STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155768	A. BUILDING 00 B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVANSVILLE PROTESTANT HOME	3701 WASHINGTON AVE EVANSVILLE, IN 47714

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Survey. This visit included a State Residential Licensure Survey. Survey dates: January 29, 30, 31, February 1, and 2, 2024. Facility number: 001125 Provider number: 155768 AIM number: 201272600 Census Bed Type: SNF/NF: 22 SNF: 20 NCC: 13 Residential: 30 Total: 85 Census Payor Type: Medicare: 10 Medicaid: 18 Other: 14 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 12, 2024.	F 0000	Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of regulatory required response and is not to be construed as agreement with the deficiencies cited.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined			

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

Anna Michelle Perry | HFA | 02/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 1 residents observed with medications in their room. (Resident 246) Finding includes: On 1/29/24 at 10:36 A.M., a tube of hydrocortisone 1% cream was observed on Resident 246's bedside table. Resident 246 indicated that she received it from the hospital upon discharge and kept it in her room to use on her face as needed for itchiness. On 1/30/24 at 9:05 A.M., a tube of hydrocortisone 1% cream was observed on Resident 246's bedside table. On 1/31/24 at 8:51 A.M., a tube of hydrocortisone 1% cream was observed on Resident 246's bedside table. On 1/30/24 at 8:23 A.M., Resident 246's clinical record was reviewed. Diagnosis included, but was not limited to, local infection of the skin and subcutaneous tissue. Resident 246 was admitted to the facility on 1/27/24. The admission MDS (Minimum Data Set) Assessment was still in progress. A BIMS (Brief Interview for Mental Status) assessment, dated 1/29/24, indicated Resident 246 was cognitively intact. A Functional Abilities Assessment, dated 1/30/24, indicated the resident required setup assistance	F 0554	**F-554 D** ***1 What corrective action will be accomplished for resident found to be affected by deficient practice?*** Resident #246 has suffered no ill effects from the hydrocortisone 1% cream observed in the room and utilized by the resident. Resident 246 was a new admission, less than 48 hours from state entrance date, and had not disclosed to nursing staff she had brought the cream into the facility the hospital had given her. Resident 246 was assessed to be cognitively intact. Resident now has orders for all medications she has been prescribed. ***2 How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be affected. The DON or designee shall ask new admissions to the facility if they have brought any medications or over the counter items into the facility and document. DON or designee shall also audit current residents for meds in room nursing is unaware of as a baseline. Any discrepancy shall be corrected immediately. All current residents have been asked this information and chart reviewed for orders and correct self-administration in the chart.	03/02/2024

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	for eating, supervision for transfers, and partial to moderate assistance for bed mobility and toileting. Current physician orders lacked an order for hydrocortisone 1% cream and an order to self administer medications. The clinical record lacked a self administration of medication evaluation. Hospital discharge papers, dated 1/11/24, indicated the resident was discharged with hydrocortisone 1% cream - 1 application topically TID (three times a day). On 1/30/24 at 9:30 A.M., RN (Registered Nurse) 3 indicated that no resident on the North Unit self administered medications. On 1/30/24 at 2:16 P.M., the Administrator indicated that in order to keep medications at bedside, a resident needed a self administration of medication evaluation and a physician order. On 1/31/24 at 11:27 A.M., the DON (Director of Nursing) indicated that Resident 246 did not have a completed self administration of medication evaluation. At that time, she indicated that she could not find an order for hydrocortisone 1% cream and wasn't aware the resident used it. On 1/31/24 at 1:47 P.M., an Administering Medications policy, revised April 2010, indicated "residents may self-administer their own medications only if the Attending Physician and Interdisciplinary Care Team, has determined that they have the decision-making capacity to do so safely". 3.1-11(a)		***3 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 admission staff shall receive in-service training regarding residents who enter with their own or over the counter meds should have a self-administration assessment completed and a physician order to accompany. ***4 How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Admission Audits referencing if resident has brought any medications or over the counter items into the facility shall be reviewed by DON or designee for completion and compliance within 24 hours. This type of questioning to new admissions shall be ongoing in order to maintain 100% compliance.	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview the facility failed to ensure residents received necessary respiratory care and services in accordance with professional standards of practice for 2 of 2 residents reviewed for respiratory care. The facility failed to date tubing and label humidification bottles, place signs indicating oxygen use, and lacked a care plan for oxygen for a resident on oxygen. (Resident 246 and Resident 11) Findings include: 1. On 1/29/24 at 10:28 A.M., an oxygen concentrator was observed in Resident 246's room. The humidification bottle and tubing was not labeled or dated. There was no "oxygen in use" sign on the resident's door. At that time, Resident 246 indicated that she occasionally needed oxygen to help keep her oxygen saturation up and that she had used oxygen last night. On 1/30/24 at 9:05 A.M., an oxygen concentrator was observed in Resident 246's room. The humidification bottle and tubing was not labeled or dated. There was no "oxygen in use" sign on the resident's door.	F 0695	**F 695 D** ***1. What corrective action will be accomplished for resident found to be affected by deficient practice?*** Resident 246 and Resident 11 have suffered no ill effects. Resident 246 was a new admission in facility during this observation. Oxygen was taken to the room as PRN order came from hospital with admission. Resident 246 has had corrections made for compliance. Resident 11 has had the oxygen use order set updated in the chart for compliance. ***2. How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be affected. The DON or designee shall audit all residents who have orders for oxygen use for compliance, specific to professional standards such as	03/02/2024

