STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155768		A. BU	A. BUILDING 00 COI B. WING 02/		COMPL	DATE SURVEY DMPLETED 2/02/2024	
	PROVIDER OR SUPPLIER			3701 W	ADDRESS, CITY, STATE, ZIP COD /ASHINGTON AVE SVILLE, IN 47714		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00 F 0554 SS=D Bldg. 00	Licensure Survey.  Non-Certified Composition included a State Survey.  Survey dates: January 2, 2024.  Facility number: 00 Provider number: 15 AIM number: 2012.  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 reaccordance with 410  Quality review composition in the self-Adm \$483.10(c)(7) Resident Self-Adm \$483.10(c)(7) The medications if the	prehensive (NCC) Survey. This e Residential Licensure ary 29, 30, 31, February 1, and 1125 55768 72600	F 00	000	Please accept this plan of correction as our credible allegation of compliance. This of correction is submitted as p of regulatory required responsand is not to be construed as agreement with the deficiencie cited.	art e	
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURI	3	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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Event ID: 5GIT11 Facility ID: 001125 If continuation sheet Page 1 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155768	B. WI	ING		02/02/	/2024
NAME OF I			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEF	C		3701 W	/ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	THOME		EVANS	SVILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s clinically appropriate.					
		on, interview, and record	F 05	554			03/02/2024
	-	failed to ensure residents that		F-554 D			
		ring medications were			1 What corrective action i		
	_	assessed for capability to self administer			be accomplished for residen		
	medications for 1 of 1 residents observed with				found to be affected by defice	ient	
	medications in their	room. (Resident 246)			practice?		
					Resident #246 has suffered no		
	Finding includes:				effects from the hydrocortison		
					1% cream observed in the roo	m	
	On 1/29/24 at 10:36 A.M., a tube of				and utilized by the resident.		
	hydrocortisone 1% cream was observed on				Resident 246 was a new		
	Resident 246's bedside table. Resident 246			admission, less than 48 hours			
	indicated that she received it from the hospital			from state entrance date, and had			
	-	kept it in her room to use on		not disclosed to nursing staff she			
	her face as needed	for itchiness.			had brought the cream into the		
					facility the hospital had given I		
		A.M., a tube of hydrocortisone			Resident 246 was assessed to		
		erved on Resident 246's			cognitively intact. Resident no		
	bedside table.				has orders for all medications	she	
					has been prescribed.		
		A.M., a tube of hydrocortisone			2 How other residents		
		erved on Resident 246's			potentially affected will be		
	bedside table.				identified and corrective acti	ons	
	- 1/00/04 · 0.00				taken?		
		A.M., Resident 246's clinical			All residents have the potentia		
		d. Diagnosis included, but was			be affected. The DON or desi	•	
	1	infection of the skin and			shall ask new admissions to the		
	subcutaneous tissue	».			facility if they have brought an	-	
	D 11 + 246	1 20 10 4 6 22			medications or over the count	er	
		dmitted to the facility on			items into the facility and		
		sion MDS (Minimum Data Set)			document. DON or designee s		
	Assessment was sti	ii in progress.			also audit current residents for		
	A DIMC (D.::-£1 (	miliony for Montal Status			meds in room nursing is unaw		
	`	erview for Mental Status)			of as a baseline. Any discrepa	-	
		/29/24, indicated Resident 246			shall be corrected immediately		
	was cognitively inta	act.			current residents have been a		
	A Français : 1 A 1 '1'	ing Appropriate 1-1-1 1/20/04			this information and chart review	ewed	
		ries Assessment, dated 1/30/24,			for orders and correct		
	indicated the reside	nt required setup assistance			self-administration in the chart		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155768	B. W	ING		02/02/	/2024
NAME OF I	DROVIDED OD GLIDDI IER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	PROVIDER OR SUPPLIEF			3701 W	/ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	T HOME		EVANSVILLE, IN 47714			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ion for transfers, and partial to			3 What measures will be		
	moderate assistance for bed mobility and toileting.				in place or systemic change		
					made to ensure the deficient	t	
		orders lacked an order for			practice does not recur?		
	-	cream and an order to self			To enhance currently complai		
	administer medications.				operations under the direction		
	and the second				the Director of Nursing license		
		lacked a self administration of			nursing staff and admission st		
	medication evaluati	on.			shall receive in-service trainin		
					regarding residents who enter		
		papers, dated 1/11/24,			their own or over the counter		
		nt was discharged with			should have a self-administrate	tion	
	hydrocortisone 1% cream - 1 application topically				assessment completed and a		
	TID (three times a d	lay).			physician order to accompany		
					4 How the corrective action	-	
		A.M., RN (Registered Nurse) 3			will be monitored to ensure		
		sident on the North Unit self			deficient practice will not re		
	administered medic	ations.			Admission Audits referencing	if	
					resident has brought any		
		P.M., the Administrator			medications or over the count	er	
		ler to keep medications at			items into the facility shall be		
	· ·	needed a self administration of			reviewed by DON or designed		
	medication evaluati	on and a physician order.			completion and compliance w		
	0.4/04/5				24 hours. This type of questio	ning	
		A.M., the DON (Director of			to new admissions shall be		
		that Resident 246 did not have			ongoing in order to maintain 1	00%	
	_	ministration of medication			compliance.		
		time, she indicated that she					
		der for hydrocortisone 1%					
	cream and wasn't av	ware the resident used it.					
	On 1/31/24 at 1·47	P.M., an Administering					
		revised April 2010, indicated					
		administer their own					
		the Attending Physician and					
		are Team, has determined that					
		on-making capacity to do so					
	safely".						
	53101)						
	3.1-11(a)		1				

