STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING 00 / B. WING	03/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE SACRED HEART HOME	515 N MAIN ST AVILLA, IN 46710

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00194189. Complaint IN00194189 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: February 26, 29, and March 1, 2, 3, 4, and 7, 2016 Facility number: 000404 Provider number: 155512 AIM number: 100290810 Census bed type: SNF: 15 SNF/NF: 93 Residential: 20 Total: 128 Census payor type: Medicare: 10 Medicaid: 71 Other: 27 Total: 108 These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1.	F 0000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Presence Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance. As we are requesting a paper compliance audit	

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

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

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	QR completed on March 9, 2016 by 17934.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.			

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NAME OF PROVIDER OR SUPPLIER PRESENCE SACRED HEART HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710	

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	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview, and record review, the facility failed to ensure the physician was notified in a timely manner of a significant weight loss for 1 of 1 residents reviewed for weight loss (Resident #111). Finding include: Review of the clinical record for Resident #111 on 03/02/2016 at 9:57:17 A.M. indicated the following, diagnosis included, but were not limited to, dementia and depression. The Census Weights for this resident included: 145 pounds (lbs) on 02/04/2016. 01/04/2016: 150 lbs (which is 5 lbs. less than on the first date or a 3.4% loss) 11/05/2015: 158 lbs (which is 13 lbs. less than on the first date or a 9.0% loss) The Departmental Notes of the Registered Dietician (RD) for Resident #111, dated 2/16/16 at 12:22 P.M., indicated, the resident's current weight was 144.8 pounds (lbs) which was a 12.9 lb weight loss and 8.2% loss over 90 days which was a significant weight loss	F 0157	The Residents Weights policy has been reviewed by the Quality Team. Education will be provided to nursing staff on the current policy. CNA worksheets have been developed to reflect the policy to ensure weights are done timely and physician notification is performed per policy requirements. All residents with significant weight changes have the potential to be affected. Nursing staff will receive in-service training on the policies for notification of change in condition and resident weights. The team leader will audit 100% of weights for 1 month & report findings to QA; Team leader to audit a 10% random sample weekly for 1 month and report findings to QA; Then team leader to audit 10% random sample monthly for 10 months reporting findings monthly and there after to assure weights are completed as required and significant changes have been reported. Team leader responsible for completion and registered dietician to monitor, calculate and assess weights. Team collaboration for physician notification. DON to monitor for 12 months QA to monitor monthly for 12 months	03/31/2016

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	over 90 days. The RD recommended an increase in the resident's mighty shakes of 120 milliliters from 2 times a day to 3 times a day to provide an extra 600 calories and 18 grams of protein daily. The February and March 2016 Medication Administration Record indicated the resident consumed 100 % of the mighty shakes. The Departmental Note for Nursing, dated 2/16/16 at 1:34 P.M., indicated Resident #111's physician was notified of the RD's recommendation and increased the mighty shake from 2 times a day to 3 times a day. On 03/02/2016 at 1:54:16 P.M., interview with LPN #5 indicated the resident use to ambulate constantly and other interventions were tried, including offering food and fluids and redirection and nothing worked. On 03/04/2016 at 2:26:46 P.M., interview with LPN #5 indicated the resident was experiencing mania when the weight loss occurred. LPN #5 indicated the resident at that time "just kept moving around wandering" and did not sleep for days or nights and Depakote (a mood stabilizer) was started."			

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	On 03/07/2016 8:19:04 AM the resident was observed to drink 100% of the mighty shake LPN #5 had provided. Interview with LPN #5 on 3/7/16 at 8:30 A.M., indicated nursing staff obtained the resident's weights and gives the weights to the RD. LPN #5 also indicated the RD received the consumption records of the meals and the mighty shakes for Resident #111. LPN #5 also indicated the resident had been in a manic phase and LPN #5 was working with the Psychiatric Physician's group to get the resident's medications adjusted and the "focus was on the "mania" the resident was experiencing at that time. Interview with the RD on 3/7/16 at 9:15 A.M., indicated the nursing staff obtained the resident's weights and the RD then entered the weights into electronic charting and it calculated the resident's weight to see if there was significant weight loss. The RD also indicated she had just spoken with LPN #5 on 3/7/16 at 9:00 A.M. and LPN #5 had indicated the resident was manic at the time of significant weight loss and the facility was working with the Physiatrist physician to get Resident #111's psychiatric medications adjusted. The RD also indicated when the RD had recommendations, the RD was to notify			

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	the nurse and then the nurse was to notify the physician of the recommendations. The current policy for Physician Notification, dated 5/5/10 and received from the Director of Nursing Service (DNS) on 3/7/16 at 9:45 A.M., indicated "It is the policy of this ministry to notify the resident's personal physician in the event there is a change in the condition of the resident." "...2. Conditions in which the physician must be immediately notified include: ...A significant change in the resident's physical...status" "A need for a significant alteration in treatment." 3.1-5(a)(3) .			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.			