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	On 1/31/24 at 8:51 A.M., an oxygen concentrator was observed in Resident 246's room. The humidification bottle and tubing was not labeled or dated. There was no "oxygen in use" sign on the resident's door. At that time, Resident 246 indicated she used oxygen last night and the concentrator was just turned off. On 1/30/24 at 8:23 A.M., Resident 246's clinical record was reviewed. Diagnoses included, but were not limited to, essential hypertension, paroxysmal atrial fibrillation, chronic respiratory failure with hypoxia - PRN (as needed) oxygen use, and obstructive sleep apnea. Resident 246 was admitted to the facility on 1/27/24. The admission MDS (Minimum Data Set) Assessment was still in progress. A BIMS (Brief Interview for Mental Status) assessment, dated 1/29/24, indicated Resident 246 was cognitively intact. A Functional Abilities Assessment, dated 1/30/24, indicated the resident required setup assistance for eating, supervision for transfers, and partial to moderate assistance for bed mobility and toileting. Current physician orders included, but was not limited to: Supplemental O2 (oxygen) 1-2LNC (liters nasal cannula) prn to maintain O2 sat (saturation) >92%, for respiratory failure, dated 1/27/24. Check O2 sat every shift (prn supplemental if <92%) for COPD (chronic obstructive pulmonary disease), dated 1/27/24. Hospital discharge paperwork, dated 1/27/24,		tubing dates, labels on humidifier bottles, oxygen signs in use, and updated care plans for oxygen use. Any discrepancy shall be corrected immediately. All current residents have been asked this information and chart reviewed for orders and correct self-administration in the chart. ***3 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 appropriate nursing staff shall receive in-service training regarding professional standards such as tubing dates, labels on humidifier bottles, oxygen signs in use, and updated care plans for oxygen use and how to immediately correct any discrepancy. Night shift nurse for each designated unit shall be responsible to replace and date tubing. Order sets regarding oxygen professional standards shall be placed in the chart as a task for completion. ***4 How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Oxygen use audits referencing professional standards such as tubing dates, labels on humidifier bottles, oxygen signs in use, and updated care plans for oxygen use shall be reviewed by DON or designee and brought to QAPI for	