PRINTED: 03/07/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155768 B. WING 02/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3701 WASHINGTON AVE **EVANSVILLE PROTESTANT HOME EVANSVILLE. IN 47714** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0695 483.25(i) SS=D Respiratory/Tracheostomy Care and Bldg. 00 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 F 0695 03/02/2024 interview the facility failed to ensure residents F 695 D received necessary respiratory care and services 1. What corrective in accordance with professional standards of action will be accomplished for practice for 2 of 2 residents reviewed for resident found to be affected respiratory care. The facility failed to date tubing deficient practice? and label humidification bottles, place signs Resident 246 and Resident 11 indicating oxygen use, and lacked a care plan for have suffered no ill effects. oxygen for a resident on oxygen. (Resident 246 Resident 246 was a new and Resident 11) admission in facility during this observation. Oxygen was taken to Findings include: the room as PRN order came from hospital with admission. Resident 1. On 1/29/24 at 10:28 A.M., an oxygen 246 has had corrections made for concentrator was observed in Resident 246's compliance. Resident 11 has had room. The humidification bottle and tubing was the oxygen use order set updated not labeled or dated. There was no "oxygen in in the chart for compliance. use" sign on the resident's door. At that time, 2. How other residents Resident 246 indicated that she occasionally potentially affected will be needed oxygen to help keep her oxygen saturation identified and corrective actions up and that she had used oxygen last night. taken? All residents have the potential to On 1/30/24 at 9:05 A.M., an oxygen concentrator be affected. The DON or designee

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the resident's door.

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

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shall audit all residents who have

professional standards such as

orders for oxygen use for

compliance, specific to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/02/2024 155768 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3701 WASHINGTON AVE **EVANSVILLE PROTESTANT HOME EVANSVILLE, IN 47714** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE tubing dates, labels on humidifier On 1/31/24 at 8:51 A.M., an oxygen concentrator bottles, oxygen signs in use, and was observed in Resident 246's room. The updated care plans for oxygen humidification bottle and tubing was not labeled use. Any discrepancy shall be or dated. There was no "oxygen in use" sign on corrected immediately. All current the resident's door. At that time, Resident 246 residents have been asked this indicated she used oxygen last night and the information and chart reviewed for concentrator was just turned off. orders and correct self-administration in the chart. On 1/30/24 at 8:23 A.M., Resident 246's clinical What measures will be put record was reviewed. Diagnoses included, but in place or systemic changes were not limited to, essential hypertension, made to ensure the deficient paroxysmal atrial fibrillation, chronic respiratory practice does not recur? failure with hypoxia - PRN (as needed) oxygen To enhance currently complaint use, and obstructive sleep apnea. operations under the direction of the Director of Nursing appropriate Resident 246 was admitted to the facility on nursing staff shall receive 1/27/24. The admission MDS (Minimum Data Set) in-service training regarding Assessment was still in progress. professional standards such as tubing dates, labels on humidifier A BIMS (Brief Interview for Mental Status) bottles, oxygen signs in use, and assessment, dated 1/29/24, indicated Resident 246 updated care plans for oxygen use was cognitively intact. and how to immediately correct any discrepancy. Night shift nurse A Functional Abilities Assessment, dated 1/30/24, for each designated unit shall be indicated the resident required setup assistance responsible to replace and date for eating, supervision for transfers, and partial to tubing. Order sets regarding moderate assistance for bed mobility and toileting. oxygen professional standards shall be placed in the chart as a Current physician orders included, but was not task for completion. limited to: How the corrective actions Supplemental O2 (oxygen) 1-2LNC (liters nasal will be monitored to ensure the cannula) prn to maintain O2 sat (saturation) >92%, deficient practice will not recur? for respiratory failure, dated 1/27/24. Oxygen use audits referencing professional standards such as Check O2 sat every shift (prn supplemental if tubing dates, labels on humidifier <92%) for COPD (chronic obstructive pulmonary bottles, oxygen signs in use, and disease), dated 1/27/24. updated care plans for oxygen use shall be reviewed by DON or

