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	04/01/2025

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 and Investigation of Nursing Home Complaint IN00451230. This visit included a Non-Certified Comprehensive (NCC) Survey. This visit included a State Residential Licensure Survey. Complaint IN00451230 - Federal/State deficiencies related to the allegations are cited at F880. Survey dates: March 25, 26, 27, 28, 31, and April 1, 2025. Facility number: 001125 Provider number: 155768 AIM number: 201272600 Census Bed Type: SNF/NF: 20 SNF: 19 NCC: 13 Residential: 21 Total: 73 Census Payor Type: Medicare: 12 Medicaid: 12 Other: 28 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 7, 2025	F 0000	This Plan of Correction is submitted in compliance with applicable law and regulation. Compliance with applicable law, and completing plan of correction set forth does not constitute agreement with the 2567. All alleged deficiencies have been, or will be completed by the dates indicated	
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anna Michelle	Perry	04/18/2025

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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Bldg. 00	Based on interview and record review, the facility failed to ensure the physician was notified when lab results were not obtained for a resident with a catheter associated urinary tract infection for 1 of 2 residents reviewed for indwelling catheters and when medication suggestions were made by the pharmacist for 1 of 2 residents reviewed for pharmacy reviews with recommendations. (Resident 27 and Resident D) Findings include: 1. On 3/26/25 at 10:22 A.M. Resident 27's clinical record was reviewed. Resident 27 was admitted on 3/26/24. Diagnoses included, but were not limited to, malignant neoplasm of bladder. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/27/24, indicated Resident 27 was moderately cognitively impaired, required partial to moderate assistance (staff does less than half of the effort) for toileting, and had an indwelling catheter. Physician orders included, but were not limited to: May re-anchor catheter if becomes dislodged or occluded as needed, Contact Medical Doctor (MD), dated 3/27/24 Foley catheter: Anchor 16 french, 30cc (cubic centimeters) balloon, provide catheter care every shift, supra pubic catheter(a thin tube inserted into the bladder through a small incision in the lower abdomen), cleanse around insertion site with soap and water, pat dry; Start date 3/7/25 Current care plans included, but were not limited to: Report signs of complications such as urinary tract infection (UTI) (acute confusion, bladder	F 0580	**F580 Notification of change** The facility failed to ensure physician was notified when lab results were not obtained for a resident with associated urinary tract infection. **What corrective action will be accomplished for resident found to be affected by deficient practice?** On 6/11/24 resident went out to ER because Resident 27 took self to restroom and threw leg bag away and this dislodged SP cath. This nurse attempted to replace SP cath but was unable to reanchor SP. Orders received to send to St Vincents ED for cath replacement. Resident returned a few hours later with suprapubic in place. Urine report completed in ER was faxed to facility on 6/12/24 from PAC office, Nitrite positive, no new orders written with report. Will f/u in am as this nurse called PAC and received no answer. On 6/15/24 floor Resident 27 was treated for the urinary tract infection. This facility could not access St Vincent lab results in order to obtain additional orders from our Medical Director. Resident D had a pharmacy recommendation made to decrease buspirone. The facility is told by PAC to address with medical personnel in the facility to decrease fax communication to PAC. The buspirone was not	04/25/2025

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	spasms, pain, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine), dated 3/27/24 A nursing progress note, dated 6/9/24 at 2:32 P.M., indicated a nurse was alerted to Resident 27's room by housekeeping that the resident was covered in blood. Resident was unsure of how it happened and he denied falling. There was no evidence that the resident had fallen. Family later came in to visit resident and were informed. Family expressed concern related to resident's catheter bag being purple. Leg bag examined per nursing and it did have a purple tint, however, urine output was darker yellow and concentrated. Minimal research revealed a possible cause being "purple catheter bag syndrome" which was usually indicative of a longstanding Foley catheter and chronic UTI. MD notified of all the above. A nursing progress note, dated 6/10/24 at 2:04 P.M., indicated a new order was received for a urinalysis and culture and sensitivity from a new catheter bag due to urine bag being purple in color. A nursing progress note, dated 6/10/24 at 11:32 P.M., indicated the current catheter was removed and a new catheter was placed suprapubic using aseptic technique with no urine return. A nursing progress note, dated 6/11/24 at 10:36 A.M., indicated Resident 27's suprapubic catheter was not in place. No urine return. The nurse adjusted catheter and when it was in place, yellow urine mixed with blood returned. Nurse attempted to replace catheter but was unable to re-anchor catheter. Orders received to send to [hospital] emergency department for catheter replacement.		addressed and the recommendation made a second time. During that time frame Resident D had been very sick and was provided a new cancer diagnosis. IDT team stopped pursing the recommendation to decrease the antianxiety as the resident's anxiety had actually increased on current dosage. Resident D remains on buspirone 10mg HS due to her terminal condition. Medical Director shall review and notate if buspirone should continue due to terminal condition. **How other residents potentially affected will be identified and corrective actions taken**? All residents have the potential to be effected by the cited deficiency. An audit shall be completed to ensure physician notification and treatment direction have been obtained for any outstanding labs and/or consultant recommendations. None were identified at this time. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** When lab/recommendation results are obtained facility shall notify provider and follow until physician provides response to treat or not to treat. Once physician is notified of labs/recommendations which need to be addressed and lab is	

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	A nursing progress note, dated 6/11/24 at 11:13 A.M., indicated family arrived and transported Resident 27 to the emergency department. Catheter bag with blood noted. A nursing progress note, dated 6/12/24 at 4:07 P.M., indicated a urine report was faxed to facility. Nitrite positive, no new orders written with report. Nursing staff called the PAC (post acute care line for physicians) and there was no answer. The clinical record lacked notification to the physician or medical director of PAC not responding to the facility. A nursing progress note, dated 6/13/24 at 3:29 P.M., indicated a request was sent to PAC to follow up on resident's urine obtained during emergency room visit which was nitrite positive, no culture report available yet. A nursing progress note, dated 6/15/2024 at 5:03 P.M., indicated a nurse called PAC related to urine culture results. Unable to obtain results at that time. The MD was notified to try and obtain results. Resident continued to have purple catheter bags despite dark yellow urine output. A nursing progress note, dated 6/18/24 at 5:24 P.M., indicated Resident 27 complained of not feeling well in his abdomen. Encouraged to eat a good dinner and milkshake. The clinical record lacked notification to the medical director of PAC not responding to the facility, or notification to the physician about the new symptoms observed. A nursing progress note, dated 8/1/24 at 11:17		finished processing, for UTI specifically involving a culture, if physician does not respond within 2 business days facility shall contact Medical Director for medical treatment. For consultant recommendations which are not escalated due to clinical change facility shall follow current policy to request from Medical Director if primary physician has not addressed in 30 days. Facility currently has systems in place for review of clinical information, 24 hours report, labs, new orders, consultant recommendations and progress notes to prompt this process. DON or designee is responsible for tracking/documenting physician notifications regarding lab results and consultant recommendations until resolution is achieved as stated above. Education regarding notification process with parameters and tracking of labs and consultant recommendations shall be provided to nurses with posttest to demonstrate comprehension. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 4/25/25 the Quality Assurance program shall review lab tracker and pharmacy recommendation audit process to ensure physician notification and response of labs and consultant	

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	A.M., indicated the catheter was changed due to occlusion. A nursing progress note, dated 8/1/24 at 6:03 P.M., indicated Resident 27 complained of pain from the catheter site. The clinical record lacked notification to the physician related to Resident 27's pain from the catheter site. A nursing progress note, dated 8/29/24 at 11:25 A.M., indicated Resident 27 notified staff he was hurting and pointed to the right groin area. The area was assessed and PAC notified. A nursing progress note, dated 8/31/24 at 9:55 A.M., indicated Resident's catheter insertion site was red. The clinical record lacked notification to the physician related to the change in condition of the catheter site. 2. On 3/26/25 at 9:20 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/12/25, indicated Resident D was cognitively intact, required setup assistance for eating, was dependent on staff for toileting, bathing, and transferring, and received an antianxiety medication during the 7-day look back period. A current care plan, revised 2/21/25, indicated Resident D received antianxiety medication related to an anxiety diagnosis. A care conference was most recently completed on 1/10/25. Care plan conference notes indicated		recommendations. The DON or designee shall document this process 7 days a week for 4 weeks and then monthly if 100% compliance has been achieved. The clinical process itself shall remain ongoing for optimal continuity of care and regulatory compliance. -	

