

| | | | | | |
|--|--|--|---|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X(2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X(3) DATE SURVEY COMPLETED 06/24/2011 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F0000 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00091768.</p> <p>Complaint Number IN00091768 substantiated, No deficiencies related to the allegation are cited.</p> <p>Survey dates: June 20, 21, 22, 23, and 24, 2011</p> <p>Facility number: 003624 Provider number: 15E680 AIM number: 200429840</p> <p>Survey team: Teresa Buske RN - TC Mary Weyls RN</p> <p>Census bed type: NF: 55 Residential: 32 Total: 87</p> <p>Census payor type: Medicaid: 49 Other: 38 Total: 87</p> <p>Sample: 14 Residential sample: 5</p> | F0000 | Submission of this plan of correction shall not constitute an admission by Providence Health Care, Inc. to the allegations contained in this survey report Providence Health Care Inc. specifically and generally denies that the survey allegations are indicative of the quality of nursing care and service provided to residents of this health care facility | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| | | | | | |
|--|--|--|--|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X(2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X(3) DATE SURVEY COMPLETED 06/24/2011 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F0323 SS=D | <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/29/11 Cathy Emswiller RN</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review, observation, and interview the facility failed to ensure adequate supervision to prevent accidents for 1 of 8 residents identified with incidents of elopement and fall from shower chair resulting in fracture in a sample of 14. (Resident # 31)</p> <p>Findings include:</p> | F0323 | <p>This plan of correcton is submitted in accordance with tthe requirements of Sttatte and Federal law.</p> <p>The fiacilityt hereby requestts consideratton of a paper compliance re-survey or desk review.</p> <p>F-323 Free of Accident Hazards/Supervision/Devices It is the policy of Providence Health Care to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receive adequate supervision and assistance devices to prevent accidents as indicated in the regulations described in F323 of this survey. I. <u>Corrective Action</u></p> | 07/22/2011 | |

| | | | | | |
|--|---|--|--|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X(2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X(3) DATE SURVEY COMPLETED 06/24/2011 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>1a. On 6/20/11 at 7 a.m., RN #1 indicated Resident #31 was confused, required the assistance of two staff for transfers, and was unable to propel self while up in the wheelchair.</p> <p>On 6/21/11 at 11:15 a.m., Resident #31 was observed to be in wheelchair . The resident was not propelling self.</p> <p>Review of the clinical record of Resident #31 on 6/22/11 at 4:45 p.m. indicated the diagnoses which included but were not limited to Alzheimer Disease, Anxiety , and Psychosis.</p> <p>Nursing progress notes dated 7/11/10 at 11:01 a.m. indicated "After breakfast [Resident #31] was maneuvering herself in her w/c [wheelchair] in dining room. [Resident #31] was attempting to stand-up...."</p> <p>Nursing progress notes dated 7/11/10 at 1:56 p.m. were noted of " [Resident #31] was very restless at lunchtime. Wanting to take self (via w/c) into other rooms. Staff did numerous diversions...Currently sitting with writer falling asleep. Writer also took sister outside for a few minutes."</p> <p>Nursing progress notes dated 7/28/10 at</p> | | <p><u>Taken related to this finding A.</u> An elopement risk assessment is performed weekly for Resident # 31 to ensure her safety in her current environment. IDT involvement will be assured by review of assessments at bi-monthly risk management meetings. B. Resident # 31 began exhibiting increased physical abilities on 7/2/11. On 7/7/11 resident wheeled self with difficulty on unit. On 7/11/11 discussion and review by IDT determined that resident # 31 would best have safety needs met by moving to the secured unit. C. On 7/8/11 an in-service was given to all nursing staff members regarding safe care provision. On 7/11/11 in-servicing began for all staff. Completion date for all staff in-servicing is expected on 7/18/11. The re-instruction includes policies and procedures related to adequate supervision for high risk residents; identifying residents at risk for elopement/falls; accuracy of assignment sheets/reviewing assignment sheets at the start of each shift; team building between shifts/disciplines; examples of hazards that could likely cause injury II. <u>Other Residents with Potential to be affected by this finding will be identified by A.</u> An audit of 20% of charts on each unit will be conducted weekly to ensure that elopement risk assessments are completed to begin the week of 7/11/11. B. At</p> | | |