Hospital discharge paperwork, dated 1/27/24,

designee and brought to QAPI for

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155768	B. W	ING		02/02/	2024
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
E) (A NO) (	W LE DOCTECTANI	TUOME			ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	I HOME		EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	indicated the reside	nt needed to be on 1L			tracking completion and		
	continuous oxygen	via nasal cannula.			compliance. Audits shall be		
					completed weekly x 8 weeks a	ınd	
	A current baseline of	care plan, dated 1/27/24, lacked			then random monthly complian		
		ndication of oxygen use.			is achieved. Audits will be		
					submitted to the Quality		
	A vitals report indic	vitals report indicated the resident received 2L			Assurance Committee for review	ew	
	•	oxygen on 1/27/24 at 11:16 P.M. and 1L oxygen on			and/or further corrective action		
	1/29/24 at 6:55 A.M.				Audits will titrate down to rand		
					monthly when QA committee		
	The January 2024 TAR (treatment administration				deems 100% compliance was		
	record) indicated the resident did not receive				achieved.		
	oxygen.						
	11-7,8-11-						
	On 1/31/24 at 8:56	A.M., the DON (Director of					
	Nursing) indicated	that nursing staff was					
	responsible for char	nging out and dating					
	humidification bott	les and tubing. She indicated					
	they performed the	task when they saw the water					
	in the bottle was ge	tting low.					
	On 1/31/24 at 11:27	7 A.M., the DON indicated					
	oxygen should be in	ncluded on the baseline care					
	plan under the card	iac or respiratory problems.					
	She indicated if the	resident came into the facility					
	with oxygen, it show	uld be addressed on the					
	baseline care plan s	omewhere.					
	On 1/31/24 at 1:49	P.M., an Oxygen Administration					
	policy, revised Octo	ober 2010, indicated "place an					
	"Oxygen in Use" si	gn on the outside of the room					
	entrance door".						
	On 2/01/24 at 8:37	A.M., a Care Plan - Baseline					
	policy, revised Dec	ember 2016, indicated "The					
	Interdisciplinary Te	eam willimplement a baseline					
	care plan to meet th	e resident's immediate care					
	_	not limited to initial goals					
	_	orders, physician orders".2.					
		2 A.M., Resident 11 was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155768		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/02/2024	
	ROVIDER OR SUPPLIER		3701 W	ADDRESS, CITY, STATE, ZIP COD /ASHINGTON AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION COMPLETION
		ed with oxygen tubing and a side of the bed without a date			
	observed sitting in a	A.M., Resident 11 was a wheelchair wearing oxygen asal cannula. The tubing lacked and date.			
	Assessment, dated was severely cognit	ly MDS (Minimum Data Set) 11/2/23, indicated Resident 11 rively impaired. Resident 11 ransfer, eating, and toileting.			
	limited to:	en at 2L/Minute for comfort d, dated 5/26/23.			
	The clinical record tubing.	lacked an order to change the			
	(Registered Nurse) was changed out we that time, she indica to change the tubing	y on 2/2/24 at 10:34 A.M., RN 3 indicated the oxygen tubing eekly on the night shift. At ated there should be an order g weekly and placed on the Administration Record).			
	Prevention of Infect 2011, was provided Administrator. The purpose of this proc	nental (Respiratory Therapy) - tion" policy, dated November on 2/2/24 at 12:20 P.M. by the policy indicated " the redure is to guide prevention ted with the respiratory			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO JILDING	INSTRUCTION 00	(X3) DATE COMPL	
		155768	B. W	ING		02/02/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3701 WASHINGTON AVE  EVANSVILLE, IN 47714				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION uipment among staff and		TAG	DEFICIENCY)		DATE
	residentsinfection control consideration related to oxygen administration includechange the cannula and tubing every 7 days or as needed".  3.1-47(a)(6)						
	3.1-47(a)(6)						
F 0880 SS=D Bldg. 00	infection prevention designed to provide comfortable environthe development a communicable dis §483.80(a) Infection program.  The facility must environment of the prevention and communicable dis §483.80(a) Infection program.	on & Control					
	identifying, reporting controlling infection diseases for all responsible to the visitors, and other services under a conducted according following accepted \$483.80(a)(2) Written and procedures for include, but are not (i) A system of sur identify possible controlling infections.	ing to §483.70(e) and I national standards; tten standards, policies, r the program, which must					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155768	B. W.	ING		02/02/	2024
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
E\/ANG\/	ILLE PROTESTAN	T HOME			'ASHINGTON AVE		
CVANSV	TLLE PROTESTAN	I NOWE		EVANS	VILLE, IN 47714		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	persons in the fac			TAG			DATE
	l -	whom possible incidents of					
	, , ,	sease 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						
		luding but not limited to: duration of the isolation,					
	depending upon the infectious agent or organism involved, and						
	(B) A requirement that the isolation should be						
	the least restrictiv	e possible for the resident					
	under the circums						
	' '	nces under which the facility					
	must prohibit emp	oloyees with a sease or infected skin					
		sease or injected skin					
		t contact will transmit the					
	disease; and						
		ene procedures to be					
	followed by staff in	nvolved in direct resident					
	contact.						
	\$492 90(a)(4) A a	votem for recording					
	- , , , ,	ystem for recording d under the facility's IPCP					
		e actions taken by the					
	facility.						
	§483.80(e) Linens						
		andle, store, process, and					
	transport linens so of infection.	o as to prevent the spread					
	or intection.						
	§483.80(f) Annual	I review.					
	` ` '	nduct an annual review of					
	its IPCP and upda	ate their program, as					
	necessary.						
	Based on observation	on, interview, and record	F 03	880	F 880 D		03/02/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	UILDING	00	COMPL	
MUDILAN	or conduction	155768	B. W		<u>55</u>	02/02/	
		100700	D. W			02/02/	, <b>, , , , , , , , , , , , , , , , , , </b>
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					/ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	I HOME		EVANS	SVILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	review, the facility	failed to ensure infection					
	control procedures	were implemented, appropriate			1 What corrective action	will	
	hand hygiene was not performed for 2 of 2				nt		
	residents observed	for wound care. (Resident 38			found to be affected by		
	and Resident 16)				deficient practice?		
					Resident # 38 and Resident #	<sup>‡</sup> 16	
	Findings include:				have suffered no ill effects.		
					Resident 38 has discharged	from	
	1. On 1/31/24 at 1:	47 P.M. Registered Nurse (RN)			facility. Resident #16 continue	es	
5 was observed performing a dressing change on				with treatments and Hospice			
Resident 38's right forearm. RN 5 entered				care.			
Resident 38's room, put on gloves, used the bed				2 How other residents			
remote to raise Resident 38's bed, and started				potentially affected will be			
	wound care without performing hand hygiene.				identified and corrective act	ions	
		ident 38's previous dressing			taken?		
		5 began pouring saline over		Audit of nursing residents who			
		ds, touching the open areas of			require wound care has been		
		e gloves. RN 5 then dried the			completed. Additional educati	on	
	_	wash cloth that was laying on			has been developed for appro	priate	
		RN 5 removed gloves, applied			staff specific to infection conti		
		rubbed hands together for 5			procedures for how hand hyg		
		another pair of gloves. RN 5			should be performed before v		
		gs to the wounds and dated			care, between glove changes		
		emoved gloves, assisted			between dirty and clean task,	and	
	-	alling their shirt sleeve down,			when task is complete.		
		ered soiled linens and trash,			3 What measures will be		
	_	fore exiting the room, no hand			in place or systemic change		
	hygiene was perform				made to ensure the deficien	t	
		10 P.M., Registered Nurse (RN)			practice does not recur?		
		se Aide (CNA) 10 was			To enhance currently compla		
	•	g a dressing change on			operations under the direction		
		4 coccyx pressure ulcer. Upon			the Director of Nursing appro	oriate	
	_	and assisting the resident, RN 5			nursing staff shall receive		
	_	gloves without performing			in-service training regarding p	roper	
		rolled Resident 16 on to her			infection control procedures		
	side and removed her brief. Resident 16 had a				specific to how hand hygiene	المرابح ط	
	-	ment which was cleaned with a			should be performed before v		
	_	ap and water. RN 5 removed			care, between glove changes		
		new ones on without			between dirty and clean task,	and	
	performing hand hy	giene. A new pad and clean			when task is complete.		l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5GIT11

