STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lowell Healthcare	710 Michigan St Lowell, IN 46356

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32582 Based on observation, record review and interview, the facility failed to ensure a resident with edema received the necessary care and treatment related to Medigrips (elastic type stocking) not in place as ordered for 1 of 2 residents reviewed for edema. (Resident 12) Finding includes: On 12/8/24 at 1:18 p.m., Resident 12 was observed seated in her wheelchair. Her legs were discolored a light purple and swollen, there were no Medigrips on her legs. On 12/10/24 at 1:22 p.m., the resident was observed in bed. Her legs were discolored, swollen and there were no Medigrips in place. On 12/11/24 at 9:38 a.m., the resident was observed with RN 1 seated in her wheelchair. There were no Medigrips in place. The RN indicated she was unsure who was responsible for putting them on or removing them. The RN later indicated the Medigrip order had been discontinued. The resident's record was reviewed on 12/10/24 at 10:54 a.m. Diagnoses included, but were not limited to, venous insufficiency, hypertensive heart disease with heart failure and dementia. The Quarterly Minimum Data Set assessment, dated 10/3/24, indicated the resident had significant cognitive impairment and required substantial assistance with bed mobility, transfers and toileting. A Physician's Order, dated 11/22/23, indicated to apply Eucerin cream generously to BKE (below knee extremities), then apply Medigrip size G cut to at least 55 centimeters daily. The November and December 2024 Medication Administration Record indicated the Eucerin and Medigrips were signed out daily as completed. There was no indication the order had been discontinued. During an interview on 12/11/24 at 9:53 a.m., the Director of Nursing (DON) indicated she thought the order had been discontinued due to the resident refusing them. She was made aware the order was still in place and being signed out as completed, no refusals were documented. The DON indicated they would correct the order. 3.1-37(a)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32582 Based on observation, record review and interview, the facility failed to ensure a resident received the necessary treatment for a pressure ulcer related to the incorrect treatment provided during wound care for 1 of 3 residents reviewed for pressure ulcers. (Resident 73) Finding includes: On 12/11/24 at 9:15 a.m., Resident 73's wound care was observed with the Wound Nurse. The resident had a stage 4 pressure ulcer to her sacral area. The nurse positioned the resident on her left side and removed the old dressing. She cleansed the wound bed with Anasept (a wound cleanser) and gauze. She then applied a sheet of collagen to the wound bed and a piece of Maxorb (absorbent material used for wounds). The wound nurse then used an absorbent island border dressing to cover the wound. The resident's record was reviewed on 12/9/24 at 12:55 p.m. Diagnoses included, but were not limited to, multiple sclerosis, diabetes mellitus and stage 4 pressure ulcer. The Quarterly Minimum Data Set assessment, dated 11/22/24, indicated the resident was cognitively intact and required moderate assistance for bed mobility and was dependent on staff for transfers. A Physician's Order, dated 11/26/24, indicated to cleanse the wound with Anasept, apply collagen, then apply Maxorb AG cut to fit, apply Sureprep to surrounding skin then cover with super absorbent dressing. During an interview on 12/11/24 at 9:35 a.m. with the Wound Nurse, she indicated she had forgotten to apply the Sureprep to the skin as ordered. 3.1-40(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32788 Based on observation, record review and interview, the facility failed to ensure a medication was kept in a locked medication cart at all times for 1 of 6 residents observed during medication administration. (Resident 10) Finding includes: On 12/11/24 at 9:17 a.m., QMA 1 was observed preparing medications for Resident 10. She indicated she could not find the resident's Miralax (a laxative medication) so she could not administer it. She notified RN 1 that she could not find the medication. RN 1 indicated she would look in the medication room to see if it was with the overflow medications. QMA 1 finished preparing the resident's other medications and gave them to the resident. On 12/11/24 at 9:33 a.m., QMA 1 began preparing Resident 9's medications. RN 1 approached the medication cart and indicated she was able to get Resident 10's Miralax from the Pyxis (a medication dispensing machine). She handed the Miralax medication to QMA 1. QMA 1 wrote Resident 10's name on the medication and set it on top of the medication cart. She then continued to prepare Resident 9's medications, entered Resident 9's room and administered his medications. QMA 1 had not put Resident 10's Miralax in the medication cart and it remained on top of the medication cart, out of her sight, while she was administering Resident 9's medications. On 12/11/24 at 10:01 a.m., QMA 1 exited Resident 9's room and returned to the medication cart. She took Resident 10's Miralax from the top of the medication cart and administered it to Resident 10. During an interview on 12/11/24 at 11:32 a.m., the Director of Nursing was made aware the QMA had not stored the medication properly. A Medication Storage policy was requested. A facility policy, titled Medication Storage and Expiration Policy, indicated, .3. Medications including treatment items should be stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors . 3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45666 Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to touching food with dirty gloves. This had the potential to affect 76 residents who received food from the kitchen. (Main Kitchen) Findings include: 1. During a follow-up tour of the kitchen on 12/11/24 at 12:00 p.m., [NAME] 1 was observed donning gloves. He picked up a box of cellophane wrap and moved it, then picked up a cardboard box containing frozen sausage patties. He opened the box of the frozen sausage patties with the same gloved hands, opened the plastic bag inside, scooped out handfuls of the sausage patties with the same gloved hands, and placed the patties on a baking sheet. He did not perform hand hygiene or change his gloves during the preparation of the food. 2. On 12/11/24 at 12:03 p.m., the Dietary Food Manager (DFM) was observed preparing food for lunch. She had placed a baking sheet that was covered by a single layer of cellophane wrap on the food preparation counter. She manipulated the cellophane wrap to try and cover the baking sheet containing bread and then moved a box of cellophane wrap. She donned clean gloves, removed a new sheet of cellophane wrap from the box, and placed it on the countertop. She removed the old cellophane wrap from the baking sheet, picked up pieces of bread with the same gloved hands, and proceeded to prepare the food. She then covered the baking sheet with the new cellophane wrap and removed her gloves. The DFM did not change her gloves or perform hand hygiene. At the time, the DFM indicated she would dispose of the food that was touched with the gloves. A policy titled, Use of Gloves, indicated .Procedure 1. Clean gloves will be worn when handling any food directly. 2. Gloves are not a substitute for handwashing. Hands will be washed before putting on gloves and upon removal .4. Gloves are just like hands; they get soiled. Anytime a contaminated surface is touched, gloves must be changed and hands washed. 5. Gloves should only be utilized for one task. Gloves should be changed between tasks or if a single task lasts longer than 4 hours. 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 32788 Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were maintained, related to staff touching pills during medication administration for 3 of 6 residents observed during medication administration. (Residents 71, 10, and 9) The facility also failed to ensure reuseable equipment was disinfected after use on residents for 2 of 6 residents observed during medication administration. (Residents 10 and 47) Findings include: 1. On 12/11/24 at 9:06 a.m., QMA 1 was observed preparing Resident 71's medications. She popped each pill out of the medication cards one at a time, into her hand, and then put them in a medication cup. She then administered the medications to the resident and continued to the next resident. At 9:17 a.m., QMA 1 was observed preparing Resident 10's medications. She popped multiple pills out of the medication cards one at a time, into her hand, and then put them in a medication cup. She then administered the medications to the resident and continued to the next resident. At 9:33 a.m., QMA 1 was observed preparing Resident 9's medications. She popped multiple pills out of the medication cards one at a time, into her hand, and then put them in a medication cup. She then administered the medications to the resident and continued to the next resident. During an interview on 12/11/24 at 11:32 a.m., the Director of Nursing was made aware QMA 1 had touched the medications with her hands. A Medication Administration policy was requested. A facility policy, titled Medication Administration (Medication Pass Procedure), indicated, .5. Medications are opened without contaminating. 2. On 12/11/24 at 9:17 a.m., QMA 1 was observed preparing Resident 10's medications. She obtained the blood pressure machine rolling cart from the Nurse's Station and entered the resident's room. QMA 1 applied the blood pressure cuff to the resident's left arm and turned on the machine. When the blood pressure was completed, QMA 1 removed the blood pressure cuff, rolled it up and returned it to the cart. The resident's blood pressure reading was low, so she informed RN 1. RN 1 then re-applied the blood pressure cuff to the resident's left arm and turned on the machine. When the blood pressure was completed, RN 1 removed the blood pressure cuff, rolled it up and returned it to the cart. Neither QMA 1 nor RN 1 had cleaned or disinfected the blood pressure cuff before or after use. 3. On 12/11/24 at 10:04 a.m., QMA 1 was observed preparing Resident 47's medications. She obtained the blood pressure machine rolling cart from the hallway and entered the resident's room. QMA 1 applied the blood pressure cuff to the resident's left arm and turned on the machine. When the blood pressure was completed, QMA 1 removed the blood pressure cuff, rolled it up and returned it to the cart. QMA 1 had not cleaned or disinfected the blood pressure cuff before or after use. During an interview on 12/11/24 at 11:32 a.m., the Director of Nursing was made aware QMA 1 and RN 1 had not cleaned the blood pressure cuff before or after use. A reuseable equipment cleaning policy was requested. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy, titled Equipment Cleaning, indicated, .Electrical equipment .4. Select appropriate germicidal/disinfectant spray or aerosol to cover all surfaces. 5. Follow label recommendations for sit time prior to wiping off sprayed surfaces . 3.1-18(b)