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	indicated the resident needed to be on 1L continuous oxygen via nasal cannula. A current baseline care plan, dated 1/27/24, lacked indication of oxygen use. A vitals report indicated the resident received 2L oxygen on 1/27/24 at 11:16 P.M. and 1L oxygen on 1/29/24 at 6:55 A.M. The January 2024 TAR (treatment administration record) indicated the resident did not receive oxygen. On 1/31/24 at 8:56 A.M., the DON (Director of Nursing) indicated that nursing staff was responsible for changing out and dating humidification bottles and tubing. She indicated they performed the task when they saw the water in the bottle was getting low. On 1/31/24 at 11:27 A.M., the DON indicated oxygen should be included on the baseline care plan under the cardiac or respiratory problems. She indicated if the resident came into the facility with oxygen, it should be addressed on the baseline care plan somewhere. On 1/31/24 at 1:49 P.M., an Oxygen Administration policy, revised October 2010, indicated "place an "Oxygen in Use" sign on the outside of the room entrance door". On 2/01/24 at 8:37 A.M., a Care Plan - Baseline policy, revised December 2016, indicated "The Interdisciplinary Team will...implement a baseline care plan to meet the resident's immediate care needs including but not limited to initial goals based on admission orders, physician orders...".2. On 1/29/24 at 11:02 A.M., Resident 11 was		tracking completion and compliance. Audits shall be completed weekly x 8 weeks and then random monthly compliance is achieved. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random monthly when QA committee deems 100% compliance was achieved.	

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	observed lying in bed with oxygen tubing and a concentrator on the side of the bed without a date or initials. On 1/31/24 at 9:41 A.M., Resident 11 was observed sitting in a wheelchair wearing oxygen at 2 liters (L) via nasal cannula. The tubing lacked a label with initials and date. On 1/29/24 at 11:02 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, cardiomegaly, cardiomyopathy, and sleep apnea. The current quarterly MDS (Minimum Data Set) Assessment, dated 11/2/23, indicated Resident 11 was severely cognitively impaired. Resident 11 was dependent for transfer, eating, and toileting. Current physician orders included, but were not limited to: Supplemental oxygen at 2L/Minute for comfort measures as needed, dated 5/26/23. The clinical record lacked an order to change the tubing. During an interview on 2/2/24 at 10:34 A.M., RN (Registered Nurse) 3 indicated the oxygen tubing was changed out weekly on the night shift. At that time, she indicated there should be an order to change the tubing weekly and placed on the MAR (Medication Administration Record). A current "Departmental (Respiratory Therapy) - Prevention of Infection" policy, dated November 2011, was provided on 2/2/24 at 12:20 P.M. by the Administrator. The policy indicated "... the purpose of this procedure is to guide prevention of infection associated with the respiratory			

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	therapy tasks and equipment among staff and residents...infection control consideration related to oxygen administration include...change the cannula and tubing every 7 days or as needed". 3.1-47(a)(6)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other			

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record	F 0880	***F 880 D***	03/02/2024

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	review, the facility failed to ensure infection control procedures were implemented, appropriate hand hygiene was not performed for 2 of 2 residents observed for wound care. (Resident 38 and Resident 16) Findings include: 1. On 1/31/24 at 1:47 P.M. Registered Nurse (RN) 5 was observed performing a dressing change on Resident 38's right forearm. RN 5 entered Resident 38's room, put on gloves, used the bed remote to raise Resident 38's bed, and started wound care without performing hand hygiene. RN 5 removed Resident 38's previous dressing dated 1/29/24. RN 5 began pouring saline over Resident 38's wounds, touching the open areas of the wounds with the gloves. RN 5 then dried the wounds off using a wash cloth that was laying on Resident 38's bed. RN 5 removed gloves, applied hand sanitizer and rubbed hands together for 5 seconds, and put on another pair of gloves. RN 5 applied the dressings to the wounds and dated the wound. RN 5 removed gloves, assisted Resident 38 with pulling their shirt sleeve down, put gloves on, gathered soiled linens and trash, removed gloves before exiting the room, no hand hygiene was performed. 2. On 1/30/24 at 1:10 P.M., Registered Nurse (RN) 5 and Certified Nurse Aide (CNA) 10 was observed performing a dressing change on Resident 16's stage 4 coccyx pressure ulcer. Upon entering the room and assisting the resident, RN 5 and CNA 10 put on gloves without performing hand hygiene. They rolled Resident 16 on to her side and removed her brief. Resident 16 had a liquid bowel movement which was cleaned with a washcloth using soap and water. RN 5 removed her gloves and put new ones on without performing hand hygiene. A new pad and clean		***1 What corrective action will be accomplished for resident found to be affected by deficient practice?*** Resident # 38 and Resident #16 have suffered no ill effects. Resident 38 has discharged from facility. Resident #16 continues with treatments and Hospice care. ***2 How other residents potentially affected will be identified and corrective actions taken?*** Audit of nursing residents who require wound care has been completed. Additional education has been developed for appropriate staff specific to infection control procedures for how hand hygiene should be performed before wound care, between glove changes, between dirty and clean task, and when task is complete. ***3 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 appropriate nursing staff shall receive in-service training regarding proper infection control procedures specific to how hand hygiene should be performed before wound care, between glove changes, between dirty and clean task, and when task is complete.	