Facility ID: 001125

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155768		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  02/02/2024	
	ROVIDER OR SUPPLIER		3701 V	ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	washcloth was used again. RN 5 remove on without perform measured the wound and put new ones of hygiene. RN 5 appl to the wound. RN 5 new ones on without dressing was placed the resident to remote front of the resident the pillows and blar trash, and handed the removed her gloves.  On 2/2/24 at 10:35. Preventionist indicate performed before with the pillows and blar trash, and handed the removed her gloves.  On 1/30/24 at 2:35. Preventionist indicate performed before with the pillows and blar trash, and handed the removed her gloves.  On 1/30/24 at 2:35. Preventionist provide "Handwashing/Han indicated "Wash hands are visite based hand rub or seafter direct contact thandling clean or seafter direct contact than the contact that the contact than the contact that the contact than the contact than the contact that the contac	ted hand hygiene should be ound care, between glove irty and clean tasks, and when P.M., the Infection		4 How the corrective activill be monitored to ensure deficient practice will not relinfection Control audits refere infection prevention standards such as how hand hygiene she performed before wound obetween glove changes, betwienty and clean task, and whe task is complete. Audits will be completed daily x 4 weeks, the weekly x 4 weeks. Audits shat brought to QAPI for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee review and/or further correctivaction. Audits will titrate down random monthly when QA committee deems 100% compliance was achieved.	the cur? encing s nould eare, veen n e en ll be
F 9999					
Bldg. 00	NCC (Non-Certifie	d Comprehensive) FINDINGS:	F 9999	F9999 #1 1 What corrective action	03/02/2024 will

PRINTED: 03/07/2024

						I KIIN	1ED. 05/07/2024
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FOF	RM APPROVED
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155768	B. WING		02/02/2024		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
				3701 W	ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	T HOME		EVANS	VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
			1		DEFLOYENCED		

NAME OF	PROVIDER OR SUPPLIER	3701 WASHINGTON AVE			
EVANS	/ILLE PROTESTANT HOME	EVANS	VILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (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	
TAG	#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	TAG	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.	DATE	
	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		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		

If continuation sheet Page 12 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5GIT11 Facility ID: 001125

