

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/18/2024
NAME OF PROVIDER OR SUPPLIER  George Ade Memorial Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3623 East State Rd 16 Brook, IN 47922	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were treated with dignity, related to urinary drainage bags not covered, for 2 or 4 residents reviewed for dignity. (Residents C and D)</p> <p>Findings include:</p> <p>1. Resident C was observed on 10/18/24 at 4:19 a.m., 4:34 a.m., and 5:49 a.m. lying in bed. The urinary drainage bag was attached to the side of the bed closest to the door. The urinary drainage bag was uncovered with urine present and visible in the bag.</p> <p>Resident C's record was reviewed on 10/18/24 at 1:31 p.m. The diagnoses included, but were not limited to, cerebral palsy and moderate intellectual disabilities.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 9/29/24, indicated a moderately impaired cognitive status, was dependent for activities of daily living, and had an indwelling urinary catheter.</p> <p>2. Resident D was observed asleep in bed at 4:30 a.m. The urinary catheter drainage bag was attached to the bed frame on the side of the bed and was uncovered with urine present and visible in the bag.</p> <p>During an observation on 10/18/24 at 4:52 a.m., Resident D was awake and sitting on the side of the bed. The urinary drainage bag remained attached and uncovered on the side of the bed. There was urine present and visible in the bag. CNA 1 entered the room and asked the resident if he would like to get out of bed or lie back down. Resident D opted to get up for the day. After morning care had been completed by CNA 1, She placed the urinary drainage bag under the wheelchair seat next to the urinary drainage bag cover and assisted the resident to the common area across from the Nurses' Station.</p> <p>During an interview on 10/18/24 at 5:15 a.m., LPN 2 indicated the urinary drainage bag was to be placed in the urinary drainage bag cover.</p> <p>Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, dementia, history of urinary tract infections, and urinary retention.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Admission MDS assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. An indwelling urinary catheter was present.</p> <p>A facility urinary catheter care policy, dated January 2013 and received from the Director of Nursing as current, indicated catheter covers/dignity bags were to be used to preserve the resident's dignity and privacy.</p> <p>3.1-3(t)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents who required assistance with activities of daily living (ADL's) received oral care and assistance with placement of eyeglasses for 2 of 3 residents reviewed for ADL's. (Residents B and D)</p> <p>Findings include:</p> <p>1. During an observation on 10/18/24 at 6:30 a.m., CNA 3 and CNA 4 entered Resident B's room. CNA 3 washed the resident's face and checked to ensure she had not been incontinent of urine or bowel. A mechanical lift was used to transfer the resident from the bed to the Broda Chair (reclining chair). Her hair was brushed and the glasses were cleaned and applied. Oral care had not been completed.</p> <p>Resident B's record was reviewed on 10/18/24 at 9:07 a.m. The diagnoses included, but were not limited to, Alzheimer's disease.</p> <p>An Annual Minimum Data Set (MDS) assessment, dated 10/8/24, indicated long and short term memory problems and was dependent on staff for hygiene and oral hygiene.</p> <p>A Care Plan, dated 10/9/24, indicated a deficit in self care. The interventions indicated the staff were to assist with oral care twice daily.</p> <p>2. During an observation on 10/18/24 at 4:52 a.m., CNA 1 provided morning care to Resident D. The resident's face and underarms were washed and incontinent care had been provided. He was dressed in clean clothing and assisted out to the common area by CNA 1. Oral care had not been completed and eyeglasses were not placed on the resident. The resident was observed with natural bottom teeth.</p> <p>Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, dementia, history of urinary tract infections, and urinary retention.</p> <p>An Admission MDS assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. The vision was adequate with corrective lenses.</p> <p>The Resident Care Card, identified as current by CNA 1 on 10/18/24 at 5:15 a.m., indicated the resident was to wear glasses.</p> <p>A Care Plan, dated 9/20/24, indicated a deficit in self-care. The interventions indicated assistance would be provided for oral care for his upper denture and lower natural teeth twice a day and as needed.</p> <p>During an interview on 10/18/24 at 10:36 a.m., the Director of Nursing indicated oral care was to be provided daily with morning care.</p> <p>During an interview on 10/18/24 at 3:29 p.m., CNA 5 indicated the resident would sometimes refuse to wear his glasses.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An undated oral hygiene policy, received from the Director of Nursing as current on 10/18/24 at 1:17 p.m., indicated oral hygiene was to be completed for the teeth, gums, and mouth. Oral hygiene was an essential part of the morning and evening care.</p> <p>An undated morning care policy, received from the Director of Nursing as current on 10/18/24 at 1:17 p.m., indicated the resident was to be assisted with oral hygiene and eyeglasses were to be cleaned and placed on the resident.</p> <p>This citation relates to Complaint IN00444647.</p> <p>3.1-38(a)(3)</p> <p>3.1-38(a)(3)(C)</p>		