| | | | | | |
|--|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/24/2011 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>10:19 p.m. indicated "[Resident #31] attempted to get up out of w/c by herself et [and] slid down onto floor by the foot pedals of her w/c. Alarm was sounding et fall was witnessed..."</p> <p>Nursing progress notes dated 8/11/10 at 3:27 p.m. were noted of physician notified of tag alarm initiated as nursing measure due to frequent attempts of resident to get out of wheelchair without assistance.</p> <p>Nursing progress notes dated 8/24/10 at 11:20 a.m. indicated "[Resident #31] is exit seeking, wanting to go home. Staff has explained to [Resident #31] several times this is her home and have attempted redirecting [Resident #31] with company, snacks, offered to take to mass etc. all unsuccessful. Will cont [continue] to monitor and redirect [Resident #31]"</p> <p>Nursing progress notes dated 8/24/10 at 2:33 p.m. indicated the resident was transferred back to secure Alzheimer Unit.</p> <p>Review of Unusual Occurrence investigation dated 8/24/10 provided by the Director of Nursing on 6/23/11 at 10 a.m. indicated Resident #31 had resided on the secured unit until May 2010 due to decline and the resident was moved to the non-secured unit at that time. Documentation indicated Resident #31</p> | | <p>least 90% of C.N.A. assignment sheets will be monitored for accuracy by the D.O.N. or designee regarding elopement risk and transfer orders beginning 7/11/11. III. <u>Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as follows</u> A. The facility policies and procedures for elopement risk and the fall program have been reviewed and no changes were found to be required. B. The nurses will be re-instructed regarding elopement risks and fall prevention at the scheduled staff meeting on 7/22/11. The relevant portion of the staff meeting will be videotaped to ensure 100% participation by licensed staff. Facility policies and procedures for elopement risk and the fall program will be reviewed annually as a part of environmental safety inservices. IV. <u>Corrective Actions will be monitored to Ensure Compliance by:</u> A. Regarding the elopement risk assessment in above I-A, the weekly review will continue for the next 6 months and review by the IDT will continue at each scheduled bi-monthly Risk Management meeting for the next six months. Assessment reviews will be gathered, reviewed, and taken to Risk Management meetings by the day shift supervisor. B. Regarding the chart audit in II-A, the day supervisor will conduct an audit of</p> | | |

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/24/2011 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>gradually improved and the resident on 8/24/10 at wheeled herself out of a door from the unit and went 200 yards from the building. According to documentation, a visitor saw the resident and reported to staff. The staff assisted the resident back into the building. The investigation documented the resident was last seen at 11:25 a.m. on 8/24/10 at the nursing station area and at 11:30 a.m. a visitor from construction reported the resident outside. Preventative measures taken indicated the interdisciplinary team made decision to return resident to secured area due to safety concern.</p> <p>Interview of the Director of Nursing on 6/22/11 at 4 p.m. indicated the resident was transferred to the secured unit the day of the elopement. The Director of Nursing indicated the resident has declined again and currently resided on the non-secured unit after October of 2010. The Director indicated the resident currently was unable to propel self in wheelchair.</p> <p>Nursing care plan at time of elopement on 8/24/10 addressed the problem of "High risk for falls: Knowledge deficit of safety awareness related to impaired cognition secondary to Alzheimer's Disease" dated 4/1/08 and revised 7/13/10. The approaches included but were not limited to approach dated 7/3/10 of keep</p> | | <p>20% of charts on each unit one time a week to ensure completion of elopement risk assessments. Audit results will be reviewed at Quarterly Quality Assurance meetings through the end of the year. C. Regarding II-B The D.O.N. (or designee in her absence) will audit 90% of C.N.A. assignment sheets daily for 1 month beginning 7/11/11; then monitor 90% of C.N.A assignment sheets three times/week for 2 months. Audit results will be taken to Quarterly Quality Assurance meetings through the end of the year. NOTE: The "2nd C.N.A" cited in Unusual Occurrence report of 10/08/11 was investigated and subsequently lost her certification. After this incident and extensive in-servicing, the following measures had been implemented and continue: Monitoring of C.N.A. assignment sheets for accuracy; retraining of C.N.A.'s on accessing care plans on the electronic medical record; following each care plan meeting C.N.A.s are required to sign off that they have knowledge of any added interventions.</p> | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | <input checked="" type="checkbox"/> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | | <input checked="" type="checkbox"/> (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | <input checked="" type="checkbox"/> (X3) DATE SURVEY COMPLETED 06/24/2011 | |
|--|---|--|---|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>[Resident #31] in view or in recliner in room with call light (or wheelchair).</p> <p>1b. Review of the clinical record of Resident #31 on 6/22/11 at 4:45 p.m. the following was noted:</p> <p>Review of nursing progress notes dated 9/25/10 at 7:11 p.m. indicated "Very restless prior and during supper. Trying to stand up on foot pedals of wheelchair and trying to push down on table, tipping wheelchair..."</p> <p>Nursing progress notes dated 9/26/10 at 6:53 p.m. were noted of "Trying to get out of chair before and during supper, each time stopped and redirected by staff..."</p> <p>Nursing progress notes dated 9/30/10 at 5 p.m. indicated "[Resident #31] had quiet morning only occ [occasionally] calling out. After breakfast transferred to recliner. At 1040 [Resident #31] started occ [occasionally] calling out. Several staff members went in talk [sic] with [Resident #31]. At 1105 about 5-10 min [minutes] after last time checked heard pressure alarm sounding. Staff immediately went to room. [Resident #31] was lying on floor on left side next to recliner. [Resident #31] had slide [sic] off foot of recliner. Noted 3 cm x 2 cm raised bump on left side of head. No other injuries</p> | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/24/2011 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>noted. Ice applied to head...Brought out nurse station. Neuro checks initiated. All have been WNL [within normal limits]."</p> <p>Nursing progress notes dated 10/3/10 at 10:04 a.m. indicated the resident was alert to person only and required total care with activities of daily living.</p> <p>Nursing progress notes dated 10/5/10 at 2:11 p.m. indicated the resident was trying to get out of chair, and that the resident thought she had the ability to get up by herself. Documentation indicated staff provided one on one during time the resident was attempting to get up.</p> <p>Nursing progress note dated 10/8/10 at 9:02 a.m. was noted of "At 0720 a.m. CNA called nurse into shower room. [Resident #31] was lying on floor next to wall in front of shower chair. Left arm was behind her back. [Resident #31] unable to move, painful, hanging limp by her side. Mid upper left arm raised knot. No injuries noted anywhere else. Denied hitting head..."</p> <p>Review of Unusual Occurrence report dated 10/8/10 on 6/21/11 at 4 p.m. indicated " Resident [#31] was assisted to shower room by 2 CNAs and a third CNA was finishing dressing a second resident. One of [Resident #31's] CNAs left to</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/24/2011 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>continue work; then second CNA left to retrieve a supply. [Resident #31] was talking to the third CNA when she suddenly slid from shower chair with upper body against wall. Shower chair was stable. This CNA [third CNA] was approximately 3 feet away, but assisting another [resident]. Type of Injury: fx [fractured] L [left] humerus...Investigation outcome: Safety can be improved by CNAs being in attendance constantly when residents are in shower room. Even though a CNA was present , she couldn't observe this resident closely enough to prevent a fall...Summary of Investigation: [second CNA] was in error by leaving [Resident #31] (dependent) s [without] direct supervision...."</p> <p>Minimum Data Set (MDS) assessment dated 10/4/10 identified the resident with cognitive impairment and total dependence for bathing.</p> <p>The resident's current plan of care dated 4/1/08 revised 10/9/10 and 3/28/11 addressed the problem of Self-care deficit: Inability to independently perform Activities of daily living related to age-related weakness (92 years old), progressive Alzheimer's Disease. The approaches included but was not limited to assistance with personal hygiene i.e. hair care, oral hygiene, washing face and</p> | | | | |

