

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 04/19/2016
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: April 11, 12, 13, 14, 18, & 19, 2016</p> <p>Facility number: 001125 Provider number: 155768 AIM number: 201272600</p> <p>Census bed type: SNF: 21 SNF/NF: 20 Residential: 56 NCC (Non Certified Comprehensive): 15 Total: 112</p> <p>Census payor type: Medicare: 7 Medicaid: 8 Other: 41 Total: 56</p> <p>NCC sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	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 construed as agreement with deficiencies cited.	
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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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F 0279 SS=E Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by #02748 on April 25, 2016.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were implemented for 4 of 20 resident's reviewed during Stage 2 of the survey. The comprehensive care plans lacked</p>	F 0279	<u>F279- Develop Comprehensive Care Plans</u> What corrective action will be accomplished for resident found to be affected by deficient practice? Resident #79 has suffered no ill effects. The hospice care plan has been	05/19/2016

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	<p>identified issues including antipsychotic and antidepressant medications, hospice services, behaviors, and urinary incontinence. (Resident #79, Resident #71, Resident #67, Resident #19)</p> <p>Findings include:</p> <p>1. On 4/13/16 at 9:36 a.m., a signed healthcare agreement for hospice was seen in Resident # 79's clinical record. An order to admit to [Name of Hospice Provider] on 3/16/16 was in the resident's clinical record. There were no care plans for hospice services in Resident #79's clinical record.</p> <p>On 4/18/16 at 10:23 a.m., the MDS (Minimum Data Set) Assessment Coordinator indicated there was not a care plan for Resident #79's hospice services.</p> <p>2. On 4/14/16 at 10:07 a.m., Resident # 71's clinical record was reviewed. Diagnoses included but were not limited to, psychotic mood disorder.</p> <p>The physicians orders included, but were not limited:</p> <p>Risperidone (an antipsychotic medication) 0.5 mg (milligrams) by mouth, daily for psychotic mood disorder Sertraline (an antidepressant</p>		<p>implemented and services provided per physician orders and applicable needs. Resident #71 has suffered no ill effects. The comprehensive care plan has been implemented for antipsychotic and antidepressant medication use. Resident #71 is reviewed at monthly behavior meeting. Resident # 67 has suffered no ill effects. The comprehensive care plan has been implemented to address current behavior tracking of history of hallucinations, anxiety, crying, and verbal outburst. Resident #19 was discharged from this facility on 1/28/16. Resident #19 suffered no ill effects and incontinence needs were met. How other residents potentially affected will be identified and corrective actions taken? All residents are potentially affected by the cited deficiency. The Director of Nursing or designee shall review current orders for comprehensive care plan implementation including but not limited too antipsychotic and antidepressant medication, hospice services, behaviors and urinary incontinence. Changes in the plan of care will be added by MDS coordinator or designee in congruence with daily orders and applicable care. Audit of last the comprehensive MDS for triggered CAAs with corresponding comprehensive care plans including but not limited too,</p>				

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	<p>medication),150 mg, by mouth, at bedtime for depression</p> <p>The clinical record lacked a care plan for the use of the antidepressant or antipsychotic medications.</p> <p>On 4/18/16 at 10:23 a.m., the MDS Assessment Coordinator indicated there was not a care plan for Resident #71's use of antidepressants or antipsychotic medications.</p> <p>3. On 4/13/16 at 8:32 a.m., Resident #67 was observed sitting in a wheelchair looking out the window.</p> <p>On 4/13/16 at 9:36 a.m., Resident #67's clinical record was reviewed. Resident #67's diagnoses included, but was not limited to, unspecified psychosis.</p> <p>The most recent signed physician's recapitulation orders, signed 4/13/16, included, but was not limited to: Zyprexa (an antipsychotic medication), 5 mg (milligrams), by mouth, two times a day, for psychotic mood disorder, ordered 2/8/16.</p> <p>The February behavior tracking indicated Resident #67 had hallucinations.</p> <p>The clinical record lacked a care plan that</p>		<p>antipsychotics and antidepressants, hospice services, behaviors and urinary incontinence shall be completed by MDS coordinator or designee. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur? To enhance currently complaint operations under the direction of the Director of Nursing licensed nursing staff and social service staff shall receive in-service training for comprehensive care plan implementation of triggered CAA's including but not limited to antipsychotic and antidepressant medication, hospice services, behaviors, and urinary incontinence. The MDS coordinator or designee shall audit triggered CAAs of each comprehensive MDS assessment done for care plan completion. Daily physician orders shall be reviewed by MDS coordinator or designee for comprehensive care plan implementation. How the corrective actions will be monitored to ensure the deficient practice will not recur? Effective 5-17-16 a Quality Assurance Program shall be implemented to ensure comprehensive care plan implementation audits are conducted and reviewed by interdisciplinary team. The MDS coordinator or designee shall audit resident care plans for identified issues including but not</p>	