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	towel were placed under the resident and a washcloth was used to clean the resident's bottom again. RN 5 removed her gloves and put new ones on without performing hand hygiene. RN 5 measured the wound. RN 5 removed her gloves and put new ones on without performing hand hygiene. RN 5 applied medicated gel and packing to the wound. RN 5 removed her gloves and put new ones on without performing hand hygiene. A dressing was placed on the wound. RN 5 rolled the resident to remove the dirty pad, wiped the front of the resident, put on a new brief, arranged the pillows and blankets on the bed, gathered trash, and handed the resident her call light. RN 5 removed her gloves and performed hand hygiene. On 2/2/24 at 10:35 A.M., the Infection Preventionist indicated hand hygiene should be performed before wound care, between glove changes, between dirty and clean tasks, and when finished. On 1/30/24 at 2:35 P.M., the Infection Preventionist provided a policy titled "Handwashing/Hand Hygeine", revised 2015, that indicated "Wash hands with soap and water a. when hands are visibly soiled. Use an alcohol based hand rub or soap and water b. Before and after direct contact with residents; g. Before handling clean or soiled dressings; i. After contact with a resident's skin; m. After removing gloves". 3.1-18(l)		***4 How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Infection Control audits referencing infection prevention standards such as how hand hygiene should be performed before wound care, between glove changes, between dirty and clean task, and when task is complete. Audits will be completed daily x 4 weeks, then weekly x 4 weeks. Audits shall be brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random monthly when QA committee deems 100% compliance was achieved.	
F 9999 Bldg. 00	NCC (Non-Certified Comprehensive) FINDINGS:	F 9999	**F9999 #1** ***1 What corrective action will***	03/02/2024

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	#1. 3.1-18 INFECTION CONTROL PROGRAM (b) The facility must establish an infection control program under which it does the following: (2) Decides what procedures (such as isolation) should be applied to an individual resident, including, but not limited to,written, current infection control program policies and procedures for an isolation/precautions system to prevent the spread of infection that isolates the infectious agent and includes full implementation of universal precautions. This state rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure infection control was during medication administration for 2 of 6 residents observed during medication administration. The blood pressure equipment was not cleaned properly between resident assessments.(Resident 32, Resident 65) Findings include: 1. On 1/30/24 at 9:11 A.M., RN (Registered Nurse) 3 was observed taking a blood pressure (BP) with a BP cuff for Resident 32 with a reading of 106/68. The RN removed the BP cuff and did not it sanitize afterwards. 2. On 1/30/24 at 9:44 A.M., RN 3 was observed taking a oxygen saturation with a pulse oximeter on Resident 65 with a reading of 98%. The machine was not cleaned after use. Hands were sanitized		***be accomplished for resident found to be affected by deficient practice?*** Resident #32 and Resident # 65 have suffered no ill effects. ***2 How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be effected according to their orders. Additional education regarding sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents. ***3 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 appropriate nursing staff shall receive in-service training regarding proper infection control procedures specific to sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents. ***4 How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Infection Control audits referencing	

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	155768	A. BUILDING 00 B. WING	02/02/2024

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	During an interview on 1/30/24 at 10:05 A.M., RN 3 indicated equipment should be cleaned in between residents with a bleach wipe. On 2/2/24 at 11:45 A.M.,the Infection Preventionist presented a current "Cleaning and Disinfection of Resident-Care Items and Equipment" policy, dated October 2009. The policy indicated "...reusable items are cleaned and disinfected or sterilized between residents...". #2. 3.1-18 Infection Control (l) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. This state rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure infection control was maintained during medication administration for 3 of 6 residents observed during medication. The nurse inadequately performed handwashing between resident assessments. (Resident 55, Resident 82, Resident 32) Findings include: 1. On 1/30/24 at 9:11 A.M., RN (Registered Nurse) was observed in Resident 32's washing her hands for 13 seconds with soap and water before leaving the room. 2. On 1/30/24 at 10:02 A.M., RN 3 was observed washing her hands after giving medications to Resident 82 for 8 seconds.		infection prevention standards such as sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents will be done daily x 4 weeks, then weekly x 4 weeks. Audits shall be brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random monthly when QA committee deems 100% compliance was achieved. **F9999 #2** ***1 What corrective action will be accomplished for resident found to be affected by deficient practice?*** Resident #32 and Resident # 82 have suffered no ill effects. ***2 How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be effected according to their orders. Additional education regarding hand hygiene standards specific to timing of handwashing shall be reviewed.	