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	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to initiate a care plan for 1 of 3 residents (Resident #112) reviewed for urinary incontinence. Findings include: On 3/3/16, at 10:00 A.M., record review for Resident #112 indicated admission to the facility on 10/21/15. Review of the admission Minimum Data Set (MDS resident assessment) on 10/27/15, indicated the resident was continent of urine on admission. On the 90 day MDS, completed on 1/19/16, Resident #112 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding).	F 0279	Resident #112 was assessed for urinary incontinence, bladder diary initiated, plan of care updated. All residents with urinary incontinence have the potential to be affected. Staff will be educated on the revised care plan nursing policy. The care plan will be initiated upon admission. A care plan will be scheduled within 7 days of admission. Within 14 days of admission the minimal data set will be completed by the interdisciplinary team. Within 21 days of admission the interdisciplinary team will meet and complete a comprehensive care plan. Both short and long term goals will be established. The care plan will be reviewed quarterly and with annual reviews. An audit of 10% of resident care plans will be conducted by the DON or designee weekly for 6 months to	03/31/2016

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	Review of Resident #112's care plans did not indicate a care plan for urinary incontinence was started after frequent urinary incontinence was identified on the MDS of 1/19/16. An interview with RN #2 on 3/3/16, at 10:53 A.M. indicated on the MDS of 1/19/16, when Resident #112 was identified as frequently incontinent of urine, a care plan should have been started. An interview with the Director of Nursing Services (DNS) on 3/7/16 at 10:05 A.M. indicated a care plan should have been started when Resident #112 became incontinent of urine. Review of a current policy provided by the DNS on 3/7/16 at 12:55 P.M., titled: Section: Resident Assessment, Subject: Resident Assessment Instrument, revised 8/13/13. On page 4: section O, an interim care plan is to be initiated upon admission; section P, the care plan will be reviewed/updated after the completion of each MDS. The problem areas are updated by each discipline as needed. 3.1-35(a)		insure a care plans in place and or updated to reflect care planning for incontinence. Results for the audits will be reported to the facility QA committee for review monthly for 6 months MDS nurses responsible. DON tomonitor. QA tomonitor monthly.	

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F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on observation, record review, and interview, the facility failed to update a care plan for 1 of 2 residents reviewed for pressure ulcers (Resident #70). Findings include: The record for Resident #70 was reviewed on 2/29/2016 at 1:40 P.M. Diagnoses included, but were not limited to, kyphosis (excessive curvature of the spine).	F 0280	Resident #70's care plan has been updated per individual's personal plan of care to includeintervention of 'U' shaped pillow. All residents have the potential to beaffected. Current nursing care plans will be reviewed by the interdisciplinaryteam to insure care plan addresses current interventions. The DON or designee will conduct an audit of 10% of nursing care plans weekly for 6 months to insure care plans reflect current interventions. Results of the audits will be	03/31/2016

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	A nursing note, dated 2/29/2016 at 9:47 A.M. indicated Resident #70 had a stage 3 pressure ulcer (full thickness tissue loss and subcutaneous fat may be visible, but bone, tendon or muscle is not exposed) on her mid back area. LPN #3 was interviewed on 2/29/2016 at 10:30 A.M. During the interview, LPN #3 indicated Resident #70 had a stage 3 pressure ulcer on her mid back area. LPN #3 indicated Resident #70 was to use a "U" shaped pillow on behind her back when up in her wheel chair and also when resting in her recliner to minimize pressure over her spine. During an observation of a dressing change on 3/3/2016 at 1:00 P.M., Resident #70 was noted to have a healing stage 3 pressure ulcer on her mid back area over her spine. Her back was also noted to be abnormally curved secondary to her kyphosis. A care plan, with a date of 3/19/2015, indicated Resident #70 had impaired skin integrity at the mid back. A review of the interventions on the care plan did not indicate staff were to place a "U" shaped pillow behind her when she was up in her wheel chair or in her recliner. The facility DNS (Director of Nursing		reviewed with the facility QA committee monthly for 6 months. MDS nurses responsible. DON to monitor. QA to monitor monthly for 6 months	

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	Services) and LPN #3 were both interviewed on 3/7/2016 at 9:55 A.M. During the interview, LPN #3 reviewed Resident #70's care plan for impaired skin integrity and indicated the intervention for placing a pillow behind the resident's back was not listed as an intervention on the care plan. The DNS indicated the intervention of placing a pillow behind the resident should have been included on the care plan. 3.1-35(d)(2)(B)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified			