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	that all current care plans were reviewed. Current physician orders included, but were not limited to: buspirone tablet (an antianxiety medication) - 10 milligrams (mg) at bedtime, dated 9/27/24 Discontinued physician orders included, but were not limited to: buspirone tablet - 10 mg once a day, dated 7/11/23 with a discontinued date of 7/10/24 buspirone tablet - 10 mg at bedtime, dated 7/11/24 with a discontinued date of 9/27/24 A pharmacy recommendation, dated 6/11/24, requested a decrease of the buspirone from 10 mg once a day to 5 mg once a day. The recommendation lacked documentation it was acted upon. A pharmacy recommendation, dated 7/16/24, requested a decrease of the buspirone from 10 mg once a day to 5 mg once a day. The recommendation lacked documentation it was acted upon. The clinical record lacked documentation that facility staff attempted to contact the physician or Medical Director to respond to the pharmacy recommendation to decrease Resident D's antianxiety medication. During an interview on 3/27/25 at 11:05 A.M., Medical Records staff indicated Resident D's physician did not respond to the pharmacy recommendations on 6/11/24 or 7/16/24. At that time, she indicated that if a resident's physician did not respond, the pharmacy requests were sent to the Medical Director to accept or decline. The			

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	Medical Director did not accept or decline the pharmacy recommendations on 6/11/24 or 7/16/24. During an interview on 3/31/25 at 1:34 P.M., the Medical Director indicated that he was not aware that there was a physician who did not review pharmacy recommendations. At that time, he indicated he was aware that staff had difficulty reaching PAC staff. He had been told by facility administration that they had reached out to PAC administration many times with no meaningful results. Consequently, he was the default contact for nursing and clinical staff when PAC could not be reached, and could be contacted directly by his direct cell phone number or text message. On 4/1/25 at 10:47 A.M., the Administrator provided a Consultant Pharmacist Reports policy, revised December 2022, that indicated "Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing ... Comments and recommendations concerning medication therapy are communicated in a timely fashion ... Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her within 30 days, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director...". On 4/1/25 at 10:44 A.M., the Administrator provided a policy titled Acute Condition Change Clinical Protocol, dated December 2015, that indicated "Nursing staff will contact the Physician based on the urgency of the situation. The attending Physician will respond in a timely			

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	manner to notification of problems or changes in condition and status". 3.1-5(a)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to ensure care plans related to high risk medications were developed for 3 of 6 residents reviewed for medication use. (Resident 3, Resident D, Resident 14) Findings include: 1. On 3/25/25 at 2:26 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, Fournier Gangrene, malignant neoplasm of prostate, and chronic pain syndrome. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 1/13/25, indicated Resident 3 was cognitively intact, was dependent on transferring, toileting, bathing, and dressing, and received an antibiotic and an opioid during the 7-day look back period. Resident 3 had a pain assessment during this time. Current physician orders included, but were not limited to: daptomycin (an antibiotic) 600 milligrams (mg) daily Intravenous (IV) for 28 days per ID (infectious disease), infuse over 60 minutes dated, 3/16/25 to 4/13/25. oxycodone (pain medication) 5 mg administer 1 tablet orally every 4 hours as needed for pain, dated 1/16/25.	F 0656	F-656 Development of Comprehensive Care Plan Facility failed to ensure care plans related to high risk medications were developed for 3 of 6 residents reviewed for medication use. **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident 3 the antibiotic monitoring and pain care plans have been updated. Appropriate orders were in place for resident treatment process, the care plans had not been updated with the new orders and treatment plan obtained from the physician. Resident D is receiving Eliquis for Afib. The Eliquis was added to the Afib care plan when the medication started but was not placed on a separate anticoagulant care plan to identify risk for bleeding as intervention. The anticoagulant care plan has been initiated for Resident D. Resident 14 has had care plans updated for antipsychotic medications, antianxiety medication, antidepressant medication, and side effect	04/25/2025

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	The current care plan lacked care plans for pain and antibiotic monitoring.2. On 3/26/25 at 9:20 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/12/25, indicated Resident D was cognitively intact, required setup assistance for eating, was dependent on staff for toileting, bathing, and transferring, and received an anticoagulant medication during the 7-day look back period. Current physician orders included, but were not limited to: Eliquis (an anticoagulant medication) tablet - 5 milligrams (mg) twice a day, dated 11/7/24 A current activity intolerance care plan, initiated 9/30/24, indicated Resident D received Eliquis to prevent embolism. A care conference was most recently completed on 1/10/25. Care plan conference notes indicated that all current care plans were reviewed. The clinical record lacked a care plan to identify interventions to monitor for the risks of side effects from the anticoagulant medication (such as risk for bleeding). During an interview on 4/1/25 at 11:05 A.M., the Administrator indicated there was not a care plan for Resident D that addressed the risk of bleeding. 3. On 3/26/25 at 8:41 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, generalized anxiety disorder, depression, and		monitoring has also been updated. These medications were previously listed under Hospice in the EMR. **How other residents potentially affected will be identified and corrective actions taken**? All residents have the potential to be effected by the cited deficiency. All new admissions and order changes should have care plans created and side effect monitoring initiated when necessary. The DON or designee will reeducate the Interdisciplinary Team (IDT) and floor nurses on the policy and procedure for development and completion of care plans based on diagnosis and orders received for each resident. Audit will be conducted and include current medication and treatment orders, assignment sheet and DME use for a complete and comprehensive care plan that reflects resident care needs. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** MDS coordinator or designee shall be responsible for developing comprehensive care plans based on regulatory requirements and timelines for each new admission and change in condition. MDS coordinator or designee shall be responsible for ongoing revisions	

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	spinal stenosis. The most current Annual Minimum Data Set (MDS) Assessment, dated 1/31/25, indicated Resident 14 had moderate cognitive impairment, required setup assistance for eating, partial to moderate assistance of staff (staff does less than half of the effort) for toileting and bathing, and received an antipsychotic medication, antianxiety medication, antidepressant, anticonvulsant, and an opioid during the 7-day look back period. Current physician orders included, but were not limited to: Ativan Benadryl Haldol gel (an antipsychotic medication) 2 milligrams (mg)- 25mg-2mg - apply 1 milliliter (ml) topically to the inner wrist every four hours as needed for agitation, dated 11/18/24 citalopram tablet (an antidepressant medication) - 10 mg once a day for depression, dated 10/6/23 gabapentin capsule (an anticonvulsant medication) - 300 mg twice a day for pain, dated 10/4/23 hydrocodone-acetaminophen tablet (an opioid pain-relieving medication) 7.5-325 mg - give one tablet every four hours as needed for pain, dated 10/4/23 hydrocodone-acetaminophen tablet 7.5-325 mg - give one tablet twice a day for pain, dated 11/12/24 lorazepam concentrate (an antianxiety medication) 2 mg/mL - give 0.25 ml sublingually every four hours as needed for anxiety and restlessness, dated 1/26/24		and updating those care plans as orders change. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 4/25/25 the Quality Assurance program shall review care plan update audit process to ensure current orders assignment sheet and DME needs have been included in the care plan. The MDS coordinator or designee shall document this process 7 days a week for 4 weeks and then monthly if 100% compliance has been achieved. The order updates shall remain ongoing for optimal continuity of care and regulatory compliance and directly delegated if/when MDS Coordinator is unavailable to complete.	

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	Roxanol (an opioid pain-relieving medication) liquid 20 mg/ml - give 0.25 ml sublingually every four hours as needed for pain and shortness of breath, dated 1/26/24 A care conference was most recently completed on 1/29/25. Care plan conference notes indicated that all current care plans were reviewed. The clinical record lacked a care plan related to antipsychotic medications, antianxiety medications, antidepressants, anticonvulsants, and opioids, the disease processes that necessitated the medications, and interventions required to monitor side effects of the medications. During an interview on 3/27/25 at 1:25 P.M., the Director of Nursing (DON) indicated that all high risk medications should have a corresponding care plan. Anticoagulants should have a risk for bleeding care plan. During an interview on 3/27/25 at 1:43 P.M., the MDS Coordinator indicated that all high risk medications should have a corresponding care plan. Care plans were created upon admission or with a change of orders. Reports showing newly prescribed medications were run daily and care plans were updated as needed. During an interview on 4/1/25 at 10:35 A.M., the Administrator indicated there were no care plans for Resident 14 that addressed antipsychotic medications, antianxiety medications, antidepressants, anticonvulsants, and opioids, the disease processes that necessitated the medications, or interventions required to monitor side effects of the medications.			