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	<p>addressed Resident #67's hallucinations.</p> <p>On 4/14/16 at 9:55 a.m., the MDS (Minimum Data Set) Assessment Coordinator indicated the behavior had not been addressed in Resident #67's care plans.</p> <p>4. On 4/13/16 at 12:57 p.m., Resident #19's clinical record was reviewed.</p> <p>The Significant Change MDS (Minimum Data Set) Assessment, dated 1/8/16, indicated Resident #19 was frequently incontinent of urine.</p> <p>The clinical record lacked a care plan to address Resident #19's urinary incontinence.</p> <p>On 4/14/16 at 9:55 a.m., the MDS Assessment Coordinator indicated a urinary incontinence care plan had not been put into place for Resident #19.</p> <p>On 4/19/16 at 8:49 a.m., the DON (Director of Nursing) provided the "Care Plans-Comprehensive" policy, revised 10/2010. The policy included, but was not limited to, each resident's comprehensive care plan is designed to: incorporate identified problem areas.....</p> <p>3.1-35(a)</p>		<p>limited to antipsychotic and antidepressant medication, hospice services, behaviors, and urinary incontinence. All audits will be completed 5 times a week for 4 weeks, 3 times a week for 4 weeks, one time weekly for 4 weeks and then monthly. Any variation in regulatory guidelines will be corrected immediately. All audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless the QA committee deems 100% compliance was achieved.</p>	

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F 9999 Bldg. 00	<p>NCC (Non Certified Comprehensive) Findings</p> <p>3.1-35 COMPREHENSIVE CARE PLAN</p> <p>(g) The services provided or arranged by the facility must:</p> <p>(2) be provided by qualified persons in accordance with each resident's written plan of care</p> <p>This State Rule was not met, as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure a functional maintenance program was provided for 3 of 3 residents reviewed for ROM (Range of Motion) exercises. (Resident #90, Resident #87, Resident #88)</p> <p>Findings include:</p> <p>1. During an observation on 4/11/16 at</p>	F 9999	<p><u>F9999 NCC Comprehensive Care Plan Restorative Program</u></p> <p>What corrective action will be accomplished for resident found to be affected by deficient practice? Resident #90 has suffered no ill effects attends daily unit exercise program, walks short distances and participates in other activities of interest which require physical movement and are helpful to maintain physical function. Resident #87 has suffered no ill effects. Resident #87 has had recent acute illness and often refused additional activity. Resident #87 is participating in the functional maintenance program currently and other activities of interest including daily visits with family. Resident #88 has suffered no ill effects. Staff report resident #88 was frequently non-compliant with the splints and there usage. Resident #88 has had a clinical decline in the last few months and was referred for hospice services. Hospice staff shall review the functional maintenance program and</p>	05/19/2016

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	<p>9:50 a.m., Resident #90 was observed to be sitting in a chair in their room, watching television.</p> <p>During an observation on 4/14/15 at 10:35 a.m., Resident #90 was observed to sitting in a chair in the dining room participating in an activity.</p> <p>During an interview on 4/13/16 at 10:00 a.m., Resident #90 indicated he used his rolling walker to ambulate in the hall.</p> <p>The clinical record for Resident #90 was reviewed on 4/11/16 at 2:08 p.m. Resident #90 had clinical diagnoses including, but not limited to, hypertension, dementia, diabetes mellitus, and asthma. Resident #90 had a quarterly MDS (Minimum Data Set) assessment, dated 4/2/16, which indicated a BIMS (Brief Interview for Mental Status) of 10, which indicated moderate cognitive impairment.</p> <p>Resident #90 had a care plan for ADL (activity of daily living) function, dated 1/19/15 and revised 4/4/16, which indicated the resident would receive AROM (Active Range of Motion) to the bilateral upper and lower extremities for 20 repetitions bid (twice a day) to all major joints.</p>		<p>address the need for splints or palm protectors which are currently in use. Hospice shall communicate their findings with family, facility and staff. Hospice shall obtain supporting physician orders. How other residents potentially affected will be identified and corrective actions taken? All residents have the potential to be affected by the cited deficiency. The Director of Nursing or designee shall audit all residents discharged from therapy in the last 60 days for written functional maintenance program implementation and appropriate documentation. Residents identified with a written functional maintenance program shall be reviewed for continued appropriateness by the interdisciplinary team. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur? To enhance currently compliant operations, under the direction of the Director of Nursing or designee nursing staff shall receive in-service training regarding implementation and documentation of the functional maintenance program. In service shall include communication of the functional maintenance program implementation when discharged from therapy, documentation of the functional maintenance program completion and/or</p>				