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155768 B. WING 02/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3701 WASHINGTON AVE **EVANSVILLE PROTESTANT HOME EVANSVILLE, IN 47714** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During an interview on 1/30/24 at 10:05 A.M., RN infection prevention standards 3 indicated equipment should be cleaned in such as sanitizing equipment between residents with a bleach wipe. between residents during medication administration which On 2/2/24 at 11:45 A.M., the Infection includes the blood pressure cuff. Preventionist presented a current "Cleaning and pulse oximeter, and other reusable Disinfection of Resident-Care Items and items which require disinfection Equipment" policy, dated October 2009. The between residents will be done policy indicated "...reusable items are cleaned and daily x 4 weeks, then weekly x 4 disinfected or sterilized between residents...". weeks. Audits shall be brought to QAPI for tracking completion and #2.. compliance. Audits will be submitted to the Quality 3.1-18 Infection Control Assurance Committee for review (1) The facility must require staff to wash their and/or further corrective action. hands after each direct resident contact for which Audits will titrate down to random hand washing is indicated by accepted monthly when QA committee professional practice. deems 100% compliance was achieved. 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 F9999 #2 administration for 3 of 6 residents observed What corrective action will during medication. The nurse inadequately be accomplished for resident performed handwashing between resident found to be affected by assessments. (Resident 55, Resident 82, Resident deficient practice? 32) Resident #32 and Resident # 82 have suffered no ill effects. Findings include: How other residents potentially affected will be 1. On 1/30/24 at 9:11 A.M., RN (Registered Nurse) identified and corrective actions was observed in Resident 32's washing her hands taken? for 13 seconds with soap and water before leaving All residents have the potential to the room. be effected according to their orders. Additional education 2. On 1/30/24 at 10:02 A.M., RN 3 was observed regarding hand hygiene standards washing her hands after giving medications to specific to timing of handwashing Resident 82 for 8 seconds. shall be reviewed.

PRINTED: 03/07/2024

	ARTMENT OF HEALTH AND HUMAN SERVICES ITERS FOR MEDICARE & MEDICAID SERVICES						
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155768	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			OMB NO. 0938-039  (X3) DATE SURVEY  COMPLETED  02/02/2024	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE		
EVANS\	/ILLE PROTESTAN	IT HOME			SVILLE, IN 47714		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		REFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	)PRIATE	COMPLETION DATE
IAU	3. On 1/31/24 at 10 leaving Resident 5 without sanitizing  On 2/2/24 at 10:35 Preventionist indice performed before we changes, between of finished.  On 1/30/24 at 2:35 "Handwashing/Hat August 2015. The alcohol-based hand alternatively, soap nonantimicrobial) before and after residents".  #3.  3.1-47 SPECIAL Notes a serious proper treat personnel for the fooffered:  (6) Respiratory car This state rule was Based on observation interview, the facility received necessary in accordance with practice for 1 of 1 in use. The facility face.	2:05 A.M., RN 3 was observed 5's room after a medication pass her hands.  6 A.M., the Infection cated hand hygiene should be wound care, between glove dirty and clean tasks, and when  6 P.M., RN 5 presented a current and Hygiene" policy, dated policy indicated "use an al rub 62% alcohol: or (antimicrobial or and water in the following: coming in contact with  NEEDS ast ensure that the residents tment and care by qualified following special services if		IAU	in place or systemic chair made to ensure the defice practice does not recur?  To enhance currently come operations under the direct the Director of Nursing appropriate training regarding adequate handwashing tean time.  How the corrective as will be monitored to ensure deficient practice will not infection Control audits refining and time daily x weeks, then weekly x 4 we haudits shall be brought to for tracking completion and compliance. Audits will be submitted to the Quality Assurance Committee for and/or further corrective as Audits will titrate down to monthly when QA committed eems 100% compliance vachieved.	plaint plaint tion of propriate  ng chnique  actions ure the t recur? ferencing ards ushing 4 eeks. QAPI d  review ction. candom tee	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

(Resident 26)

Finding includes:

Event ID:

5GIT11

Facility ID: 001125

F9999 #3

1.

action will be accomplished for

What corrective

If continuation sheet Page 14 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155768 B. WING 02/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3701 WASHINGTON AVE **EVANSVILLE PROTESTANT HOME EVANSVILLE, IN 47714** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE resident found to be affected On 2/1/24 at 9:35 A.M., the oxygen concentrator, deficient practice? humidified bottle, and oxygen tubing in Resident Resident 26 has had corrections 26's room was observed without a date and label. made for compliance. 2. How other residents On 2/2/24 at 9:00 A.M., the oxygen concentrator, potentially affected will be humidified bottle, and oxygen tubing in Resident identified and corrective actions 26's room was observed without a date and label. taken? All residents have the potential to On 2/1/24 at 10:00 A.M., Resident 26's clinical be affected. The DON or designee record was reviewed. Diagnoses included, but shall audit all residents who have were not limited to, COPD (Chronic Obstructive orders for oxygen use for Pulmonary Disease) and acute respiratory failure compliance, specific to with hypoxia. professional standards such as tubing dates, labels on humidifier The current service plan, dated 12/11/23, indicated bottles, oxygen signs in use, and the resident was cognitively intact and was updated care plans for oxygen independent with dressing, toileting and, eating. use. Any discrepancy shall be corrected immediately. All current Current physician orders included but not limited residents have been asked this information and chart reviewed for Oxygen 1-2 Liters PRN (as needed) to keep O2 orders and correct (oxygen) above 93%, as needed, dated 12/22/2023. self-administration in the chart. What measures will be put During an interview on 2/2/24 at 10:34 A.M., RN in place or systemic changes (Registered Nurse) 5 indicated the oxygen tubing made to ensure the deficient was changed out weekly on the night shift. At practice does not recur? that time, she indicated there should be an order To enhance currently complaint to change the tubing weekly and placed on the operations under the direction of MAR (Medication Administration Record). the Director of Nursing appropriate nursing staff shall receive A current "Departmental (Respiratory Therapy) in-service training regarding Prevention of Infection" policy, dated November professional standards such as 2011, was provided on 2/2/24 at 12:20 P.M. by the tubing dates, labels on humidifier Administrator. The policy indicated "... the bottles, oxygen signs in use, and purpose of this procedure is to guide prevention updated care plans for oxygen use of infection associated with the respiratory and how to immediately correct therapy tasks and equipment among staff and any discrepancy. residents...infection control consideration related How the corrective actions