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	On 4/1/25 at 10:47 A.M., the Administrator provided a current Comprehensive Assessment and the Care Delivery Process policy, revised December 2016, that indicated "Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions ... Define issues, including problems, risk factors, and other concerns ... Identify the current interventions and treatments; and Link these to problems and diagnoses they are supposed to be treating ... a person-centered plan of care includes: selecting and implementing interventions, based on the results of the above". 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview, observation, and record review, the facility failed to ensure a resident's plan of care was implemented for 1 of 1 residents reviewed for nutrition. (Resident 29) Finding includes: On 3/26/25 at 10:07 A.M., Resident 29's clinical record was reviewed. Resident 29 was admitted on 2/15/25. Diagnoses included, but were not limited to, chronic kidney disease. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 3/6/25, indicated Resident 29 was cognitively intact, required setup assistance (staff setup meals before dining) for eating, and had an unplanned weight loss of 5% or more in the last month.	F 0657	**F 657 D Care Plan Timing and Revision** Facility failed to ensure resident's plan of care was implemented. **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident 29 has suffered no ill effects. Resident 29 received a recommendation to add ice cream to her lunch tray for added calories. Care plan and altered diet/supplement list has been updated. **How other residents potentially**	04/25/2025

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	The current care plan included, but was not limited to: Recent significant weight loss in part related to increase in diuretic but also due to inadequate calorie intakes; Start date 2/17/25 Ice cream daily for added calories due to weight loss; Start date 3/6/25 During an observation on 3/26/25 at 11:45 A.M., Resident 29 was observed in the dining room and did not receive an ice cream with lunch. During an observation on 3/28/25 at 12:54 P.M., Resident 29 was observed sitting in her room eating lunch. Resident 29 indicated she was supposed to receive ice cream but did not receive it. There was not an ice cream on Resident 29's tray. The lunch ticket that indicated what Resident 29 should have received on the tray indicated vanilla ice cream was to be included. On 3/27/25 at 1:04 P.M., the Dietary Manager provided a list of residents who received supplemental foods. Resident 29 was not listed to receive ice cream supplement as care planned. On 4/1/25 at 10:50 A.M., the Administrator provided an undated policy titled Goals and Objectives, Care Plans that indicated "Care plan goals and objectives are defined as the desired outcome for a specific resident problem. Goals and objectives are reviewed and revised when there has been a significant change in the resident's condition; when the desired outcome has not been achieved; when the resident has been readmitted to the facility; at least quarterly." 3.1-35(g)(1)		**affected will be identified and corrective actions taken**? All residents have the potential to be effected by the cited deficiency. All dietary interventions shall be care planned according to regulatory compliance and include items which should be kept on the altered diet/supplement list. DON or designee shall track dietician recommendations and when orders are obtained complete dietary communication so tray tickets, altered diet/supplement list, and care plan can be updated timely. Dietician shall complete audit of recommendations, orders and altered diet list. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** To enhance operations, under the direction of the Dietary Manager or designee in-service training shall be completed to obtain orders for dietary supplements, care plan and update the altered diet supplement list. The in-service training shall include the importance of resident receiving ordered recommendation items, updating careplans, altered diet lists, and tray tickets accordingly. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 4/25/25 the Quality Assurance program shall review	

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			care plan update audit process to ensure current orders recommendations and supplement list have been included in the care plan. The MDS coordinator or designee shall document this process 7 days a week for 4 weeks and then monthly if 100% compliance has been achieved. The order updates shall remain ongoing for optimal continuity of care and regulatory compliance and directly delegated if/when MDS Coordinator is unavailable to complete. **What date systemic changes will be completed?4/25/25**	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to revise care plans and follow interventions to reduce the risk of falls for 1 of 1 resident reviewed for falls with major injury. This deficient practice resulted in two falls with fractures requiring hospitalization and a significant decline in the resident's Activities of Daily Living (ADLs). (Resident 7) Finding includes: On 3/26/25 at 10:11 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, displaced comminuted fracture	F 0689	**F 689 Free of Accidents Hazards** Facility failed to revise care plans and follow interventions to reduce the risk of falls. **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident 7 does have a concave mattress on her bed. Although the care plan does not reflect the dated interventions, the interventions identified were indeed in place and listed on the DME	04/25/2025

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	of shaft of right femur, fracture of upper end of right humerus, fracture of superior rim of right pubis, and vascular dementia. The most recent Annual Minimum Data Set (MDS) Assessment, dated 11/23/24, indicated Resident 7 had severe cognitive impairment, required setup assistance of staff (staff sets up/cleans up; resident completes the activity) with eating, required supervision of staff (staff provides verbal cues or touching/steadying assistance as resident completes the activity) for toileting and sit to stand transfers, was independent rolling left and right, required partial to moderate assistance of staff (staff does less than half of the effort) for bathing, and had no falls since the prior assessment. An annual fall risk assessment was completed on 11/23/24 that indicated Resident 7 was at low risk for falls. A current falls care plan, initiated 5/7/23 and last revised on 3/3/25, indicated Resident 7 was at risk for falls due to weakness. Interventions included: Assure I have appropriate footwear before ambulating, dated 5/17/23 Fluorescent tape added to call light as a visual cue, dated 5/17/23 Keep call light and personal items within reach, dated 5/17/23 Educated resident to utilize the call light for assistance when not feeling well, dated 1/22/24 Gripper socks when shoes are not on, dated 4/1/24 Fluorescent tape to walker to remind resident to take walker to restroom, dated 12/29/24 Concave mattress, dated 3/3/25 A care conference was most recently completed on 3/20/25. Care plan conference notes indicated		audit and the assignment sheet. Resident 7 has had clinical changes in the last 6 months including urinary tract infections, hallucinations, and changes in cognition with an overall decline in condition at 102 yrs of age. Resident 7 fall risk was completed and still indicates a high risk for falls. **How will you identify other residents having the potential to be affected by the same deficient practice**? All current residents have the potential to be affected by this alleged deficient practice. Fall risk assessments shall be audited for each resident to ensure high risk fallers are identified and interventions care planned timely. All residents that require fall interventions have the potential to be affected by this alleged deficient practice. · Fall Risk audit completed to ensure that all current residents which have high fall risk score have fall interventions in place. Inservice education shall be provided regarding falls and the importance of interventions and care plan updates. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DON or designee shall audit high risk fall scores and fall intervention	

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	that all current care plans were reviewed. The clinical record indicated Resident 7 fell four times between 12/29/24 and 3/1/25. Fall 1 On 12/29/24 at 10:00 A.M., Resident 7 sustained an unwitnessed fall without injury while walking without her walker. Fluorescent tape to walker to remind resident to take walker to restroom was added to the care plan on 12/29/24. A fall risk assessment was completed on 12/29/24 that indicated Resident 7 was at low risk for falls. Fall 2 On 1/4/25 at 10:15 P.M., Resident 7 sustained an unwitnessed fall while getting out of bed. At that time, no injury was noted. A fall risk assessment was completed on 1/4/25 that indicated Resident 7 was at high risk for falls. A nursing progress note, dated 1/4/25 at 10:49 P.M., indicated staff notified the physician of the fall, confusion, and a high blood pressure of 154/80. An order was received for a urinalysis (UA) to check for infection. A nursing progress note, dated 1/4/25 at 11:26 P.M., indicated the resident complained of right hip pain with no bruising or swelling noted upon assessment. A nursing progress note, dated 1/5/25 at 6:02 A.M., indicated the resident complained of hip and back pain with difficulty ambulating. Pain medication was given. Urine was collected at that time. A nursing progress note, dated 1/5/25 at 10:52 P.M., indicated the resident complained of hip		care plans to ensure that the appropriate measures are in place. The results of these audits will be reviewed in Quality Assurance and documented until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of care as indicated. ·All staff educated on the need for fall interventions to be in place timely and reflect in the record timely. **What date systemic changes will be completed? 4/25/25**	

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	pain and was observed with a slow and unsteady gait. A nursing progress note, dated 1/6/25 at 3:35 A.M., indicated the physician was notified of the resident's continued complaints of bilateral hip pain and back pain. Progress notes from 1/6/25 at 3:35 A.M. to 1/7/25 at 1:14 P.M lacked documentation to indicate the physician responded or staff attempted to follow up with the physician or the medical director. An Interdisciplinary Team (IDT) note, dated 1/6/25 at 10:40 A.M., indicated Resident 7's 1/4/25 fall was reviewed. The new intervention was a clinical assessment. The care plan was not updated with a new intervention at that time. A nursing progress note, dated 1/7/25 at 5:08 A.M., indicated the resident complained of hip and back pain, was unable to ambulate, and required assistance of two staff for toileting and transferring. A nursing progress note, dated 1/7/25 at 1:14 P.M., indicated the resident complained of bilateral hip pain and had a decline in mobility. Staff attempted to call the physician to request an x-ray of the bilateral hips. A nursing progress note, dated 1/7/25 at 6:09 P.M., indicated a transfer order was received from the physician and the resident was transferred to the hospital for evaluation and x-rays. Hospital discharge paperwork, dated 1/7/25 at 10:50 P.M., indicated Resident 7 had superior and inferior pubic ramus fractures and multiple closed stable lateral compression fractures of the pelvis			

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	that did not require surgery. The resident was recommended to start physical therapy and follow up as needed. A nursing progress note, dated 1/8/25 at 1:45 A.M., indicated the resident returned to the facility from the hospital with no new orders. A therapy evaluation indicated Resident 7 began physical therapy on 1/9/25. A nursing progress note, dated 1/10/25 at 9:19 A.M., indicated the urine obtained on 1/5/25 was negative and did not indicate an infection was present. A review of progress notes from 1/6/25 to 1/20/25 lacked documentation to indicate the IDT met to follow up on the negative UA and determine a new intervention following the resident's fall on 1/4/25 to prevent further falls. Fall 3 On 1/20/25 at 12:15 A.M., Resident 7 sustained an unwitnessed fall while attempting to self-transfer to the bathroom. A fall risk assessment was completed on 1/20/25 and indicated that Resident 7 was at high risk for falls. A nursing progress note, dated 1/20/25 at 12:26 A.M., indicated the resident complained of pain and moved all extremities "as normal for resident with a pelvic fracture". An IDT Note, dated 1/20/25 at 10:21 A.M., indicated Resident 7's 1/20/25 fall was reviewed. The new interventions were concave mattress and offer the opportunity to lay in bed between 9 P.M. and 11 P.M. The interventions were not added to the care plan at that time.			