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	3. On 1/31/24 at 10:05 A.M., RN 3 was observed leaving Resident 55's room after a medication pass without sanitizing her hands. On 2/2/24 at 10:35 A.M., the Infection Preventionist indicated hand hygiene should be performed before wound care, between glove changes, between dirty and clean tasks, and when finished. On 1/30/24 at 2:35 P.M., RN 5 presented a current "Handwashing/Hand Hygiene" policy, dated August 2015. The policy indicated "...use an alcohol-based hand rub 62% alcohol: or alternatively, soap (antimicrobial or nonantimicrobial) and water in the following: ...before and after coming in contact with residents". #3. 3.1-47 SPECIAL NEEDS (a) The facility must ensure that the residents receive proper treatment and care by qualified personnel for the following special services if offered: (6) Respiratory care. This state rule was not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure resident received necessary respiratory care and services in accordance with professional standards of practice for 1 of 1 residents reviewed for oxygen use. The facility failed to date tubing and label humidification bottles for a resident on oxygen. (Resident 26) Finding includes:		***3 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 appropriate nursing staff shall receive in-service training regarding adequate handwashing technique and time. ***4 How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Infection Control audits referencing infection prevention standards such as adequate handwashing technique and time daily x 4 weeks, then weekly x 4 weeks. Audits shall be brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random monthly when QA committee deems 100% compliance was achieved. **F9999 #3** ***1. What corrective action will be accomplished for***	

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	On 2/1/24 at 9:35 A.M., the oxygen concentrator, humidified bottle, and oxygen tubing in Resident 26's room was observed without a date and label. On 2/2/24 at 9:00 A.M., the oxygen concentrator, humidified bottle, and oxygen tubing in Resident 26's room was observed without a date and label. On 2/1/24 at 10:00 A.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and acute respiratory failure with hypoxia. The current service plan, dated 12/11/23, indicated the resident was cognitively intact and was independent with dressing, toileting and, eating. Current physician orders included but not limited to: Oxygen 1-2 Liters PRN (as needed) to keep O2 (oxygen) above 93%, as needed, dated 12/22/2023. During an interview on 2/2/24 at 10:34 A.M., RN (Registered Nurse) 5 indicated the oxygen tubing was changed out weekly on the night shift. At that time, she indicated there should be an order to change the tubing weekly and placed on the MAR (Medication Administration Record). A current "Departmental (Respiratory Therapy) - Prevention of Infection" policy, dated November 2011, was provided on 2/2/24 at 12:20 P.M. by the Administrator. The policy indicated "... the purpose of this procedure is to guide prevention of infection associated with the respiratory therapy tasks and equipment among staff and residents...infection control consideration related to oxygen administration include... change the		***resident found to be affected by deficient practice?*** Resident 26 has had corrections made for compliance. ***2. How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be affected. The DON or designee shall audit all residents who have orders for oxygen use for compliance, specific to professional standards such as tubing dates, labels on humidifier bottles, oxygen signs in use, and updated care plans for oxygen use. Any discrepancy shall be corrected immediately. All current residents have been asked this information and chart reviewed for orders and correct self-administration in the chart. ***3 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 appropriate nursing staff shall receive in-service training regarding professional standards such as tubing dates, labels on humidifier bottles, oxygen signs in use, and updated care plans for oxygen use and how to immediately correct any discrepancy. ***4 How the corrective actions will be monitored to ensure the***	