to oxygen administration include... change the

will be monitored to ensure the

PRINTED: 03/07/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155768	A. BU B. WI	ILDING NG	00	02/02/	
				_	ADDRESS CITY STATE ZIR COD	1 02/02/	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD /ASHINGTON AVE		
EVANSV	ILLE PROTESTAN	IT HOME			SVILLE, IN 47714		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
TAG		g every 7 days or as needed".		TAG	deficient practice will not re	cur?	DATE
		,			Oxygen use audits referencing		
					professional standards such a	is	
					tubing dates, labels on humid		
					bottles, oxygen signs in use, a		
					updated care plans for oxyger		
					shall be completed by DON of designee weekly for 8 weeks		
					brought to QAPI for tracking	and	
					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.		
					Compilation was define vod.		
R 0000							
Bldg. 00							
		State Residential Licensure	R 00	000	Please accept this plan of		
		included a Recertification and			correction as our credible		
		rvey. This visit included a nprehensive (NCC) Survey.			allegation of compliance. This	-	
	Non-Certified Con	iprenensive (NCC) survey.			of correction is submitted as p of regulatory required respons		
	Survey dates: Janu	ary 29, 30, 31, February 1, and			and is not to be construed as	,,,	
	2, 2024.				agreement with the deficiencie	es	
					cited.		
	Facility number: 0	01125					
	Residential Census	:: 30					
	These State Reside	ential Findings are cited in 10 IAC 16.2-5.					
R 0216	410 IAC 16.2-5-2	(c)(1-4)(d)					
	Evaluation - None						
Bldg. 00	(c) The scope and	d content of the evaluation					

State Form Event ID: 5GIT11 Facility ID: 001125 If continuation sheet Page 16 of 23

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON			X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
155768		155768	B. WI	NG		02/02/	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3701 WASHINGTON AVE EVANSVILLE, IN 47714				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	shall be delineated manual, but at a nassessment shall following: (1) The resident 's mental status. (2) The resident 's activities of daily li (3) The resident 's admission and set (4) If applicable, the self-administer met (d) The evaluation writing and kept in Based on observation interview the facilit was safely administ have a self administic evaluation for 2 of 6 Medications were let the presence of the 25)  Findings include:  1. On 1/31/24 at 7: Practical Nurse) 12 13's medication in the room without medications.	d in the facility policy ninimum the needs include an evaluation of the sphysical, cognitive, and sindependence in the living. It is sweight taken on miannually thereafter. The resident's ability to edications. In shall be documented in the facility.  In precord review, and y failed to ensure medication dered to residents who did not tration of medication administrations. The facility and taken in murse. (Resident 13, Resident the room on a table and exited conitoring the resident taking dications were left in the room: milligrams)	R 02		R216  1. What corrective action will be accomplished resident found to be affected by deficient practice? Resident 13 and Resident 25 suffered no ill effects. For both residents the medication administration observed is respreference. Facility understan compliance is the priority and there is not a self-administration order for either of the resident listed above. Social Service of designee shall be asked to spwith residents regarding these compliance concerns.  2. How other residents potentially affected will be identified and corrective activaten?  All residents have the potential be affected. The DON or desishall audit all residents who have educate residents who have educate residents.	have have dident ds on s r eak dident	03/02/2024

State Form Event ID: 5GIT11 Facility ID: 001125 If continuation sheet Page 17 of 23