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	A Significant Change MDS Assessment was completed on 1/20/25. It indicated Resident 7 had severe cognitive impairment, required setup assistance of staff (staff sets up/cleans up; resident completes the activity) with eating, required supervision of staff (staff provides verbal cues or touching/steadying assistance as resident completes the activity) for toileting and sit to stand transfers, was independent rolling left and right, required partial to moderate assistance of staff (staff does less than half of the effort) for bathing, and had one fall since the prior assessment. A nursing progress note, dated 1/22/25 at 2:35 P.M., indicated the resident complained of pain while walking. A nursing progress note, dated 1/22/25 at 10:32 P.M., indicated the resident complained of pain in the right hip. Staff attempted to notify the physician of the increased pain. A nursing progress note, dated 1/23/25 at 11:56 A.M., indicated staff attempted to contact the physician about the resident's pelvic pain. A nursing progress note, dated 1/23/25 at 12:15 P.M., indicated the physician's nurse returned the call to obtain more information. Staff reported that the resident was having increased pain and more difficulty ambulating. The physician's nurse indicated she would forward the information to the physician. A nursing progress note, dated 1/23/25 at 1:47 P.M., indicated a new order was received for an x-ray of the pelvis and the hips.			

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	A nursing progress note, dated 1/23/25 at 4:44 P.M., indicated a mobile x-ray service completed a bilateral hip and pelvis x-ray in the facility. A nursing progress note, dated 1/23/25 at 10:34 P.M., indicated x-ray results were received. Results indicated "Cannot exclude nondisplaced right pubic rami fracture. Consider follow up with a three view pelvis series vs. Computed Tomography (CT) scan (a medical imaging technique used to obtain detailed internal images of the body) for further evaluation". Therapy discharge paperwork, dated 2/6/25, indicated Resident 7 was discharged from physical therapy because she had reached her highest practical level. Fall 4 A nursing progress note, dated 3/1/25 at 5:50 P.M., indicated Resident 7 sustained an unwitnessed fall while walking in her room. The resident complained of pain in her right shoulder, right arm, and right hip. Her right leg was noted to appear shorter than her left leg, her right foot was rotated outward, and it was tender to touch. An ambulance was called and the resident was taken to the emergency room. A fall risk assessment was completed 3/1/25 that indicated the resident was at high risk for falls. A Hospital Trauma Services note, dated 3/2/25 at 12:51 A.M., indicated the resident was admitted to the hospital with diagnoses of a right humoral surgical neck fracture (shoulder) and a right femur fracture (long bone in the leg). An IDT note, dated 3/3/25 at 10:09 A.M., indicated Resident 7's 3/1/25 fall was reviewed. The new			

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	intervention was "Resident sent to the hospital". "Concave mattress" was added to the care plan on 3/3/25. Hospital discharge paperwork, dated 3/5/25 at 2:25 P.M., indicated that the resident was being discharged back to the facility after receiving an open reduction and internal fixation (ORIF) (a surgical procedure used to treat severe fractures or dislocations by realigning the broken bones and stabilizing them with internal hardware, such as screws, plates, or rods) on her right distal femur fracture. The right shoulder fracture did not require surgery and the resident's right arm was placed in a sling for comfort. A nursing progress note, dated 3/5/25 at 5:15 P.M., indicated the resident returned to the facility from the hospital with new orders. Admission physician orders included, but were not limited to: tramadol (an opioid pain-relieving medication) tablet - give 50 milligrams (mg) every six hours as needed, dated 3/5/25 Safety Device: Bed pad alarm. Check placement and function every shift, dated 3/5/25 Safety Device: Chair pad alarm. Check placement and function every shift, dated 3/5/25 Concave Pressure Relieving Mattress, dated 3/5/25 Sling in place to right arm, dated 3/5/25 Immobilizer in place to right leg. May remove for skin care and therapy only, dated 3/7/25			

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A nursing progress note, dated 3/6/25 at 2:17 P.M., indicated the resident returned from the hospital with a wound vacuum device to a right hip incision, a long leg immobilizer to the right leg, and a sling to the right arm. The skin underneath the immobilizer was intact with bruising at the back of the brace where the metal rod was positioned. There was a very large bruise on the right arm and shoulder.

A review of progress notes from 1/23/25 to 3/26/25 lacked documentation to indicate the physician was notified of or reviewed the x-ray results or a follow up scan was completed.

A Significant Change MDS Assessment was completed on 3/11/25. It indicated Resident 7 had severe cognitive impairment, required partial to moderate assistance of staff (staff does less than half of the effort) with eating, was dependent on staff (staff does everything) for rolling left to right, toileting, bathing, sit to stand and toilet transfers were not attempted, and there were no falls since the prior assessment.

On 3/26/25 at 2:35 P.M., Resident 7 was observed lying in bed with a concave mattress with an immobilizer on her right leg. The call light did not have fluorescent tape on it.

During an interview on 3/27/25 at 11:00 A.M., Physical Therapy Assistant (PTA) 9 indicated Resident 7 was up ad lib (as desired) for three years before she broke her pelvis. After she broke her pelvis, she was weight bearing as tolerated with assistance of one staff. She was discharged from therapy on 2/6/25 and was able to ambulate with a walker and assistance of one staff. After her fall on 3/1/25 she became non weight bearing

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	on her right leg and right arm. At that time, she indicated the intervention put in place after the fall on 1/20/25 was to add a concave mattress. She was unsure why it was not added to the care plan until 3/3/25 and was unsure when the resident received the concave mattress. After the resident fell on 3/1/25, new fall interventions were not added to the care plan because the resident became non weight bearing, was not trying to get up, and was not using her walker. During an interview on 3/27/25 at 1:25 P.M., the Director of Nursing (DON) indicated that after a resident fell, the nurse created a fall event. IDT staff ran a report daily of the new fall events, and new falls were discussed in morning meeting to identify appropriate and new interventions. The new intervention determined went into the care plan at that time. If the intervention was a lab or assessment, the results were followed up on. If the lab or assessment was not the cause of the fall, the resident would not always get a new intervention because it was "hard to find things that worked". On 4/1/25 at 10:47 A.M., the Administrator provided a current Falls - Clinical Protocol policy, revised March 2018, that indicated "For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes ... The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable ... Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling ... If underlying causes cannot be readily identified or corrected, staff will			

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	try various relevant interventions, based on assessment of the nature or category of falling ... If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes". On 4/1/25 at 10:47 A.M., the Administrator provided a current Goals and Objectives, Care Plan policy, revised April 2009, that indicated "When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly ... Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment ... Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved ... Goals and objectives are reviewed and/or revised: when there has been a significant change in the resident's condition...". On 4/1/25 at 10:47 A.M., the Administrator provided a current Physician Services policy, revised April 2013, that indicated "The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident. The attending physician will determine the relevance of any recommended			

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	interventions from any discipline ... The medical director will identify attending physician qualifications and responsibilities, based on clinical and regulatory requirements...". 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on record review and interview, the facility failed to ensure a resident was treated for a urinary tract infection in a timely manner for 1 of 2 residents reviewed for indwelling catheter care. (Resident 27) Finding includes: On 3/26/25 at 10:22 A.M. Resident 27's clinical record was reviewed. Resident 27 was admitted on 3/26/24. Diagnoses included, but were not limited to, malignant neoplasm of bladder. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/27/24, indicated Resident 27 was moderately cognitively impaired, required partial to moderate assistance of staff (staff does less than half of the effort) for toileting, and had an indwelling catheter. Physician orders included, but were not limited to: May re-anchor catheter if becomes dislodged or occluded as needed, Contact MD (medical doctor); Start date 3/27/24 Foley catheter: Anchor 16 french, 30cc (cubic centimeters) balloon, provide catheter care every shift, supra pubic catheter(a thin tube inserted into the bladder through a small incision in the lower abdomen), cleanse around insertion site	F 0690	**F 690** **Bowel/Bladder/Incontinence, UTI** Facility failed to ensure resident was treated for a UTI in a timely manner **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident 27 has been treated for all lab values obtained to date. A Care plan has been added via UTI committee related to frequent urinary tract infections and intervention of handwashing has been added to promote hand hygiene. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be effected by the cited deficiency. An audit shall be completed to ensure physician notification and treatment direction have been obtained for any outstanding labs. None were	04/25/2025

