

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Lake Pointe Village		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W Moonglo Rd Scottsburg, IN 47170	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>34309</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>The urine culture results from the urine collection, 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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Quarterly MDS (Minimum Data Set) assessment, dated 4/18/24, indicated the resident was cognitively intact.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>3.1-41(a)(2)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34309</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The record for Resident 34 was reviewed on 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.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 3/8/24, indicated the resident was cognitively intact. She required substantial assistance with toileting.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse's note, dated 5/8/24 at 11:06 p.m., indicated the hematuria was resolving. The resident showed no signs or symptoms of discomfort.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>3.1-18(l)</p>		