

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155768	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/13/2014
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NAME OF PROVIDER OR SUPPLIER  EVANSVILLE PROTESTANT HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WASHINGTON AVE EVANSVILLE, IN 47714
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 5, 6, 10, 11, 12, 13, 2014</p> <p>Facility Number: 001125 Provider Number: 155768 AIMS Number: NA</p> <p>Survey Team: Denise Schwandner, RN-TC Diane Hancock, RN Barbara Fowler, RN Diana Perry, RN Anna Villain, RN</p> <p>Census Bed Type: SNF: 36 NCC [Non-Certified Comprehensive]: 13 Residential: 66 Total: 115</p> <p>Census Payor Type: Medicare: 10 Other: 105 Total: 115</p> <p>These deficiencies also reflect the state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of the regulatory required response and is not to be a construed as agreement with deficiencies cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F000371 SS=E	<p>Quality review completed on March 18, 2014, by Jodi Meyer, RN</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was distributed in a sanitary manner, in that, bread was handled with bare hands for 5 of 22 residents and hands were not washed appropriately. This had the potential to affect 22 of 22 residents eating the noon meal in the dining room. (Resident #16, Resident #39, Resident #25, Resident #49, Resident #45)</p> <p>Findings include:  On 3/5/14 at 11:40 a.m., observed LPN #2 wash hands for 3 seconds between passing the noon meal trays.  On 3/5/14 at 11:45 a.m., observed LPN #2 wash hands for 5 seconds</p>	F000371	<p><b>F-371 E</b></p> <p><b>1. What corrective action will be accomplished for resident found to be affected by deficient practice?</b></p> <p>Residents 16-39-25-49-45 have suffered no ill effects.</p> <p><b>2. How other residents potentially affected will be identified and corrective actions taken?</b></p> <p>DON or designee shall audit all dining rooms for glove availability during meal pass. Employees shall receive in-service regarding Employee Hygiene and Sanitary practice guidelines by Dietary Services Manager or designee. Completion date 4-12-14.</p> <p><b>3. What measures will be put in place or systemic changes made to</b></p>	04/12/2014

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	<p>between passing the noon meal trays.</p> <p>On 3/5/14 at 11:53 a.m., observed CNA #1 handle Resident #16's bread with bare hands.</p> <p>On 3/5/14 at 11:55 a.m., observed LPN #4 handle Resident #39's bread with bare hands.</p> <p>On 3/5/14 at 11:56 a.m., observed CNA #1 handle Resident #25's bread with bare hands.</p> <p>On 3/5/14 at 11:58 a.m., observed CNA #1 handle Resident #49's bread with bare hands.</p> <p>On 3/5/14 at 11:59 a.m., observed LPN #2 handle Resident #45's bread with bare hands.</p> <p>On 3/12/14 at 2:30 p.m., interviewed LPN #2. LPN #2 indicated food should not be handled with bare hands.</p> <p>On 3/13/14 at 10:20 a.m., the Administrator provided the "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" policy. The policy indicated, "Contact between food and bare (ungloved) hands is</p>		<p><b>ensure the deficient practice does not recur?</b></p> <p>In addition to routine visual monitoring of meal service the DON or designee is responsible to ensure implementation of Employee Hygiene and Sanitary practices which includes no contact between food and bare (ungloved hands). Meal Service audits shall monitor for food to ungloved hand contact during meal service. Meal service audits shall be performed daily by the DON or designee and any discrepancy shall be corrected immediately. The annual infection control in-service shall include information regarding food handling practices via Employee Hygiene and Sanitary Practice guidelines.</p> <p><b>4. How the corrective actions will be monitored to ensure the deficient practice will not recur?</b></p> <p>Meal service audits shall be brought to quality assurance for review and recommendation. Audits shall occur daily with meal service, alternating breakfast lunch and dinner for 3 months. After 3 months if 100% compliance is achieved facility shall perform monthly audits thereafter.</p>	

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	<p>prohibited."</p> <p>On 3/13/14 at 10:54 a.m., the Administrator provided the "Handwashing/Hand Hygiene" policy. The policy indicated, "Employees must wash their hands for at least fifteen (15) seconds...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure medications were not stored longer</p>	F000431	<p>F-431 D</p> <p>1. <i>What corrective action will be accomplished for resident found</i></p>	04/12/2014	

