| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155715 | A. Building<br>B. Wing | 09/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lutheran Community Home | 111 W Church Ave<br>Seymour, IN 47274 |

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) |
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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>34232<br><br>Based on interview, observation, and record review, the facility failed to provide perineal care in an appropriate manner for a resident with a history of UTIs (Urinary Tract Infections) for 1 of 3 residents reviewed for UTIs. ( Resident 55)<br><br>Findings include:<br><br>During an interview on 09/05/24 at 12:55 P.M., Resident 55 indicated she had recently been tested for a UTI and was unsure if the facility had started them on an antibiotic. When being toileted, the resident indicated some of the staff members cleaned them well, and some did not.<br><br>(continued on next page) |

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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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Morning care for the resident was observed on 09/12/24 at 9:39 A.M. CNA (Certified Nurse Aide) 2 gathered clean linens from a linen closet in a common hallway and entered the resident's room. The CNA assisted the resident from her bed to the bathroom, donned gloves, removed their brief, helped the resident to sit on the toilet, removed her gloves, and gave the resident a moment to use the toilet. The CNA used hand sanitizer then went out into the resident's room to gather clothes for the day and reentered the bathroom. The CNA donned gloves, wet a couple of washcloths and left them lying in the bathroom sink bowl. She applied soap to one cloth, handed it to the resident to wash her face, put the soapy cloth back in the sink, picked a wet cloth out of the sink, handed it to the resident to rinse her face, rinsed the cloths with water, leaving them both lying in the sink, and handed the resident a small towel to dry her face. The CNA added soap to one cloth, handed it to the resident to wash under her breasts and arms, put the soapy cloth back in the sink bowl, picked a wet cloth out of the sink, handed it to the resident to rinse the soap off, placed the cloth back in the sink, handed the resident the towel to dry with, then assisted her with her shirt. The CNA removed her gloves, wrapped a clean brief around the resident's legs, put the resident's glasses on, removed the resident's shoes, assisted her with her pants, pulling them up to her knees, used hand sanitizer, put the resident's shoes back on her feet, and donned clean gloves. The CNA assisted the resident to a standing position, rinsed the two washcloths in water, put soap on one, wiped the resident's buttocks, wiped the buttocks with the other wet cloth, left the two cloths in the sink, and dried the resident's backside. The CNA rinsed the cloths, left them lying in sink, added soap to one cloth, briefly wiped at the front of the resident's private area, wiped with the rinsing cloth, then wiped with the towel. The CNA removed her gloves, adjusted the resident's brief, then assisted the resident to wash her hands and move to her wheelchair in the resident's room. During an interview and observation, in the resident's bathroom, the CNA indicated she used two washcloths, a soapy one, one to rinse, and a small towel to dry. The washcloths used were observed on the side of the sink. The soapy washcloth was marked with a two-inch wide streak of brown feces. There were only the two washcloths and one small towel in the bathroom that had been used for the procedure.<br><br>During an interview on 09/12/24 at 10:02 A.M., when toileting a resident, CNA 2 indicated you should wash the front of the peri area first, and she had not done it that way with Resident 55.<br><br>During an interview on 09/12/24 at 1:55 P.M., RN 3 indicated Resident 55 had a lot of UTIs. Usually when she had a UTI she would complain of burning. The resident had received antibiotics through an IV (Intravenous) line and IM (Intramuscularly) at times due to having a lot of allergies to antibiotics. The resident currently received the antibiotic Linezolid for a UTI. Other than IV antibiotics, the Linezolid was the only one the resident was not allergic too and it came in pill form.<br><br>The clinical record was reviewed on 09/12/24 at 2:10 P.M. An Annual MDS (Minimum Data Set) assessment, dated 09/03/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, peripheral vascular disease, hypertension, and glaucoma.