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	cannula and tubing every 7 days or as needed".		***deficient practice will not recur?*** Oxygen use audits referencing professional standards such as tubing dates, labels on humidifier bottles, oxygen signs in use, and updated care plans for oxygen use shall be completed by DON or designee weekly for 8 weeks and brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random monthly when QA committee deems 100% compliance was achieved.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Survey. Survey dates: January 29, 30, 31, February 1, and 2, 2024. Facility number: 001125 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of regulatory required response and is not to be construed as agreement with the deficiencies cited.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation			

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	shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview the facility failed to ensure medication was safely administered to residents who did not have a self administration of medication evaluation for 2 of 6 medication administrations. Medications were left at bedside and not taken in the presence of the nurse. (Resident 13, Resident 25) Findings include: 1. On 1/31/24 at 7:18 A.M., LPN (Licensed Practical Nurse) 12 was observed leaving Resident 13's medication in the room on a table and exited the room without monitoring the resident taking the medications. The following medications were left in the room: 1 Aspirin 325 mg (milligrams) 1 Calcium pill 1 Preservision capsule 1 Metoprolol 50 mg 1 Amlodipine 1 Fluoxetine 20 mg	R 0216	**R216** ***1. What corrective action will be accomplished for resident found to be affected by deficient practice?*** Resident 13 and Resident 25 have suffered no ill effects. For both residents the medication administration observed is resident preference. Facility understands compliance is the priority and there is not a self-administration order for either of the residents listed above. Social Service or designee shall be asked to speak with residents regarding these compliance concerns. ***2. How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be affected. The DON or designee shall audit all residents who have orders for self-administration and educate residents who have	03/02/2024

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	The nurse did not go back to see if the resident took the medication. On 2/1/24 at 2:06 P.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, aftercare following joint replacement surgery and presence of left artificial shoulder joint. The service plan, dated 7/4/23, indicated the resident was cognitively intact and independent with dressing, eating, and toileting. The service plan also indicated the resident's medications were to be administered by the nursing staff. Current physician orders included, but was not limited to: Nursing to administer all medications dated 7/5/23. The clinical record lacked an order and evaluation for self administration of medications. The Self-Administration of Medication Assessment completed on 7/5/23 indicated nursing was to administer medications. 2. On 1/31/24 at 8:45 A.M., LPN 12 was observed leaving Resident 25's medications in the room on a table and exited the room without monitoring the resident taking the medications. The following medications were left in the room: 1 Carbidopa/ levodopa 25/100 mg 1 KCL (potassium chloride) 20 meq (milliequivalent) 1 Aspirin 81 mg 1 Lexapro 20 mg 1 Ferrous sulfate 324 mg 1 Flonase 1 Cinamide 2.5 mg		personal preferences to take meds at will instead of when nurse brings them. Any discrepancy shall be corrected immediately. Resident Council in residential setting was held to assist with communication regarding medication administration practice. ***3 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 appropriate nursing staff shall receive in-service training regarding professional standards of medication administration, how to accommodate personal preferences and comply with regulatory requirements and how to immediately correct any discrepancy. ***4 How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Medication Administration audits referencing professional standards of medication administration including visualizing medication consumption shall be completed daily for 8 weeks and brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random	

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	1 Meclizine 12.5 mg 1 Metoprolol 50 mg 1 Torsemide 20 mg 1 Preservision Miralax 17 gm mixed with 8 ounces of water The nurse did not go back to see if the resident had taken the medication. On 2/1/24 at 1:43 P.M., Resident 25's clinical record was reviewed. Diagnoses included, but were not limited to, iron deficiency anemia secondary to blood loss (chronic), urinary tract infection, and other encephalopathy. The most recent service plan, dated 1/26/24, indicated the resident was cognitively intact and was independent with toileting, dressing, and eating. Current physician orders included, but not limited to: Nursing to administer medications, dated 9/1/23. The clinical record lacked an order and evaluation for the self administration of medications. On 1/30/24 at 2:16 P.M., the Administrator indicated that in order to keep medications at bedside, a resident needed a self administration of medication evaluation and a physician order. On 1/31/24 at 2:37 P.M., the Director of Nursing presented a current "Administering Medication" policy, dated April 2010. The policy indicated "Medications shall be administered in a safe and timely manner, and as prescribed...residents may self-administer their own medications only if the Attending Physician in conjunction with the Interdisciplinary Care Planning Team, has		monthly when QA committee deems 100% compliance was achieved.	