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	<p>than recommended for 2 of 4 medication carts observed. This affected 3 residents who had medications stored on the carts. (North unit cart) (Resident #14, Resident #59, Resident #32)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an observation of the North unit medication carts on 3/10/14 at 1:54 p.m., Resident #14 was found to have an open bottle of Novolog insulin 100 units/ml with an open date of 12/23/13. LPN #3 indicated the Novolog insulin had been discontinued on 1/15/14.</li> <li>2. Resident #59 was found to have an open bottle of Novolog insulin 100 unit/ml with the open date of 1/25/14 on the bottle. LPN #3 indicated the Novolog insulin had been discontinued on 1/25/14.</li> <li>3. During an observation of the North unit medication cart on 3/10/14 at 1:45 p.m., Resident #32 was found to have an opened bottle of Levimir insulin 100 unit/ml with the open date of 2/8/14 on it.</li> </ol> <p>During an interview on 3/10/14 at 2:15 p.m., LPN #3 indicated insulin which had been opened should be</p>		<p><b>to be affected by deficient practice?</b></p> <p>Resident 14 has suffered no ill effects and the discontinued Novolog was removed from the cart. Resident 59 has suffered no ill effects and the discontinued Novolog on the cart has been removed. Resident 32 has suffered no ill effects and the Levimir has been removed from the cart.</p> <p><b>2. How other residents potentially affected will be identified and corrective actions taken?</b></p> <p>The DON or designee shall audit medication carts in the facility for compliance with medication storage and labeling. Any discrepancy shall be corrected immediately. Pharmacy technician shall review carts monthly for proper drug storage, labeling and documentation with results forwarded to the facility DON for review and proper completion. Completion date 4-12-2014.</p> <p><b>3. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b></p> <p>In-service regarding medication storage, labeling and destruction shall be completed by Pharmacy Nurse or designee by 4-12-2014. The DON or designee shall perform weekly cart reviews for proper</p>				

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	<p>discarded after 28 days. LPN #3 further indicated discontinued medications are sent back to the pharmacy when they are discontinued.</p> <p>During an interview on 3/10/14 at 2:35 p.m., LPN #1 indicated insulins are good for 30 (thirty) days after the bottles are opened.</p> <p>A policy, dated 2001 and revised on 4/2007, and obtained from the administrator on 3/13/14 at 9:47 a.m., indicated all drugs shall be returned to the dispensing pharmacy or destroyed if outdated or discontinued.</p> <p>A policy, obtained from the administrator on 3/13/14 at 10:51 a.m., indicated insulin vials are good for 28-30 days after they are opened.</p> <p>3.1-25(o)</p>		<p>medication storage, labeling, and destruction of medication. Any discrepancy shall be corrected immediately.</p> <p><b>4. How the corrective actions will be monitored to ensure the deficient practice will not recur?</b></p> <p>Weekly cart review audits shall be reviewed by DON or designee for completion and compliance. Weekly cart review audits shall be brought to Quality Assurance for review and recommendation. After 3 months if 100% compliance is achieved will perform monthly audits thereafter. Pharmacy technician cart reviews shall continue monthly regardless of compliance.</p>		

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed</p>	F000441	<b>F-441 E 1. What corrective action will be accomplished for</b>	04/12/2014	

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	<p>to ensure infection control procedures were implemented to ensure a glucometer was cleansed and disinfected between residents for 3 of 3 residents observed, out of 8 who received routine blood glucose tests. (residents #71, #27, and #60)</p> <p>Findings include:</p> <p>On 3/10/14 at 11:25 a.m. LPN #1 was preparing to do blood glucose check on Resident #60. LPN #1 entered the room of Resident #60, and obtained the blood sugar using the glucometer. LPN #1 proceeded to med storage area where LPN #1 placed glucometer on medication cart, prepared supplies for next resident. LPN #1 was interviewed in regards to glucometer sanitizing. He indicated they were sanitized Gluco-Chlor wipes (germicide disinfectant) after all residents were tested. LPN#1 was questioned if this was policy, LPN #1 indicated it was policy.</p> <p>At 11:25 a.m. LPN #1 entered the room of Resident #71 with the same glucometer. LPN #1 then checked Resident # 71's blood sugar. LPN #1 came back to medication storage room, placed the glucometer on the</p>		<p><b>resident found to be affected by deficient practice?</b> Resident 60, 71, and 27 have suffered no ill effects. There was no visible blood on the glucometer and the lancet was changed each time the glucometer was used. The nurse was educated immediately regarding proper infection control practice between each resident.</p> <p><b>2. How other resident potentially affected will be identified and corrective actions taken?</b> Observations were completed during survey of other nursing staff regarding multiple accu-checks using a common glucometer machine and nurses were observed following proper infection control practice, cleaning machine between each resident. Completion date 3-13-2014. <b>3. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b> To enhance currently compliant operations the facility has added an additional option as a step in the infection control process for obtaining multiple accu-checks using a common glucometer machine or a 2 glucometer machine method. A 2 glucometer machine method shall be utilized for infection control purposes. After each resident accu-check is obtained the machine shall be cleaned per Gluco-Chlor guidelines and a second glucometer used for the next</p>		