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	with soap and water, pat dry; Start date 3/7/25 Current care plans included, but were not limited to: Resident requires a suprapubic catheter related to obstructive uropathy; Start date 3/27/24 Report signs of complications such as urinary tract infection (UTI) (acute confusion, bladder spasms, pain, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine); Start date 3/27/24 Resident 27's clinical record indicated the following urinary tract infection occurrences since June 2024: UTI 1: A nursing progress note, dated 6/9/24 at 2:32 P.M., indicated a nurse was alerted to Resident 27's room by housekeeping that resident was covered in blood. Resident unsure of how it happened. He denied falling and there was no evidence that resident had fallen. Family later came in to visit resident and were informed. Family expressed concern related to resident's catheter bag being purple. Leg bag examined per nursing and it did have a purple tint, however, urine output was darker yellow and concentrated. Minimal research revealed a possible cause being "purple catheter bag syndrome" which was usually indicative of a longstanding Foley catheter and chronic UTI. MD notified of all the above. A nursing progress note, dated 6/10/24 at 2:04 P.M., indicated a new order was received for a urinalysis and culture and sensitivity from a new catheter bag due to urine bag being purple in		identified at this time. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** When labs are obtained facility shall notify provider and follow until physician provides response to treat or not to treat. Once physician is notified of labs which need to be addressed, and lab is finished processing, for UTI specifically involving a culture, if physician does not respond within 2 business days facility shall contact Medical Director for medical treatment. Facility currently has systems in place for review of clinical information, 24 hours report, labs, new orders, consultant recommendations and progress notes to prompt this process. DON or designee is responsible for tracking/documenting physician notifications regarding lab results until resolution is achieved as stated above. Education regarding physician notification, lab results, and treatment response shall be provided to nurses with posttest to demonstrate comprehension. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 4/25/25 the Quality Assurance program shall review lab tracker audit process to ensure physician notification and	

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	color. A nursing progress note, dated 6/10/24 at 11:32 P.M., indicated current catheter removed and new catheter placed suprapubic using aseptic technique with no urine return. A nursing progress note, dated 6/11/24 at 10:36 A.M., indicated Resident 27's suprapubic catheter was not in place. No urine return. The nurse adjusted catheter and when it was in place, yellow urine mixed with blood returned. Nurse attempted to replace catheter but was unable to re-anchor catheter. Orders received to send to [hospital] emergency department for catheter replacement. A nursing progress note, dated 6/11/24 at 11:13 A.M., indicated family arrived and transported Resident 27 to the emergency department, catheter bag with blood noted. A nursing progress note, dated 6/12/24 at 4:07 P.M., indicated a urine report was faxed to facility. Nitrite positive, no new orders written with report. A facility nurse called the PAC (post acute care line for physicians) and there was no answer. A nursing progress note, dated 6/13/24 at 3:29 P.M., indicated request sent to PAC to follow up on resident's urine obtained during emergency room visit which was nitrite positive, no culture report available yet. A nursing progress, note dated 6/15/2024 at 5:03 P.M., indicated nurse called PAC related to urine culture results. Unable to obtain results at that time. MD notified to try and obtain results. Resident continued to have purple catheter bags despite dark yellow urine output.		response to lab results are completed. The DON or designee shall document this process 7 days a week for 4 weeks and then monthly if 100% compliance has been achieved. The clinical process itself shall remain ongoing for optimal continuity of care and regulatory compliance.	

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	A nursing progress note, dated 6/18/24 at 5:24 P.M., indicated Resident 27 complained of not feeling well in his abdomen. Encouraged to eat a good dinner and milkshake. The clinical record lacked a direct call to the hospital laboratory to obtain culture results. A nursing progress note, dated 6/19/24 at 10:25 A.M., indicated urine culture was >100,000 E-Coli and faxed to physician triage for review. Resident was to receive an injection that day. The electronic medication administration record (EMAR) indicated Resident 27 started cephalexin 500mg (milligrams) twice a day for seven days on 6/20/24. A hospital culture report indicated the urine collected in the emergency department on 6/11/24 had a final culture and susceptibility result available on 6/13/24 at 7:57 A.M. UTI 2: A nursing progress note, dated 8/1/24 at 11:17 A.M., indicated catheter was changed due to occlusion. A nursing progress note, dated 8/1/24 at 6:03 P.M., indicated Resident 27 had complaints of pain from the catheter site. The clinical record lacked any observation or progress notes related to catheter, pain, or UTI monitoring from 8/2/24 to 8/19/24. A nursing progress note, dated 8/20/24 at 2:56 P.M., indicated the nurse practitioner (NP) was notified that Resident 27 had a purple urine bag again. The nurse indicated last time that			

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	happened, the resident had a UTI. No new orders at that time. A nursing progress note, dated 8/22/24 at 1:56 P.M., indicated the NP was in the facility and gave orders for urinalysis and culture and sensitivity tests, and to change catheter to obtain urine. A nursing progress note, dated 8/22/24 at 2:31 P.M., indicated the catheter was changed but unable to obtain enough urine at that time for urinalysis. A late entry nursing progress noted, dated 8/22/24 at 3:10 P.M., indicated urine obtained. A urine culture lab report, dated 8/22/24 at 3:35 P.M., indicated the method of urine collection was clean catch and indicated a contaminated specimen. A nursing progress note, dated 8/23/24 at 3:11 P.M., indicated urine results faxed to PAC. A nursing progress note, dated 8/24/24 at 5:05 P.M., indicated urine culture results received indicating contaminated sample. A voicemail was left for PAC. A nursing progress note, dated 8/24/24 at 10:24 P.M., indicated the PAC gave new orders to recollect urine specimen. Urine specimen collected with purulent urine return. A nursing progress note, dated 8/26/24 at 1:18 P.M., indicated an order for cephalexin was received on 8/23/24, but was not initiated. The resident was noted to be more confused and lethargic. Order received to start cephalexin 250mg (milligrams) three times a day for 10 days for			

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	urinary tract infection. A nursing progress note, dated 8/27/24 at 1:24 P.M., indicated lab stated the second urine specimen was also contaminated. A nursing progress note, dated 8/27/24 at 1:30 P.M., indicated resident always had his hands on his catheter tubing. The clinical record lacked a care plan related to frequent urinary tract infection and prevention of urinary tract infection including promoting hand hygiene for Resident 27. A nursing progress note, dated 8/29/24 at 11:25 A.M., indicated Resident 27 notified staff he was hurting and pointed to the right groin area. The area was assessed and PAC notified. A nursing progress note, dated 8/31/24 at 9:55 A.M., indicated the resident's catheter insertion site was red. UTI 3: A nursing progress note, dated 9/8/24 at 6:01 P.M., indicated Resident 27's family expressed concern related to the catheter insertion site. Site was red with drainage and swelling. The resident complained of severe pain and tenderness to touch. PAC notified and orders given for a urinalysis and culture and sensitivity tests. A nursing progress note, dated 9/9/24 at 6:33 A.M., indicated catheter changed and not enough urine to collect for specimen. A nursing progress note, dated 9/9/24 at 10:31 P.M., urine was obtained and notified lab to pick up.			

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A nursing progress note, dated 9/12/24 at 3:04 P.M., indicated a new order was received for ciprofloxacin 250mg two times a day for seven days for UTI.

During an interview on 3/28/25 at 8:22 A.M., the Director of Nursing (DON) indicated Resident 27 had a history of chronic urinary tract infections, culture reports often resulted as contaminated specimens, and resident was not receiving any type of prophylactic measures.

During an interview on 4/1/25 at 11:31 A.M., a policy related to urinary tract infection protocol was requested. The Administrator indicated the facility did not have a written policy related to urinary tract infections and the facility's policy was to notify the physician and follow physician orders.

On 4/1/25 at 10:44 A.M., the Administrator provided a policy titled Acute Condition Change Clinical Protocol, dated December 2015, that indicated "Before contacting a physician about someone with an acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the physician. The nursing staff and physician will discuss possible causes of the condition change based on factors including resident history, current symptoms, medication regimen, and existing test results. The physician will help identify and authorize appropriate treatments."

