching and infection. She last educated staff on catheter monitoring and care in March, April, July and August 2024. During an interview on 8/30/24 at 8:45 a.m., the Activities Director indicated she would watch for the catheter tubing to make sure it was fastened under the wheelchair. She heard the sound when she pushed the wheelchair up to the table for Resident Council, but thought it was just the brakes making the sound. She would be more mindful in the future of the tubing. During an interview on 8/30/24 at 9:00 a.m., QMA (Qualified Medication Aide) 4 indicated the aides performed catheter care often during their shift. The Nursing policy, last revised June 2024, included, but was not limited to, " ... b. Urinary		be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the Catheter QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance Date: 09-30-2024	

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	catheters should have a catheter bag cover over them or a wash basin underneath them as a barrier to prevent catheter bag or tubing from touching the ground ..." 3.1-41(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure that infection control practices were followed related to placement of the indwelling urinary catheter tubing and bag at the bedside for 1 of 3 residents observed for infection control prevention. (Resident 34) Findings include: During an initial observation on 8/27/24 at 8:31 a.m., Resident 34's indwelling urinary catheter bag was in a bath basin, but the tubing was on the floor. During an observation on 8/29/24 at 10:33 a.m., the resident was asleep in bed and her catheter bag was sitting on the floor. During an observation on 8/29/24 at 2:32 p.m., the resident was asleep in bed with her catheter bag folded in half on the fall mat with her bed in its' lowest position. The tubing was on the fall mat. During an observation on 8/30/24 at 8:17 a.m., the resident's tubing was on the floor under the indwelling urinary catheter bag and the bag was scrunched down. There was orange urine backed up in the tubing up to the resident's upper leg. The record for Resident 34 was reviewed on	F 0880	It is the policy of this facility to ensure that each resident with indwelling catheters receives appropriate care and services for infection prevention. What corrective action will be done by the facility? All nursing staff were re-educated regarding infection prevention r/t residents who have indwelling catheters, including assurance that the resident's catheter bag and tubing do not touch the floor at any time. Resident 34 no longer has indwelling catheter. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents having catheters have the potential to be affected and are at increased risk of infection. All resident with catheters were reviewed to ensure tubing was appropriately placed. If any resident with an indwelling catheter is observed to have his/her catheter tubing and/or	09/30/2024

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	8/29/24 at 2:38 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic nephropathy, anemia, obstructive and reflux uropathy, personal history of urinary tract infections with ESBL (extended spectrum beta lactamase), and the need for assistance with personal care. The Quarterly MDS (Minimum Data Set) assessment, dated 3/8/24, indicated the resident was cognitively intact. She required substantial assistance with toileting. The care plan, dated 4/16/24 indicated the resident required an indwelling urinary catheter related to obstructive and reflux uropathy. The intervention, dated 4/16/24, included, but was not limited to, do not allow the tubing or any part of the drainage system to touch the floor. The nurse's note, dated 4/30/24 at 11:13 p.m., indicated the resident's Foley catheter to the bedside drain was in place and patent with dark brown colored urine. The nurse's note, dated 5/5/24 at 1:38 p.m., indicated the CNA (Certified Nurse Aide) notified the nurse of blood in the resident's indwelling urinary catheter bag. The urine was assessed with a moderate amount of hematuria and a small clot in the tubing. The resident denied burning or pain to the area. Hospice was notified and the nurse waited for a return call. The nurse's note, dated 5/5/24 at 2:57 p.m., indicated hospice placed a new order to discontinue the Eliquis and continue to monitor for hematuria or worsening. The nurse's note, dated 5/8/24 at 11:06 p.m.,		catheter drainage bag touching the floor, the DNS/designee will address the issue with the staff involved at that time. Once the staff reposition the bag and tubing are in the proper position, the DNS/designee will re-train the staff involved on the facility policy regarding how the drainage bag and tubing should be placed so that it does not touch the floor. Written counseling will be completed for continued noncompliance. What measures will be put into place to ensure that this practice does not recur? DNS/designee will conduct rounds each shift to ensure tubing is placed appropriately. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the Infection Control QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance Date: 09-30-2024	

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	indicated the hematuria was resolving. The resident showed no signs or symptoms of discomfort. During an interview on 8/30/24 at 8:20 a.m., the DON (Director of Nursing) indicated the indwelling urinary catheter bag did not need to be in the position it was in. This could cause infections. The catheter bag was supposed to be placed in a bath basin. Staff should check the catheter bag and tubing every time they go into a resident's room. During an interview on 8/30/24 at 8:44 a.m., the IP (Infection Preventionist) indicated the indwelling urinary catheter tubing and bag should be kept off the floor to prevent pinching and infection. She last educated staff on catheter monitoring and care in March, April, July and August 2024. The Nursing policy, last revised June 2024, included, but was not limited to, " ... b. Urinary catheters should have a catheter bag cover over them or a wash basin underneath them as a barrier to prevent catheter bag or tubing from touching the ground ..." 3.1-18(l)			