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	<p>medication cart and prepared supplies for next resident's blood sugar testing. LPN #1 was questioned in reference to sanitizing of glucometer, LPN #1 indicated it was not sanitized until all residents were tested, then it was sanitized and left to dry for 5 minutes.</p> <p>At 11:30 a.m. Resident #27's room was entered by LPN #1 and blood glucose was checked. LPN #1 proceeded to medication room, placed glucometer on medication cart.</p> <p>At 11:45 a.m. LPN #1 was questioned in reference to sanitizing the glucometer again. LPN #1 indicated originally they used to clean glucometer after each resident, now they only did it after all patients were tested. LPN #1 was informed that was not an acceptable practice or policy, and the glucometer should be sanitized before and after each resident.</p> <p>At 1:30 p.m. the Administrator was interviewed about the infection control issue with blood glucose checks. She indicated this was not policy, LPN #1 should know better.</p> <p>The policies and procedures on</p>		<p>residents' accu-check. Alternating machines allows for proper Gluco-Chlor guidelines to be followed and multiple accu-checks to be taken in a timely fashion. The nursing staff shall be in-serviced regarding the 2 step glucometer infection control practice by the DON or designee by 4-12-2014.</p> <p>Glucometer use infection control audits shall be performed daily by DON or designee on alternating shifts to ensure compliance with infection control procedures. Any discrepancy shall be corrected immediately. <b>4. How the corrective actions will be monitored to ensure the deficient practice will not recur?</b> Audits shall be reviewed by quality assurance committee and recommendations made based audit findings. Audits shall continue daily x30 days, weekly times 60 days and then monthly thereafter is 100% compliance is achieved.</p>		

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	<p>"Obtaining a Fingerstick Glucose Level" dated October 2010, and "Cleaning and Disinfecting of the Assure Platinum Glucometer" were recieved from the Administrator at 3/10/14 at 2:20 p.m. The policy and procedure for obtaining a Fingerstick Glucose Level, included but, was not limited to:</p> <p>16. Discard disposable supplies in designated container 17. Cleanse and disinfect reusable equipment between uses according to manufacturer's instructions and current infection control standard of practices 18. Remove gloves and discard into designated container 19. Wash hands</p> <p>The Glucometer Assure Platinum instructions included, but were not limited to:</p> <p>1.We suggest cleansing and disinfecting the meter between patient use, cleansing and disinfection can be completed by using commercially available EPA-registered disinfectant or germicide wipe. 2.To use a wipe, remove from container and follow product label instructions to disinfect meter.Take extreme care not to get liquid in the test slip and key ports of the meter</p>				

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F000504 SS=D	<p>3. Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used, uses one wipe to clean and a second wipe to disinfect.</p> <p>On 3/12/14 at 3:00 p.m. LPN #3 was interviewed and indicated there were 8 residents who recieved blood glucose checks.</p> <p>3.1-18(b)(1)</p> <p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview, the facility failed to ensure services were provided in accordance with the written orders for 1 of 14 residents in the stage 2 sample of 14 residents, whose records were reviewed for physician's orders, in that laboratory tests were not done after being</p>	F000504	<p>F-504 D</p> <p><b>1. What corrective action will be accomplished for resident found to be affected by deficient practice?</b></p> <p>Resident #4 has suffered no ill effects. Physician was contacted during survey and labs have been completed per current physician</p>	04/12/2014