On 4/1/25 at 10:44 A.M., the Administrator provided a policy titled Prevention and Screening Clinical Protocol, dated December 2012, that indicated "Where medically indicated, the attending physician will identify primary,

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	secondary, and tertiary preventative and screening measures. Primary prevention is aimed at reducing the incidence of a disease or condition by preventing its onset. Secondary prevention targets early identification of a condition to limit its course and complications. Tertiary prevention focuses on prevention of additional complications that is not preventable or fully correctable." 3.1-41(a)(2)			
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP Based on interview and record review, the facility failed to ensure a resident was assessed by a physician since admission for 1 of 2 residents admitted in the last 90 days reviewed for accidents. (Resident 22) Finding includes: On 3/26/25 at 1:55 P.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 1/26/25. Diagnoses included, but were not limited to, dementia. The most recent Admission Minimum Data Set (MDS) Assessment, dated 1/26/25, indicated Resident 22 was severely cognitively impaired and required partial assistance (staff does less than half of the effort) for toileting and bathing. The clinical record, including assessments, progress notes, and documents, lacked assessment of Resident 22 by a physician in the facility since admission. During an interview on 3/28/25 at 8:22 A.M., the Director of Nursing (DON) indicated she could	F 0712	**F 712 physician visit-frequency/timeliness** Facility failed to ensure physician had seen resident once every 30 days for first 90 days after admission and at least once every 60 thereafter. Visit is considered timely if less than 10 days after the visit was required. **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident 22 has been seen by the physician. Resident was seen next day after transferring from Apartment setting to SNF bed, by NP when she moved to nursing. **How will you identify other residents having the potential to be affected by the same deficient practice?** Physician tracking log shall be monitored by Medical Records or designee. Communication with physician offices to ensure	04/25/2025

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	not find a physician assessment for Resident 22. On 4/1/25 at 10:47 A.M., the Administrator provided an undated policy titled Physician Services that indicated "The physician will perform pertinent, timely medical assessments; visit the resident at appropriate intervals ... Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy." 3.1-22(d)(1)		residents are seen timely shall occur weekly. Medical Director shall be asked to see residents in the 10 day grace period if primary physician has not responded or is unavailable. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** Medical Records Coordinator shall establish communication with appropriate office individual and coordinate timely medical assessments at appropriate intervals. Medical records coordinator shall communicate with Medical Director when necessary due to lack of compliance by other physicians. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Effective 4/25/25 Physician Tracking Log shall be reviewed at QA for 100% compliance. Patterns and trends shall warrant additional communication to physicians directly. EPH has a medical records consultant. Facility shall request consultant review physician tracking log with every visit to ensure regulatory compliance. -	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On			

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	Based on interview and record review, the facility failed to ensure pharmacy recommendations were acted upon for 1 of 5 residents reviewed for unnecessary medications. (Resident D) Finding includes: On 3/26/25 at 9:20 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/12/25, indicated Resident D was cognitively intact, required setup assistance for eating, was dependent on staff for toileting, bathing, and transferring, and received an antianxiety medication during the 7-day look back period. A current care plan, revised 2/21/25, indicated Resident D received antianxiety medication related to an anxiety diagnosis. A care conference was most recently completed on 1/10/25. Care plan conference notes indicated that all current care plans were reviewed. Current physician orders included, but were not limited to: buspirone tablet (an antianxiety medication) - 10 milligrams (mg) at bedtime, dated 9/27/24 Discontinued physician orders included, but were not limited to: buspirone tablet - 10 mg once a day, dated 7/11/23 with a discontinued date of 7/10/24 buspirone tablet - 10 mg at bedtime, dated 7/11/24 with a discontinued date of 9/27/24	F 0756	**F 756 Drug Regimen Review** Facility failed to ensure pharmacy recommendations were acted upon **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident D had a pharmacy recommendation made to decrease buspirone. The facility is told by PAC to address with medical personnel in the facility to decrease fax communication to PAC. The buspirone was not addressed and the recommendation made a second time by pharmacist. During that time frame Resident D had been very sick and was provided a new cancer diagnosis. IDT team stopped pursing the recommendation to decrease the antianxiety as the resident's anxiety had actually increased on current dosage due to clinical decline. Resident D remains on buspirone 10mg HS due to her terminal condition. . Medical Director shall review and notate if buspirone should continue due to terminal condition. **How will you identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be effected by the cited deficiency. An audit shall be completed to ensure physician	04/25/2025

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	A pharmacy recommendation, dated 6/11/24, requested a decrease of the buspirone from 10 mg once a day to 5 mg once a day. The recommendation lacked documentation it was acted upon. A pharmacy recommendation, dated 7/16/24, requested a decrease of the buspirone from 10 mg once a day to 5 mg once a day. The recommendation lacked documentation it was acted upon. During an interview on 3/27/25 at 11:05 A.M., Medical Records staff indicated the physician Resident D used did not come to the facility and all pharmacy reviews had to be faxed out. The resident's physician did not respond to the pharmacy recommendations on 6/11/24 or 7/16/24. At that time, she indicated that if an outside physician did not respond, the pharmacy requests were sent to the Medical Director to accept or decline. The Medical Director did not accept or decline the pharmacy recommendations on 6/11/24 or 7/16/24. On 4/1/25 at 10:47 A.M., the Administrator provided a Consultant Pharmacist Reports policy, revised December 2022, that indicated "Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing ... Comments and recommendations concerning medication therapy are communicated in a timely fashion ... Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her within 30 days, the Director of Nursing and/or the		notification and treatment direction have been obtained for any outstanding pharmacy recommendations. None were identified at this time. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** When recommendations are received facility shall notify provider recommendations are in-house for review and follow until physician provides response. For consultant recommendations which are not escalated due to clinical change facility shall follow current policy to request from Medical Director if primary physician has not addressed in 30 days. Facility currently has systems in place for review of clinical information, 24 hours report, labs, new orders, consultant recommendations and progress notes to prompt this process. Medical Records Coordinator or designee is responsible for tracking/documenting physician notifications regarding recommendations until resolution is achieved as stated above. Education regarding pharmacy recommendation process shall be provided to nurse manager and behavior monitoring team with posttest to demonstrate comprehension. **How the corrective actions will**	

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	consultant pharmacist may contact the Medical Director...". 3.1-25(i)		**be monitored to ensure the deficient practice will not recur?** Effective 4/25/25 the Quality Assurance program shall review pharmacy recommendation tracker audit process to ensure recommendations have been addressed within 30 days. The Medical Records Coordinator or designee shall document this process monthly when recommendation are received. If a pharmacy recommendation is made a second time because physician has not addressed in the initial 30 day window the facility shall ask the Medical Director to address. The clinical process itself shall remain ongoing for optimal continuity of care and regulatory compliance.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 2 of 3 residents reviewed for as needed anti-anxiety medication use. Residents' as needed anti-anxiety medication was ordered for greater than 14 days. (Resident 29 and Resident 27) Findings include: 1. On 3/26/25 at 10:07 A.M., Resident 29's clinical record was reviewed. Resident 29 was admitted on 2/15/25. Diagnoses included, but were not limited to, chronic kidney disease.	F 0758	**F758 free from unnecessary psychotropic meds** Facility failed to ensure residents were free of unnecessary medications, PRN antianxiety for greater than 14 days. **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident 27 and 29 were not negatively affected by the cited deficiency. Resident 27 and 29 has been assessed, the Physician	04/25/2025

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	The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 3/6/25, indicated Resident 29 was cognitively intact, and was dependent (staff does all of the work) for transfers. Current physician orders included, but were not limited to: alprazolam (anti-anxiety medication) 0.25 milligrams (mg), one tablet by mouth three times daily as needed for pain; Start date 2/27/25 (no end date) The clinical record lacked a physician reassessment of the medication, or indication of contraindication for discontinuation of the medication, beyond 14 days. 2. On 3/26/25 at 10:22 A.M., Resident 27's clinical record review was reviewed. Resident 27 was admitted on 3/26/24. Diagnoses included, but were not limited to, atrial fibrillation. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/27/24, indicated Resident 27 was moderately cognitively impaired and required partial (staff does less than half of the work) assistance for toileting. Current physician orders included, but were not limited to: clonazepam (anti-anxiety medication) 1 milligram (mg) one tablet by mouth three times a day as needed for anxiety; Start date 3/14/25 (no end date) The clinical record lacked a physician reassessment of the medication, or indication of contraindication for discontinuation of the		has been updated and the psychotropic medication orders updated for compliance. **How will you identify other residents having the potential to be affected by the same deficient practice?** Although no residents were negatively impacted by the citation all residents receiving PRN antianxiety medications have the potential to be affected. All residents receiving PRN antianxiety medications have been reviewed to ensure that they are receiving the order as prescribed by the physician and the documentation reflects this. The Physician has been notified of any discrepancies noted and orders changed when necessary. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** The facility policies regarding psychotropic medications have been reviewed with no changes at this time. Nursing and Social Service staff has been reeducated on the facility policy regarding use of PRN antianxiety medications with special focus on not having antianxiety PRN medication orders unless required and if they are in place ensuring documentation by the physician is present in the EMR. Facility audit revealed hospice residents are the primary cause of these order sets	