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	persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician for 1 of 1 residents reviewed for dialysis (Resident #180). Findings include: Review of the clinical record for Resident #180 on 3/4/16 at 11:30 A.M. indicated diagnoses included, but were not limited to, end stage renal disease and delirium secondary to general medical condition. The resident was receiving dialysis. The hospital discharge orders dated 2/23/16 for Resident #180 indicated an order for the medication Seroquel (treats delirium) 50 milligrams (mg) by mouth once a day. The facility Physician's Order dated 2/23/16 indicated Resident #180 was receiving the medication Seroquel 25 mg once a day instead of Seroquel 50 mg once a day. The February 2016 Medication Administration Record indicated the medication Seroquel 25 mg for Resident #180 was signed by the nurses as given	F 0282	Resident #180 has been discharged from facility with no harm. Facility will review and update admissions procedure policy. Staff will be educated on policy updates. All residents upon admission the admitting nurse will review the discharge orders. The Nurse will compare the medication information and clarify any discrepancies. The Nurse team leader will monitor for completion, DON will review for changes. Nurse teamleader responsible. DON or designee will conduct an audit for new admissions of 50% for 6 months, 25% for the following 6 months and 25% on-going. DON will report findings at monthly QA meetings monthly for 12 months	03/31/2016

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	from 2/23/16 through 2/29/16. An interview on 3/4/16 at 3:00 P.M. with the Director Nursing Service (DNS) indicated the medication Seroquel 25 mg was transcribed incorrectly for the resident and the dosage should have been Seroquel 50 mg. The DNS also indicated the admission nurse had transcribed the order for Seroquel 25 mg incorrectly. The DNS indicated a second Nurse checked the first nurse's work and did not find the error after the the first nurse transcribed the orders incorrectly. The current policy "Medication Reconciliation" dated 3/31/15 received from the DNS on 3/7/16 at 9:45 A.M. indicated: "A. Upon admission to the facility, the admitting nurse will review the discharge orders including the medications from the sending Hospital...". "D. The Nurse will compare the medication information the Hospital...provides with the medication order to identify and resolve discrepancies". 3.1-35(g)(2)			

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F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview the facility failed to ensure 2 of 3 residents (#112 and #17) reviewed for urinary incontinence had individualized toileting programs.	F 0315	Resident #17 and #112 were assessed for urinary incontinence, based upon assessment findings care plans were updated to add resident individualized interventions to address urinary incontinence. All residents with urinary	03/31/2016

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NAME OF PROVIDER OR SUPPLIER PRESENCE SACRED HEART HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710	

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	Findings include: 1. On 3/3/16, at 10:00 A.M., record review for Resident #112 indicated admission to the facility on 10/21/15. Review of the admission Minimum Data Set (MDS) on 10/27/15, indicated the resident was continent of urine on admission. On the 90 day MDS, completed on 1/19/16, Resident #112 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding in the 7 day review period). An interview with LPN #5, on 3/7/16, at 9:45 A.M., indicated she could not locate a 3 day voiding diary for Resident #112. LPN #5 indicated after a urinary continence decline is identified, a 3 day voiding diary should be completed, and a care plan started based on the patterns from the diary. 2. Resident # 17's record was reviewed on 3/3/16 at 9:15 A.M.. The admission MDS of 11/20/15 indicated Resident #17 was occasionally incontinent of urine(less that 7 episodes of urinary incontinence in the 7 day review period) upon admission. The 90 day MDS of 2/9/16 indicated Resident #17 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of		incontinence have the potential to be affected. Facility will review bladder retraining program and update current policy. Residents will be assessed upon admission for urinary incontinence. Residents will be reassessed quarterly and with change of condition to ensure individual toileting goals are in place. The DON or designee will review a 10% sample of resident incontinence assessments for 6 months . DON or designee to report findings to QA team monthly for 6 months. Restorative nurse responsible. DON tomonitor. QA tomonitor monthly for 6 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155512	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/07/2016
NAME OF PROVIDER OR SUPPLIER PRESENCE SACRED HEART HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710	

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	continent voiding in the 7 day review period). An interview on 3/7/16 at 1:27 P.M. with LPN #5 indicated she could not locate any 3 day voiding diaries for Resident #17. LPN #5 indicated a 3 day voiding diary should have been completed after the admission MDS indicated the resident was occasionally incontinent of urine to identify patterning to base a care plan on. LPN #5 indicated after Resident #17 was identified as being frequently incontinent after the 90 day MDS on 2/9/16, a 3 day voiding diary should have been completed to identify patterning to update the care plan for urinary incontinence. 3.1-41(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155512		03/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE SACRED HEART HOME	515 N MAIN ST AVILLA, IN 46710

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential census: 20 Sample: 5 Presence Sacred Heart Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Presence Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance. As we are requesting a paper compliance audit	