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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>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>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a urinary catheter and history of urinary tract infections received proper care and services related to improper placement of the urinary catheter drainage bag and tubing, catheter care not completed, and the outlet tube was not disinfected after emptying the urinary drainage bag, for 1 of 2 residents reviewed for urinary catheters. (Resident D)</p> <p>Finding includes:</p> <p>During an observation on 10/18/24 at 4:52 a.m., Resident D was awake and sitting on the side of the bed. CNA 1 entered the room and asked the resident if he would like to get out of bed or lie back down. Resident D opted to get up for the day. The urinary drainage bag on the side of the bed contained a large amount of clear yellow urine. CNA 1 unattached the urinary drainage bag from the side of the bed and placed the bag on the floor. She changed the resident's pants and each time after threading the catheter through the leg of the pants, the drainage bag was placed on the floor. The urinary drainage bag laid on the floor throughout the morning care and CNA 1 had stepped over the urinary drainage bag on the floor several times during the morning care. The catheter tubing was also on the floor and the resident was observed rolling the tubing with his foot. CNA 1 then placed the plastic urine measuring container on the floor and opened the outlet tube and drained the urine from the bag. After 850 cubic centimeters of urine was drained, the outlet tubing was clamped and returned to the holder on the drainage bag without being disinfected. The resident stood up on the side of the bed. The brief was soiled with bowel movement. CNA 1 washed the buttocks and placed a clean incontinent brief on the resident and completed dressing the lower part of his body. The urinary catheter was not washed. The resident was then assisted to the wheelchair. CNA 1 placed the urinary drainage bag under the wheelchair seat. The catheter tubing was on the floor.</p> <p>At the time of the observation, CNA 1 indicated she was unsure if the catheter tubing could be touching the floor and stated, it usually is. She then assisted the resident in the wheelchair to the Nurses' Station, with the catheter tubing still on the floor.</p> <p>During an interview on 10/18/24 at 5:15 a.m., LPN 2 indicated the catheter tubing was not to be touching the floor.</p> <p>Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, dementia, history of urinary tract infections, and urinary retention.</p> <p>An Admission Minimum Data Set assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. An indwelling urinary catheter was present.</p> <p>A Care Plan, dated 9/20/24, indicated a there was a risk for infections related to an indwelling catheter. The interventions indicated, the urinary drainage bag was to be stored in a protective bag, the drainage system was not to touch the floor, and catheter care was to be completed every shift and as needed.</p> <p>(continued on next page)</p>		

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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>A facility urinary catheter care policy, dated January 2013 and received from the Director of Nursing as current, indicated the urinary drainage bags and tubing were to be positioned to prevent touching of the floor. The outlet tubes were to be disinfected with an antiseptic after emptying the drainage tube. The resident was to receive perineal and catheter care with soap and water at least twice daily.</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>20580</p> <p>Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff members (CNA 1 and CNA 6) when providing care to residents (Residents D and C) who were in Enhanced Barrier Precautions (EBP) for two random observations for infection control.</p> <p>Findings include:</p> <p>1. During an observation on 10/18/24 at 4:52 a.m., CNA 1 entered Resident D's room and prepared to start the morning care without any PPE being worn. CNA 1 was stopped before care was started. CNA 1 indicated if the resident was on EBP, there was usually a cart outside of the room. She acknowledged a sign above the bed, which indicated the resident was on EBP. CNA 1 then donned the PPE and began the morning care.</p> <p>Resident D's record was reviewed on 10/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, dementia, history of urinary tract infections, and urinary retention.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 9/27/24, indicated a moderately impaired cognitive status, supervision was required for oral hygiene and hygiene and moderate assistance was required for bathing. An indwelling urinary catheter was present.</p> <p>A Care Plan, dated 10/4/24, indicated EBP was required. The interventions included PPE would be used when care was provided. A sign would be placed outside the door that indicated EBP was required. The staff were to wear gown and gloves while care was provided and a face shield was to be worn if needed.</p> <p>A Physician's Order, dated 10/1/24, indicated enhanced barrier precautions were ordered.</p> <p>2. During an observation on 10/18/24 at 5:49 a.m., CNA 6 prepared to complete morning care for Resident C without any PPE being worn. CNA 6 was stopped prior to the start of the care. She acknowledged a sign on the wall above the bed that indicated the resident was on EBP. She then donned a gown and gloves.</p> <p>Resident C's record was reviewed on 10/18/24 at 1:31 p.m. The diagnoses included, but were not limited to, cerebral palsy, moderate intellectual disabilities.</p> <p>A Quarterly MDS assessment, dated 9/29/24, indicated a moderately impaired cognitive status, was dependent for all activities of daily living, and an indwelling catheter was present.</p> <p>A Care Plan, dated 10/4/24, indicated EBP was required. The interventions included PPE would be used when care was provided. A sign would be placed outside the door that indicated EBP was required. The staff were to wear gown and gloves while care was provided and a face shield was to be worn if needed.</p> <p>A Physician's Order, dated 10/1/24, indicated enhanced barrier precautions were ordered.</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>During an interview on 10/18/24 at 2:20 p.m., the Director of Nursing indicated the signs for EBP had been moved to above the residents' beds to make it a little more confidential.</p> <p>A facility EBP policy, dated August 2024, and received from the Director of Nursing as current, indicated EBP was to be used during high contact activities, which included hygiene and bathing activities. EBP was to be used if the resident had an indwelling device, which included indwelling urinary catheters. Gowns and gloves would be available near or outside the resident's room.</p> <p>3.1-18(b)</p>		