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	<p>The "Restorative Nursing Category Report" indicated Resident #90 had received AROM to the bilateral upper and lower extremities only once as followed: 3/7/16, 3/22/16, 3/23/16, 3/25/16, 3/31/16, 3/31/16, and 4/11/16.</p> <p>During an interview on 4/14/16 at 1:40 p.m., RN #1 indicated Resident #90 was on a restorative program twice a day. RN #1 indicated the CNAs (certified nursing assistants) provided the AROM. RN #1 further indicated the CNAs documented the AROM in the kyosk each time the ROM was provided.</p> <p>During an interview with the MDS Coordinator on 4/13/16 at 2:10 p.m., the MDS Coordinator indicated the CNAs would document the AROM in the kyosk. The MDS Coordinator further indicated LPN #1 oversaw the restorative program and would document in the Progress Notes section in the chart. The progress notes lacked documentation of a restorative program from 2/1/16 through 4/18/16.</p> <p>2. During an observation on 4/11/16 at 11:15 a.m., Resident #87 was observed to be in a chair in the room, visiting with family.</p>		<p>refusal, and referrals to therapy for noted physical decline not related to an acute event. Nurses will also be inserviced to run the functional maintenance program completion report at the end of each shift and it will be turned in with the 24 hour report to the Director of Nursing or designee for review. How the corrective actions will be monitored to ensure the deficient practice will not recur? In addition to the verbal review of at weekly Medicare meeting for functional maintenance program recommendations a copy of the therapy discharges which reference a functional maintenance program shall be provided to the Director of nursing or designee before therapy discharge for tracking. Implementation of Functional Maintenance programs and the corresponding documentation shall be audited 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks and monthly. Any variation in protocol or processing will result in immediate correction. Audits shall be submitted to the Quality Assurance Committee for review and further corrective action. Audits will not titrate down unless QA committee deems 100% compliance was achieved.</p>		

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	<p>During an observation on 4/13/16 at 11:20 a.m., Resident #87 was observed to be in a wheelchair in the activity room, participating in an exercising activity.</p> <p>During an interview on 4/11/16 at 1:52 p.m., LPN #1 indicated Resident #87 was on a restorative program and received AROM twice a day.</p> <p>The clinical record for Resident #87 was reviewed on 4/11/16 at 1:20 p.m. Resident #87 had diagnoses including, but not limited to pneumonia, iron deficiency anemia, hypertension, congestive heart failure and chronic obstructive pulmonary disease. An annual MDS assessment, dated 1/17/16, indicated Resident #87 had a BIMS score of 15, which indicated no cognitive impairment.</p> <p>Resident #87 had a care plan for "ADL Functional/Rehabilitation Potential", dated 12/10/15, which indicated the resident was to receive AROM to upper extremities and lower extremities bid for 20 repetitions each to all major joints.</p> <p>The "Restorative Nursing Category Report", obtained from the MDS Coordinator on 4/14/16 at 10:05 a.m., indicated Resident #87 had received AROM only once on 3/3/16, 3/8/16,</p>			

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	<p>3/9/16, 3/28/16, 3/29/16, 3/30/16, 4/1/16, 4/2/16, and 4/8/16. The report further indicated the resident had not received AROM to the bilateral upper and lower extremities on 4/3/16.</p> <p>During an interview on 4/14/16 at 9:05 a.m., Resident #87 indicated she usually participated in the exercise activity when the facility had them.</p> <p>3. During an observation on 4/13/16 at 11:35 a.m., Resident #88 was observed to be lying in bed. Resident #88 the bilateral hands. Two (2) rolled washcloths were observed to be lying on the bed, but were not in her hands.</p> <p>During an observation 4/14/16 at 11:40 a.m., Resident #88 was observed to be assisted out of bed and ambulated to the bathroom with a walker and assistance of 2 persons.</p> <p>The clinical record for Resident #88 was reviewed on 4/12/16 at 12:05 p.m. Resident #87 had clinical diagnoses including, but not limited to, depressive disorder, Alzheimer's dementia, and degenerative joint disease. A significant change MDS (Minimum Data Set) assessment, dated 3/22/16, indicated Resident #87 had a BIMS (Brief Interview for Mental Status) of 3 which</p>			