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	LETED
		155768	B. W	ING		02/02	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ASHINGTON AVE		
EVANSVILLE PROTESTANT HOME					VILLE, IN 47714		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	_	go back to see if the resident			personal preferences to take	meds	
	took the medication	1.			at will instead of when nurse		
	0.0/1/04 +0.06 F	NA D. 11 (12) 11 1 1			brings them. Any discrepancy		
		P.M., Resident 13's clinical			shall be corrected immediately	•	
		ed. Diagnoses included, but			Resident Council in resident		
		, aftercare following joint			setting was held to assist with	l	
		y and presence of left artificial			communication regarding		
	shoulder joint.				medication administration		
	The	-4-17/4/22 :1:4-14			practice.	4	
	_	ated 7/4/23, indicated the tively intact and independent			3 What measures will be		
	_	ng, and toileting. The service			in place or systemic change made to ensure the deficien		
		the resident's medications				ι	
	_	tered by the nursing staff.			practice does not recur?	nt	
	were to be adminis	tered by the hursing starr.			To enhance currently complai operations under the direction		
	Current physician	orders included, but was not			the Director of Nursing approp		
	limited to:	orders included, but was not			nursing staff shall receive	Jilale	
		ter all medications dated 7/5/23.			in-service training regarding		
	Truising to duminis	ter an inecreations dated 7/3/23.			professional standards of		
	The clinical record	lacked an order and evaluation			medication administration, ho	w to	
	for self administrat				accommodate personal	W to	
					preferences and comply with		
	The Self-Administr	ration of Medication			regulatory requirements and h	าดพ	
		eted on 7/5/23 indicated			to immediately correct any		
	_	ninister medications.			discrepancy.		
					4 How the corrective active	ons	
	2. On 1/31/24 at 8:	:45 A.M., LPN 12 was observed			will be monitored to ensure		
		5's medications in the room on a			deficient practice will not re		
	_	e room without monitoring the			Medication Administration aud		
	resident taking the				referencing professional standards		
					of medication administration		
	The following med	ications were left in the room:		including visualizing medication		on	
	1 Carbidopa/ levod				consumption shall be complet		
	1 KCL (potassium	chloride) 20 meq			daily for 8 weeks and brought		
	(milliequivalent)				QAPI for tracking completion		
	1 Aspirin 81 mg				compliance. Audits will be		
	1 Lexapro 20 mg				submitted to the Quality		
	1 Ferrous sulfate 32	24 mg			Assurance Committee for revi	ew	
	1 Flonase				and/or further corrective actio	n.	
	1 Cinamide 2.5 mg				Audite will titrate down to rand	lom	1

State Form Event ID: 5GIT11 Facility ID: 001125 If continuation sheet Page 18 of 23

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155768		î í	UILDING	onstruction 00	(X3) DATE : COMPL <b>02/02</b> /	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3701 WASHINGTON AVE EVANSVILLE, IN 47714					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	1 Meclizine 12.5 m 1 Metoprolol 50 mg 1 Torsemide 20 mg 1 Preservision Miralax 17 gm mix				monthly when QA committee deems 100% compliance was achieved.			
	The nurse did not go back to see if the resident had taken the medication.							
	record was reviewe were not limited to,	M., Resident 25's clinical d. Diagnoses included, but iron deficiency anemia loss (chronic), urinary tract encephalopathy.						
	indicated the reside	rvice plan, dated 1/26/24, nt was cognitively intact and ith toileting, dressing, and						
	Current physician o	orders included, but not limited						
	-	ter medications, dated 9/1/23.						
		lacked an order and evaluation tration of medications.						
	indicated that in ord bedside, a resident	P.M., the Administrator der to keep medications at needed a self administration of on and a physician order.						
	presented a current policy, dated April "Medications shall timely manner, and self-administer thei Attending Physician	P.M., the Director of Nursing "Administering Medication" 2010. The policy indicated be administered in a safe and as prescribedresidents may r own medications only if the n in conjunction with the are Planning Team, has						

State Form Event ID: 5GIT11 Facility ID: 001125 If continuation sheet Page 19 of 23

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155768			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/02/2024
	ROVIDER OR SUPPLIER		3701 W	ADDRESS, CITY, STATE, ZIP COD VASHINGTON AVE SVILLE, IN 47714	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	determined that they capacity to do so sa	y have the decision-making fely".			
R 0407	410 IAC 16.2-5-12 Infection Control -				
Bldg. 00	(b) The facility mu control program the (1) A system that of analyze patterns of symptoms. (2) Provides orienteducation on infecting universal (3) Offering health including, but not be transmission and if (4) Reporting compublic health author Based on observation interview, the facility control practices was proper equipment so The nurse did not old 3 of 6 residents observations.	st establish an infection hat includes the following: enables the facility to of known infectious  tation and in-service ction prevention and control, I precautions. Information to residents, limited to, infection immunizations. municable disease to	R 0407	R 407 1 What corrective action was be accomplished for resident found to be affected by deficient practice? Resident #4, #11 and Resident # 39 have suffered neffects. 2 How other residents	t
	Findings include:			potentially affected will be identified and corrective acti	ons
	Practical Nurse) 12 Resident 13's pulse sanitize the equipme 2. On 1/31/24 at 7:2 checking the pulse of 12 did not sanitize t 3. On 1/31/24 at 7:3	8 A.M., LPN (Licensed was observed checking oximetry. LPN 12 did not ent afterwards.  20 A.M., LPN 12 was observed oximeter of Resident 11. LPN he equipment afterwards.		taken? All residents have the potential be affected according to their orders. Additional education regarding sanitizing equipmen between residents during medication administration which includes the blood pressure cupulse oximeter, and other reusitems which require disinfection between residents.	t ch uff, sable