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	<p>ordered by a physician. (Resident #4)</p> <p>Finding includes:</p> <p>The clinical record of Resident #4 was reviewed on 3/6/14 at 1:58 p.m. Resident #4 had a diagnosis including, but not limited to, hypothyroidism. The MDS (Minimum Data Set) assessment indicated Resident #4 had hypothyroidism.</p> <p>Resident #4 had a physician's order, dated 11/8/12, for Synthroid (a medication used to treat hypothyroidism) 75 mcg (micrograms) one (1) tablet p.o. (by mouth) every Sunday.</p> <p>A physician's order, dated 4/16/13, indicated Resident #4 was to receive Synthroid 150 mcg 1 tablet daily except on Sundays.</p> <p>A physician's order, dated 11/5/13, indicated Resident #4 was to have a TSH (thyroid stimulating hormone) level and a T4 (blood tests for measuring thyroid levels) done in 3 months, which would have been in February, 2014.</p> <p>Interview with LPN #1 on 3/10/14 at</p>		<p>orders.</p> <p><b>2. How other resident potentially affected will be identified and corrective actions taken?</b></p> <p>The Treatment Administration Record shall be reviewed by DON or designee for completion of labs indicated per physician orders. Any discrepancy shall be reported to the physician and corrected immediately. Completion date 4-12-2014.</p> <p><b>3. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b></p> <p>To enhance currently compliant operations lab tracking audits shall be completed by DON or designee. Lab completion process according to physician orders shall be in-serviced to nursing staff by DON or designee by 4-12-2014.</p> <p><b>4. How the corrective actions will be monitored to ensure the deficient practice will not recur?</b></p> <p>Lab tracking audits shall be performed daily for 3 months. Audits shall be brought to Quality Assurance for review and recommendation. After 3 months if 100% compliance is achieved monthly audits shall continue</p>				

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R000000	<p>11:05 a.m., indicated Resident #4 had the TSH and T4 done at the physician's office on 2/19/14. LPN #1 indicated, after telephoning the physician's office and the laboratory, the TSH or T4 had not been done on Resident #4.</p> <p>Resident #4's chart lacked any documentation of a TSH or T4 being done.</p> <p>3.1-49(f)(1)</p> <p>The following residential findings were cited in accordance with 410IAC16.2-5.</p>	R000000	<p>thereafter.</p> <p>Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of the regulatory required response and is not to be a construed as agreement with deficiencies cited.</p>	

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R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review the facility failed to ensure clinical records were complete, in that physicians orders had not been signed for more than 180 days for 2 of 7 residents reviewed. (Resident #140, Resident #121)</p> <p>Findings include:</p> <p>1. On 3/11/14 at 2:40 p.m., Resident #140's clinical record was reviewed. Resident #140's clinical record lacked signed physician's recapitulation orders.</p> <p>On 3/11/14 at 3:45 p.m., interviewed LPN #5. LPN #5 indicated the record lacked signed physician's recapitulation orders. LPN #5 further indicated recapitulation orders must be signed every 180 days.</p> <p>On 3/11/14 at 3:55 p.m., interviewed</p>	R000349	<p><b>R-349 Clinical Records</b></p> <p><b>1. What corrective action will be accomplished for resident found to be affected by deficient practice?</b></p> <p>Resident 140 and 121 have suffered no ill effects. Each resident has been seen by their primary care physician for medical review according to residential guidelines. The physician orders were signed during survey.</p> <p><b>2. How other resident potentially affected will be identified and corrective actions taken?</b></p> <p>Residential records have been reviewed for compliance of clinical record documentation, via physician signature of orders at last primary care physician visit. Any discrepancy was addressed with physician notification via fax requesting proper signature. Physician Order Signature for accurate clinical record documentation in residential setting</p>	04/12/2014	

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	<p>the MRE (Medical Records Employee). The MRE indicated the last signed physician's recapitulation orders for Resident #140 were dated 1/26/13.</p> <p>2. The record for Resident #121</p>		<p>shall be complete by 4-12-2014.</p> <p><b>3. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?</b></p> <p>Medical records currently tracks physician visits for apartment residents, to enhance this currently compliant process medical records or designee shall also audit physician order signature for accurate clinical record documentation. Medical Records shall be notified via internal communication report each time an apartment resident is seen by their attending physician. Nursing staff shall be in-serviced regarding physician visits, requirements of physician order signatures, and use of internal communication report regarding physician visits. Medical Records or designee shall complete in-service by 4-12-2014.</p> <p><b>4. How the corrective actions will be monitored to ensure the deficient practice will not recur?</b></p> <p>Medical Records shall report compliance to Quality Assurance Committee of accurate clinical record documentation of apartment residents regarding physician visits and signature. This process shall continue indefinitely.</p>	

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	<p>was reviewed on 3/11/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, memory loss, vitamin D deficiency, osteoarthritis, glaucoma, hypertension, hyperlipidemia, and depressive disorder. The resident's record failed to reveal signed physician recapitulation orders.</p> <p>An interview with the MRE on 3/12/14 at 10:15 a.m., indicated that she was waiting for the physician orders to be signed from 2/1/14 and that she faxed the physician orders to the physician's office for his signature. A copy of the signed physician's orders were obtained from the MRE and were dated 3/12/14.</p> <p>An interview with the Administrator on 3/12/14 at 3:30 p.m., indicated that no signed physician orders were found in the resident's record when she spoke with the MRE.</p>				