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	medication, beyond 14 days. During an interview on 3/28/25 at 8:22 A.M., the Director of Nursing (DON) indicated as needed anti-anxiety medication should only be ordered for 14 days and should be reviewed during monthly interdisciplinary team (IDT) meetings. On 4/1/25 the clinical record continued with the current order of clonazepam without stop date, the last recorded dose administered was 3/22/25. On 4/1/25 at 11:29 A.M., the Administrator provided a policy titled Medication Monitoring and Management, dated December 2022, that indicated "As needed (PRN) orders for antipsychotic drugs are limited to 14 days without exception. If the attending physician or prescribing practitioner wishes to continue a PRN antipsychotic drug beyond 14 days, the attending physician or prescribing practitioner must first perform an in-person evaluation of the resident and then write a new order." 3.1-48(a)(6)		and additional education has been provided to our hospice partners. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** The DON or designee shall be responsible for reviewing daily orders for antianxiety PRN medications and corrections made per regulation. This monitoring will occur 7 days a week for 4 weeks and if 100% compliance achieved weekly for four weeks and then monthly. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly behavior meetings on an ongoing basis. The plan will be adjusted as indicated by increasing or decreasing the monitoring of services until 100% compliance is achieved and maintained. Effective 4/25/25 the Quality Assurance program shall review PRN medication tracker audits for compliance. -	
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff Based on record review and interview, the facility failed to ensure the Dietary Manager met required qualifications for 1 of 1 dietary manager qualifications reviewed.	F 0801	- **F801 Qualified Dietary Staff** Facility failed to make sure the Dietary Manager met qualifications **What corrective action will be**	04/07/2025

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	Finding includes: During an interview on 3/25/25 at 9:01 A.M., the Dietary Manager indicated she did not have a dietary manager certification and had not enrolled in the program. During an interview on 3/26/25 at 11:27 A.M., the Dietitian indicated she was aware the Dietary Manager was not certified but had not increased her visits; she was currently in the facility once a week. On 3/28/25 at 1:16 P.M., the Dietary Manager's employee file was reviewed. The Dietary Manager job description, signed on 3/11/25, indicated qualifications to accepting the role of dietary manager required completion of state-approved food service management course, or presently enrolled in a program. During an interview on 4/1/25 at 10:59 A.M., the Administrator indicated the facility did not have a written policy related to qualifications of the dietary manager, and the policy was to follow state regulations. 3.1-20(e)		**accomplished for resident found to be affected by deficient practice?** No residents were affected by the cited deficiency. Staff Member AM has completed the Serve Safe Manager Online Course which qualifies under state regulations. **How will you identify other residents having the potential to be affected by the same deficient practice?** Residents were not affected by the cited deficiency, the staff member had only been in her role for 3 weeks when state entered the building for annual survey. The course had already been purchased in preparation to meet compliance. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur**? Proof of certification of completion of state approved Dietary Manager Course will be obtained by facility if additional staff turnover occurs. Facility shall promote course completion by another staff member to avoid future concern. Business office staff shall be educated on this requirement as they audit license and certification monthly for the facility. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** Business office monitors licensure	

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			requirements within the facility. If audit determines we are out of compliance it will be brought to QA for corrective actions including but not limited too requesting the Registered Dietician increase hours until adequate coverage is obtained.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to safely store and label food under professional standards related to food items not labeled or stored properly for 1 of 1 dietary areas observed. Findings include: During a kitchen walk through on 3/25/25 at 8:44 A.M., the following was observed: Walk in refrigerator: Bag of mixed broccoli, carrots, and celery open to air, no date Chunk of ham, dated 2/15 Carton of molded strawberries A container of bran mixture labeled prepped 3/8 A container of banana cake labeled prepped 3/16 Dry storage room: Rice crispy treats directly on the floor	F 0812	F 812-Food Procurement Store/Prepare/Serve **What corrective action will be accomplished for resident found to be affected by deficient practice?** Residents were not affected by the cited deficiency. **How other residents potentially affected will be identified and corrective actions taken?** Additional refrigerator/freezer audits were completed throughout the facility and no additional concerns were noted. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** Food Storage and labeling audits have always been routinely completed on Wednesday when the Registered Dietician rounds in the facility. Visual food storage audits will be expanded to daily and involve the Dietary Manager or	04/25/2025

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	Box of sandwich crackers directly on the floor Walk in freezer: Bag of pepperonis doubled bagged; inside bag dated 12/21/23 and outside bag dated 6/29/24 On 4/1/25 at 10:44 A.M., the Administrator provided a policy titled Food Storage, dated 2017, that indicated "Food will be stored a minimum of six inches above the floor ... leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be labeled and dated before being refrigerated. Leftover foods is used within seven days or discarded per federal food code." 3.1-21(i)(2) 3.1-21(i)(3)		cook on shift. Education has been provided to dietary staff regarding facility policy for food storage, labeling, and preparation which included a post test and label specifics. **How the corrective actions will be monitored to ensure the deficient practice does not recur?** Daily audits by the dietary manager or designee shall occur for 30 days, if 100% compliance is achieved those will titrate down to weekly audits and continue forward as best practice. Effective 4/25/25 facility QA committee will review audits to ensure compliance.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure a catheter change was accurately documented for 1 of 2 residents reviewed for catheter associated urinary tract infections. (Resident 2) Finding includes: On 3/26/25 at 9:08 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 2/16/24. Diagnoses included, but were not limited to, urine retention. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/26/25, indicated	F 0842	F 842-Resident Records Facility failed to ensure a catheter change was accurately documented **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident2 was not affected by the cited deficiency. The catheter change was completed by Licensed Nurse 16 using sterile technique. **How other residents potentially affected will be identified and**	04/25/2025

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	Resident 2 was cognitively intact, required maximal assistance (staff does more than half of the work) for toileting, bathing, and chair to bed transfers, and had an indwelling catheter. Physician orders included, but were not limited to: Change Foley catheter monthly: 18 French with 30 mL (milliliter) balloon on the 27th of the month; 2/1/25-3/2/25. Change Foley catheter monthly: 18 French with 30 mL (milliliter) balloon on the 2nd of the month; Start date 3/2/25. On 3/28/25 at 1:15 P.M., the Director of Nursing (DON) provided a document titled Treatment Administration History that indicated Qualified Medication Aide (QMA) 7 had changed Resident 2's catheter on 2/27/25. During an interview on 3/28/25 at 1:43 P.M., QMA 7 stated she did not change Resident 2's catheter on 2/27/25, and believed a nurse charted the catheter change under her username. A nursing progress note, dated 3/2/25 at 12:38 P.M., indicated Resident 2 stated that his catheter was due to be changed on 2/27, however, the task was not completed. Registered Nurse (RN) 16 then used sterile technique to change the catheter. On 4/1/25 at 11:29 A.M., the Administrator provided a document titled Charting and Documentation, dated July 2017, that indicated "Documentation in the medical record will be objective, complete, and accurate." 3.1-50(a)(2)		**corrective actions taken?** Nurse Manager, who is a QMA, accidently signed the cath change as she was assisting nurse with job completion orders verifying items were complete for the shift, such as, ½ side rails, up with rolling walker, pressure reducing cushion, cath care ect….. and misread cath change when she came across it. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** Medical Records Coordinator or designee shall provide education to nursing staff regarding the importance of resident record integrity, and thoroughly reading each line item to ensure accuracy. Cath change orders shall be moved to the MAR to prevent reoccurrence. As a reminder scope of practice shall be reviewed with current QMA's licensed in this facility. **How the corrective actions will be monitored to ensure the deficient practice does not recur?** Random Audits of documentation accuracy and cath change order placement on the MAR shall be performed by medical records coordinator or designee. Effective 4/25/25 facility QA committee will review audits to ensure compliance.	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to implement infection control practices to ensure the proper use of Enhanced Barrier Protocol (EBP) and Personal Protective Equipment (PPE) for 2 of 2 random observations of wound care. (Resident T and Resident D) Findings include: 1. On 3/26/25 at 11:44 A.M., Resident T's clinical record was reviewed. Diagnoses includes, but were not limited to, Parkinson's Disease. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/13/25, indicated that the resident was severely cognitively impaired and was dependent on staff for eating, transferring, hygiene, and toileting. During that assessment, the resident was considered a risk for pressure wounds and had a stage 4 pressure wound present. Current physician orders included, but were not limited to: Skin preparation to bilateral heels every shift for protection dated 9/6/22. Wound: Coccyx Stage 4, clean area with wound cleanser and pat dry with 4 x 4 gauze. Cut a strip of calcium alginate (wound dressing) into a thin long strip and pack loosely into the 11 o'clock tunnel and spread to cover wound bed and pack wound also, skin prep peri wound and cover with	F 0880	F880 Infection Prevention & Control **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident T and Resident D were not affected by the cited deficiency. The wound care was completed on Resident D and wound found to be healed, which removed this resident from the enhanced barriers list. Staff did not know the wound would be considered healed when they entered room to perform treatment. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?** The facility recognizes that all residents have the potential to be affected by this deficient practice. Gown and gloves will be worn for residents who have the enhanced barrier precautions. EBP is indicated outside the room door so staff are aware of precautions to take. Facility provides multiple areas for PPE access to be utilized on the unit. **What measures will be put into**	04/25/2025