<br><br>The recent physician's orders for antibiotics for UTIs were provided by the ADON (Assistant Director of Nursing) on 09/13/24 at 11:12 A.M., and indicated the resident had received the following:<br><br>- Daptomycin 700 mg (milligrams) IV, once a day, with a start date of 02/01/24, and an end date of 02/08/24,<br><br>- Cephalexin 125 mg, by mouth, as a preventative due to frequent UTIs, once a day, with a start date of 04/11/23, and an end date of 09/10/24,<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Ertapenem 1 gram, IM, once a day, with a start date of 08/02/24, and an end date of 08/06/24, and<br><br>- Linezolid 600 mg, by mouth, twice a day, for seven days, with a start date of 09/09/24, that the resident was currently receiving.<br><br>The current Perineal Care policy, dated 02/2018, was provided by the DON (Director of Nursing) on 09/12/24 at 2:33 P.M. The policy indicated, .It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible .Gather supplies needed .Basin .If perineum is grossly soiled .Cleanse buttocks and anus, front to back; vagina to anus .<br><br>3.1-41(a)(2) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>38239<br><br>Based on record review and interview, the facility failed to ensure medications were administered as ordered to prevent significant medication errors for 1 of 5 residents reviewed for medications. (Resident 10)<br><br>Findings include:<br><br>Resident 10's clinical record was reviewed on 09/13/24 at 10:38 A.M. An Annual MDS (Minimum Data Set) assessment, dated 07/12/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Parkinson's disease, psychotic disorder, epilepsy, and dementia.<br><br>The resident's February 2024 EMAR (Electronic Medication Administration Record) included, but was not limited to, the following medication orders:<br><br>- A physician's order, with a start date of 09/28/22 and an end date of 04/29/24, to administer two 50 mg (milligram) chewable phenytoin (an anti-seizure medication) tablets twice a day (once between 7:00 A.M. and 10:00 A.M., and then again between 7:00 P.M. and 10:00 P.M.).<br><br>- A physician's order, with a start date of 09/28/22 that was discontinued on 02/16/24, to administer one half (25 mg) of a 50 mg chewable phenytoin tablet at bedtime.<br><br>The resident would have received 100 mg of the phenytoin medication in the morning and 125 mg of the medication at bedtime.<br><br>A Progress Note, dated 02/16/24 at 1:30 P.M., indicated there was a new order from the Nurse Practitioner to increase the resident's bedtime dose of phenytoin to 150 mg due to low levels of the medication identified in the resident's recent bloodwork.<br><br>- A new physician's order, with a start date of 02/16/24 and an end date of 03/08/24, indicated staff were to administer 1.5 (one and a half) of a 50 mg chewable phenytoin tablet at bedtime.<br><br>The February and March 2024 EMAR documentation indicated the 100 mg of the phenytoin medication continued to be administered twice a day as ordered and the additional 1.5 tablet dose of the medication (75 mg) was administered every evening until the order was discontinued on 03/08/24.<br><br>A pharmacy recommendation, dated 03/07/24, indicated the resident had been receiving 100 mg of the phenytoin medication in the morning and 125 mg of the medication in the evening. The medication order was changed and now the resident was receiving 100 mg in the morning and 175 mg in the evening. The order from the Nurse Practitioner was to increase the dose to 150 mg in the evening. The pharmacist indicated they thought the staff put the order in computer incorrectly and the medication dose should have only gone from 125 mg to 150 mg in the evening. Please evaluate and change the order.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 09/13/24 at 12:50 P.M., the ADON (Assistant Director of Nursing) indicated she thought the order was clarified when it was originally received. She thought the pharmacy put a sticker on the medication card that would have ensured staff administered the appropriate dose of the medication (50 mg not 75 mg) but was unable to provide any supportive documentation. There was no indication in the resident's record the medication order was clarified. Nursing staff initialed the EMAR each time the medication was administered, and the EMAR indicated the amount of the medication administered was 75 mg. The facility didn't have a policy related to ensuring physician's orders were input correctly or regarding obtaining clarification if there were questions. It was just standard nursing practice to ensure orders were implemented accurately.<br><br>3.1-48(c)(2) |