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	<p>indicated severe cognitive impairment.</p> <p>The "ADL Functional/Rehabilitation Potential" care plan, dated 12/21/15 and reviewed on 3/29/16, indicated Resident #88 would have a splint applied throughout the day and night. The care plan indicated the splint would be removed for skin care and meals.</p> <p>During an interview on 4/14/16 at 2:00 p.m., Resident #88's family member indicated the resident did not have anything for her hand contractures to wear. The family member indicated Resident #88 had, at one time, wore a stretch-type device on her hands but the facility was unable to find them. The family member also indicted the resident had splints for both hands but therapy had removed the splints when the resident started on hospice services. The family member further indicated hospice would not provide the splints or a palm protector for the resident.</p> <p>During an interview on at 4/14/16 at 2:20 p.m., RN #1 indicated Resident #88 was supposed to have splints for her hand contractures but she did not know where they were at this time. RN #1 indicated she would speak to therapy and hospice regarding obtaining the splints for the resident.</p>			

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R 0000 Bldg. 00	<p>A policy titled, Goals and Objectives, Restorative Services," received from the DON on 4/19/16 at 9:35 a.m., indicated rehabilitative goals and objectives would be developed for each resident and outlined in their plan of care relative to therapy services.</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 56</p> <p>Sample: 7</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	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 construed as agreement with deficiencies cited.	
R 0246 Bldg. 00	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All</p>			

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	<p>contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on interview, and record review, the facility failed to ensure as needed medications administered by a QMA (Qualified Medication Aid) were authorized by a licensed nurse for 1 of 7 residents reviewed. (Resident #111)</p> <p>Findings include:</p> <p>On 4/18/16 at 2:00 p.m., Resident #111's clinical record was reviewed.</p> <p>The most recent signed physician's recapitulation orders, signed 4/14/16 included, but was not limited to: Dilaudid (an opiod analgesic medication), 2 mg (milligrams), by mouth, every 4 (four) hours, as needed, for pain.</p> <p>The eMAR (Electronic Medication Administration Record) indicated Resident #111 had received, Dilaudid 2 mg, by a QMA on: 3/6/16 at 5:21 a.m. 3/7/16 at 5:30 a.m. 3/9/16 at 5:22 a.m. 3/12/16 at 5:27 a.m. 3/20/16 at 5:37 a.m. 3/21/16 at 5:34 a.m.</p>	R 0246	<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 construed as agreement with deficiencies cited. <u>R-246 PRN QMA Administration</u> What corrective action will be accomplished for resident found to be affected by deficient practice? Resident #111 has suffered no ill effects and received all pain control medication as ordered by the physician. How other residents potentially affected will be identified and corrective actions taken? All residents have the potential to be affected by the cited deficiency. The Director of Nursing or designee shall complete a PRN medication review for residents who reside in the residential setting. All identified PRN medications shall be reviewed by the physician for continued use. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur? To enhance currently complaint operations under the direction of the Director of Nursing or designee the current medication administration policy</p>	05/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155768	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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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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	<p>3/26/16 at 5:45 a.m. 4/3/16 at 5:15 a.m. 4/4/16 at 5:07 a.m. 4/9/16 at 5:54 a.m. 4/14/16 at 5:37 a.m.</p> <p>The clinical record lacked a documented authorization by a licensed nurse.</p> <p>On 4/18/16 at 2:28 p.m., the MDS (Minimum Data Set) Assessment Coordinator indicated the authorization by a licensed nurse would be documented in the nurses notes. The MDS Coordinator verified there was not a documented authorization.</p> <p>On 4/19/16 at 8:38 a.m., the DON (Director of Nursing) provided the "Administering Medications" policy, revised 4/2010. The policy included, but was not limited to: only persons licensed or permitted by this State to prepare, administer and document the administration of medications may do so.</p>		<p>which follows regulations and states a QMA may administer PRN medications when authorized and cosigned by a licensed nurse shall be revised. The new policy shall read QMA's employed at Evansville Protestant Home are prohibited to administer PRN medications and treatments. Licensed nursing staff and QMAs shall receive in-service regarding the change in PRN administration by QMAs. The new scope of practice shall be utilized for current and new employees. How the corrective actions will be monitored to ensure the deficient practice will not recur? PRN medication administration report shall be ran at the end of each shift for verification a licensed nurse completed the administration. This audit shall be completed 5 days a week for 4 weeks, 3 times a week for 4 weeks and monthly for 3 months. Any variation in protocol or processing will result in immediate correction. Audits shall be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate unless QA committee deems 100% compliance was achieved.</p>	