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	4 x 4 Foam border dressing PRN (As Needed) dislodgment or soiling, dated 3/7/25. Care plan conference notes indicated the care plan was reviewed on 1/13/25. The current care plan for infection indicated that the resident had a need for EBP related to wound care. Interventions included, but were not limited to: Enhanced Barrier Precautions Signs will be hung on the appropriate rooms, dated 4/10/24 PPE will be placed outside of rooms for staff use, dated 4/10/24. Staff will use appropriate PPE during resident care, dated 2/21/25. On 3/27/25 at 11:02 A.M., Registered Nurse (RN) 16 and RN 12 were observed performing wound care without a gown as noted on the Enhanced Barrier Protocol sign posted outside the resident's door. During an interview on 3/27/25 at 11:15 A.M., RN 12 indicated that she forgot to put on the gown prior to wound care.2. On 3/26/25 at 9:20 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified ulcer on right buttock. The most current Minimum Data Set (MDS) Assessment, dated 1/12/25, indicated Resident D was cognitively intact, was dependent on staff (staff does all of the effort) for toileting, bathing, and transferring, and had no pressure injuries. Current physician orders included, but were not limited to: Cleanse area to buttocks with wound cleanser and apply thin layer of hydrophilic wound paste		**place and what systemic changes will be made to ensure that the deficient practice does not recur?** Enhanced barrier precaution education will be provided for all nursing staff and audits will be conducted to ensure proper PPE is utilized for all residents with enhanced barrier precautions. Residents are placed on EBP based on diagnosis on admission and with order changes. Audits will be conducted 5x per week for one month, weekly for 1 month and then random with monthly Infection Prevention program for an ongoing basis and best practice. **How the corrective actions will be monitored to ensure the deficient practice does not recur?** Infection Preventionist or designee shall perform daily audits of proper PPE for enhanced barrier precaution residents for 30 days, if 100% compliance is achieved the audits will titrate to weekly and then random Monthly audits to ensure compliance. Infection Preventionist or designee shall be responsible for using door indicator and adding residents to an ongoing EBP list within the facility. Effective 4/25/25 the QA committee shall review audit results and make sure corrective actions were performed during the point of care.	

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	(Coloplast) and cover with a large sacral foam border dressing daily and as needed when soiled, once a day every three days, dated 2/14/25 A current pressure ulcer care plan, initiated 12/12/24, indicated Resident D had a pressure ulcer on her buttock. A care conference was most recently completed on 1/10/25. Care plan conference notes indicated that all current care plans were reviewed. A wound management report, dated 2/4/25 at 4:14 P.M., indicated an unspecified ulcer that was not present on admission was identified on Resident D's right buttock. The ulcer measured 1 centimeter (cm) in length and 0.8 cm in width. The most current wound management report, dated 3/22/25 at 9:00 A.M., indicated the ulcer on Resident D's right buttock measured 0.7 cm in length by 0.3 cm in width. The clinical record lacked an order or care plan that indicated Resident D was on Enhanced Barrier Precautions (EBP) due to the wound. On 3/27/25 at 10:31 A.M., Registered Nurse (RN) 16 and RN 5 were observed performing wound care on Resident D's ulcer on her right buttock. RN 16 and RN 5 were not wearing gowns during wound care. There was not an EBP sign observed in or near the resident's room. On 3/28/25 at 8:31 A.M., the Director of Nursing (DON) provided a list of all residents on EBP, and Resident T was listed. Resident D's name was not on the list. During an interview on 3/28/25 at 8:40 A.M., the			

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	DON indicated EBP was used for residents who had an indwelling catheter, wound, or open surgical incision. At that time, she indicated Resident D should be on EBP and staff should be wearing a gown and gloves while providing wound care to the resident. During an interview on 3/28/25 at 10:36 A.M., the Infection Preventionist (IP) indicated that staff should use EBP with direct patient care if the resident had a wound or an indwelling catheter. On 4/1/25 at 11:00 A.M., the Administrator provided a current undated Enhanced Barrier Precautions for Skilled Nursing Facilities policy that indicated "...nursing staff ensures that the resident and staff are aware of need to use EBP and the necessary supplies are provided...EBP signage outside resident's room and provide readily available personal protective equipment (PPE), including gowns and gloves...". This citation relates to complaint IN00451230. 3.1-18(b)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Nursing Home Complaint IN00451230. This visit included a Non-Certified Comprehensive (NCC) Survey. Survey dates: March 25, 26, 27, 28, 31, and April 1, 2025 Facility number: 001125	R 0000	This Plan of Correction is submitted in compliance with applicable law and regulation. Compliance with applicable law, and completing plan of correction set forth does not constitute agreement with the 2567. All alleged deficiencies have been, or will be completed by the dates indicated	

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	Residential Census: 21 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were completed and signed by the resident every six months for 7 of 7 residents reviewed. (Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, and Resident 27) Findings include: 1. On 3/28/25 at 10:47 A.M., Resident 21's clinical record was reviewed. Resident 21 was admitted to the facility on 10/19/22. Diagnoses included, but were not limited to, obstructive uropathy. The clinical record lacked a service plan reviewed and signed in the past year. 2. On 3/28/25 at 11:05 A.M., Resident 22's clinical record was reviewed. Resident 22 was admitted to the facility on 7/4/23. Diagnoses included, but were not limited to, hypertension. The clinical record lacked a service plan reviewed and signed in the past year. 3. On 3/31/25 at 8:41 A.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 23 was admitted to the facility on 8/23/24. The most current service plan, dated 3/17/25, was not signed by the resident.	R 0217	R217**Residential-Sign plan of Correction** **What corrective action will be accomplished for resident found to be affected by deficient practice?** Resident 21,22,23,24,25,26, and 27 have suffered no ill effects from not signing the service plan in the electronic medical record. The facility has implemented proper equipment for digital signing. Each resident service plan was signed and reported to surveyors while on site. **How other residents potentially affected will be identified and corrective actions taken?** On a monthly basis the residential apartment manager currently completes a service plan audit for IDT review. The audit currently list resident name, date of last service plan update, and reason for service plan update. The form shall be reviewed by the residential service plan manger or designee and service plans listed	04/25/2025

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	04/01/2025

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

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	4. On 3/31/25 at 8:28 A.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, end stage heart failure. Resident 24 was admitted to the facility on 3/9/25. The most current service plan, dated 3/20/25, was not signed by the resident. 5. On 3/31/25 at 8:16 P.M., Resident 25's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Resident 25 was admitted to the facility on 7/29/23. The most current service plan, dated 3/12/25, was not signed by the resident. 6. On 3/28/25 at 1:25 P.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 26 was admitted to the facility on 2/16/25. The most current service plan, dated 2/17/25, was not signed by the resident. 7. On 3/28/25 at 1:03 P.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, fracture of left pubis. Resident 27 was admitted to the facility on 12/20/24. The most current service plan, dated 2/25/25, was not signed by the resident. During an interview on 3/31/25 at 1:10 P.M., the Administrator indicated service plans had not been signed because there was a staffing change and it hadn't gotten done. On 4/1/28 at 11:39 A.M., the Administrator provided an undated current Service Plan		checked for resident signature. Any non- compliance shall be corrected immediately. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** The monthly service plan audit form shall be modified and a column added to check for resident signature. Residential apartment manager or designee is responsible for completion. During 24 hour report review at clinical meeting the DON or designee shall note any change of condition or medication order change that warrants a service plan update and check the electronic medical record for resident signature. Any non-compliance shall be corrected immediately. **How the corrective actions will be monitored to ensure the deficient practice does not recur?** Effective 4/25/25 the Quality assurance committee shall review the most recent service plan update audit to ensure resident signature. The DON or designee shall complete 24 hour clinical review service plan audit which includes resident signature 5 days a week for 4 weeks and then monthly if 100% compliance has been achieved. The modified form shall be complete for QA	

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	Evaluation and Plan of Care policy that indicated "Service plan must be reviewed with resident/representative and signed and dated by the resident/representative".		committee on a monthly basis ongoing.	