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PRINTED: 03/07/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155768		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/02/2024	
NAME OF P	ROVIDER OR SUPPLIER	·		ADDRESS, CITY, STATE, ZIP COD	
				WASHINGTON AVE	
EVANSVILLE PROTESTANT HOME			EVAIN	SVILLE, IN 47714	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	without cleaning the	e equipment.		3 What measures will be	·
	During an interview	on 1/31/24 at 9:11 A.M., LPN		in place or systemic change made to ensure the deficier	
	_	wipes were used to clean the		practice does not recur?	
	equipment in betwe	-		To enhance currently compla	int
	1 1			operations under the direction	
	On 2/2/24 at 11:45	A.M., the Infection		the Director of Nursing appro	
		nted a current "Cleaning and		nursing staff shall receive	
		ident-Care Items and		in-service training regarding	oroper
		dated October 2009. The		infection control procedures	
		reusable items are cleaned and		specific to sanitizing equipme	ent
	disinfected or steril	ized between residents".		between residents during	
				medication administration wh	
				includes the blood pressure of	
				pulse oximeter, and other reu	
				items which require disinfecti	
				between residents. Review o product instructions shall be	
				included in the education.	
				4 How the corrective act	ions
				will be monitored to ensure	
				deficient practice will not re	
				Infection Control audits refere	
				infection prevention standard	-
				such as sanitizing equipment	
				between residents during	
				medication administration wh	
				includes the blood pressure of	
				pulse oximeter, and other reu	
				items which require disinfecti	
				between residents daily x 4 wand then weekly x 4 weeks.	reeks
				Audits shall be brought to Q	ΔPI
				for tracking completion and	W I
				compliance. Audits will be	
				submitted to the Quality	
				Assurance Committee for rev	riew
				and/or further corrective action	
				Audits will titrate down to ran	dom
				monthly when QA committee	

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155768	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  02/02/2024	
NAME OF PROVIDER OR SUPPLIER  EVANSVILLE PROTESTANT HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD  3701 WASHINGTON AVE  EVANSVILLE, IN 47714				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
				TAG	deems 100% compliance was achieved.		DATE
R 0414	410 IAC 16.2-5-12 Infection Control -	• •					
Bldg. 00	hands after each	st require staff to wash their direct resident contact for ng is indicated by accepted ice.					
			R 04	414			03/02/2024
	interview, the facili control practices wa medication adminis observed during me nurse did not clean equipment in betwe (Resident 39, Resid Findings include:	on, record review, and ty failed to ensure infection as maintained during tration for 2 of 6 residents dication administration. The or sanitize vital sign en resident assessments. ent 10)			R 414  1.What corrective action will accomplished for resident for to be affected by deficient practice?  Resident #39 has suffered ill effects.  2.How other residents potentially affected will be identified and corrective activaten?  All residents have the potential	ound nt I no ions	
	medications for Res many Eliquis pills of the extra medication sanitizing his hands resident 39's pulse of without cleaning the 2. On 2/1/24 at 12:0 leaving of Resident medication and did	was observed preparing sident 39. LPN 12 took too but of the bottle and returned in to the bottle without.  At that time, LPN 12 checked oximetry and left the room e equipment.  25 P.M., LPN 12 was observed 39's room after passing not sanitize his hands.			be effected according to their orders. Additional education regarding sanitizing equipment between residents during medication administration whi includes the blood pressure or pulse oximeter, and other reusitems which require disinfection between residents.  3. What measures will be put place or systemic changes into ensure the deficient practions.	ch uff, sable on t <b>in</b> made	
	leaving Resident 10 medication and did	's room after passing not sanitize his hands.			To enhance currently complai operations under the direction the Director of Nursing appropriate the complex of the Director of Nursing appropriate the complex of the Director of Nursing appropriate the complex of the Director of Nursing appropriate the Director of Nursing appropria	of	
	On 2/2/24 at 10:35	A.ivi., the injection	- 1		nursing staff shall receive		1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		155768	B. WI	B. WING			02/02/2024	
NAME OF PROVIDER OR SUPPLIER  EVANSVILLE PROTESTANT HOME			STREET ADDRESS, CITY, STATE, ZIP COD  3701 WASHINGTON AVE  EVANSVILLE, IN 47714					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	Preventionist indica performed before w changes, between d finished.  On 1/30/24 at 2:35 "Handwashing/Han August 2015. The p alcohol-based hand alternatively, soap ( nonantimicrobial) a	pated hand hygiene should be be bound care, between glove clirty and clean tasks, and when be between glove clirty and clean tasks, and when be be because of the beautiful P.M., RN 5 presented a current and Hygiene" policy, dated boolicy indicated "use an rub 62% alcohol: or		IAG	in-service training regarding prinfection control procedures specific to sanitizing equipment between residents during medication administration which includes the blood pressure of pulse oximeter, and other reusitems which require disinfection between residents.  4. How the corrective actions be monitored to ensure the deficient practice will not reconstruction prevention standards such as sanitizing equipment between residents during medication administration which includes the blood pressure of pulse oximeter, and other reusitems which require disinfection between residents will be done daily x 4 weeks, then weekly x weeks. Audits shall be brough QAPI for tracking completion a compliance. Audits will be submitted to the Quality Assurance Committee for review and/or further corrective action Audits will titrate down to rand monthly when QA committee deems 100% compliance was achieved.	ch chuff, sable in chuff, sabl	DATE	

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