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	determined that they have the decision-making capacity to do so safely...". 410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
R 0407 Bldg. 00	Based on observation, record review, and interview, the facility failed to ensure infection control practices was maintained due to lack of proper equipment sanitization between residents. The nurse did not clean or sanitize equipment for 3 of 6 residents observed during medication administration. (Resident 4, Resident 11, Resident 39) Findings include: 1. On 1/31/24 at 7:18 A.M., LPN (Licensed Practical Nurse) 12 was observed checking Resident 13's pulse oximetry. LPN 12 did not sanitize the equipment afterwards. 2. On 1/31/24 at 7:20 A.M., LPN 12 was observed checking the pulse oximeter of Resident 11. LPN 12 did not sanitize the equipment afterwards. 3. On 1/31/24 at 7:35 A.M., LPN 12 checked resident 39's pulse oximetry and left the room	R 0407	**R 407** ***1 What corrective action will be accomplished for resident found to be affected by deficient practice?*** Resident #4, #11 and Resident # 39 have suffered no ill effects. ***2 How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be affected according to their orders. Additional education regarding sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents.	03/02/2024

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	without cleaning the equipment. During an interview on 1/31/24 at 9:11 A.M., LPN 12 indicated bleach wipes were used to clean the equipment in between residents. On 2/2/24 at 11:45 A.M., the Infection Preventionist presented a current "Cleaning and Disinfection of Resident-Care Items and Equipment" policy, dated October 2009. The policy indicated "...reusable items are cleaned and disinfected or sterilized between residents...".		***3 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 appropriate nursing staff shall receive in-service training regarding proper infection control procedures specific to sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents. Review of product instructions shall be included in the education. ***4 How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Infection Control audits referencing infection prevention standards such as sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents daily x 4 weeks and then weekly x 4 weeks. Audits shall be brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random monthly when QA committee	

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			deems 100% compliance was achieved.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review, and interview, the facility failed to ensure infection control practices was maintained during medication administration for 2 of 6 residents observed during medication administration. The nurse did not clean or sanitize vital sign equipment in between resident assessments. (Resident 39, Resident 10) Findings include: 1. On 1/31/24 at 7:35 A.M., LPN (Licensed Practical Nurse) 12 was observed preparing medications for Resident 39. LPN 12 took too many Eliquis pills out of the bottle and returned the extra medication to the bottle without sanitizing his hands. At that time, LPN 12 checked resident 39's pulse oximetry and left the room without cleaning the equipment. 2. On 2/1/24 at 12:05 P.M., LPN 12 was observed leaving of Resident 39's room after passing medication and did not sanitize his hands. 3. On 1/31/24 at 9:02 A.M., LPN 12 was observed leaving Resident 10's room after passing medication and did not sanitize his hands. On 2/2/24 at 10:35 A.M., the Infection	R 0414	**R 414** ***1.What corrective action will be accomplished for resident found to be affected by deficient practice?*** Resident #39 has suffered no ill effects. ***2.How other residents potentially affected will be identified and corrective actions taken?*** All residents have the potential to be effected according to their orders. Additional education regarding sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents. ***3.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 appropriate nursing staff shall receive	03/02/2024

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	Preventionist indicated hand hygiene should be performed before wound care, between glove changes, between dirty and clean tasks, and when finished. On 1/30/24 at 2:35 P.M., RN 5 presented a current "Handwashing/Hand Hygiene" policy, dated August 2015. The policy indicated "...use an alcohol-based hand rub 62% alcohol: or alternatively, soap (antimicrobial or nonantimicrobial) and water in the following: ...before and after coming in contact with residents".		in-service training regarding proper infection control procedures specific to sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents. ***4.How the corrective actions will be monitored to ensure the deficient practice will not recur?*** Infection Control audits referencing infection prevention standards such as sanitizing equipment between residents during medication administration which includes the blood pressure cuff, pulse oximeter, and other reusable items which require disinfection between residents will be done daily x 4 weeks, then weekly x 4 weeks. Audits shall be brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will titrate down to random monthly when QA committee deems 100% compliance was achieved.	