| | | | | | |
|--|---|--|--|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X(2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X(3) DATE SURVEY COMPLETED 06/24/2011 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F0371 SS=E | <p>hands.</p> <p>Interview of the Director of Nursing on 6/21/11 at 4 p.m. indicated Resident #31 should not have been left directly unattended in shower room on 10/8/10.</p> <p>3.1-45(a)(2)</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to maintain food temperatures and/ or sanitize a thermometer, during checking food temperatures for 34 of 55 residents who resided on East/West units and received meals from 1 of 2 facility kitchen steam tables.</p> <p>Findings include:</p> <p>On 6/20/11 at 7:55 a.m., cook #2 was serving food from a steam table for residents that resided on the East and West units. With the Dietician present, cook #2, checked the steam table temperatures. Sausage pattiesfor regular diets were measured at 120 degrees</p> | F0371 | <p>F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY I. <u>Corrective Action Taken Related to this Finding A.</u> On 2/23/11 The dietary policy titled "Food Temperatures" was revised to include: The steam table will not be turned off at any time during meal service. B. An all dietary staff in-service will be conducted on 7/13/11 to review thermometer sanitation and the above policy revision. II. <u>Measures and Systemic Changes put into Place to Assure Deficit Practices do not Recur are as Follows</u> A. Unannounced spot checks to the kitchen during meal preparation and serving time will be conducted weekly to ensure proper sanitation and appropriate steam table settings. After three</p> | 07/15/2011 | |

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/24/2011 |
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>Fahrenheit. The steam table was observed to be off. Cook #2 was observed to test sausage temperatures and then without sanitizing the thermometer, to test the temperature of the scrambled eggs.</p> <p>During interview of Cook #2 on 6/20/11 at 8 a.m., the Cook indicated she had turned the steam table off, but was unable to identify why.</p> <p>During interview of the Dietician on 6/24/11 at 3:45 p.m., the Dietician indicated dietary staff had been inserviced to sanitize the thermometer between checking food temperatures. The Dietician indicated the food during service should be maintain at 135 degrees Fahrenheit.</p> <p>During review of the facility policy with a subject title of "Food Temperatures", received on 6/24/11 at 3:15 p.m. from the Dietician, documentation indicated the following, but not limited to, "Food temperatures must meet the standards by the Food Code regulations. If the food temperatures do not meed the standard prior to service, the food will be reheated to the correct temperature before service.</p> <p>3.1-21(i)(3)</p> | | <p>months the audits will be conducted every other week through the end of the year.</p> <p><u>III. Corrective Actions will be Monitored to Ensure Compliance by:</u> A. Weekly spot check audits will be reported at each bi-weekly risk management meeting for the next three months. Audits will be reviewed at the Quarterly Compliance Meetings through the end of the year.</p> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2011

FORM APPROVED

OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/24/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN47876 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | | | |