

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 02/12/2015
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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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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 5, 6, 9, 10, 11, and 12, 2015.</p> <p>Facility number: 000404 Provider number: 155512 AIM number: 100290810</p> <p>Survey team: Diane Nilson, RN, TC Carol Miller, RN Rick Blain, RN Tim Long, RN</p> <p>Census bed type: SNF: 16 SNF/NF: 99 Residential: 16 Total: 131</p> <p>Census payor type: Medicare: 13 Medicaid: 70 Other: 32 Total: 115</p> <p>Residential sample: 7</p>	F000000	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 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.

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F000176 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 13, 2015 by Randy Fry RN.</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, record review, and interviews, the facility failed to ensure a resident was assessed prior to self administration of her own medications that were kept in the resident's room. This deficiency affected 1 of 6 residents observed during medication administration (Resident #136).</p> <p>Findings include:</p> <p>On 2/10/15 at 8:45 A.M. RN #1 was observed in Resident #136's room and removed a bottle of Probiotic and supplements from the resident's bedside drawer. RN #1 then poured and administered the medications to Resident #136.</p>	F000176	Residents will be assessed upon admission to determine safety and desire for self administration of medications. Residents will be reassessed quarterly, and with change of condition to ensure safety measurements are met. Current residents will be assessed for self administration of medications per policy requirements and assessments will be completed by 2/20/2015. Nurse will ask resident on a daily basis if meds were self administered during routine med pass and document accordingly to ensure documentation is in the residents clinical record. Assessments will be located on each residents chart. Team leaders responsible, MDS to monitor quarterly assessments	02/28/2015

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	<p>Resident #136's chart was reviewed on 2/10/15 at 11:00 A.M. and indicated a Physician's Order dated 12/19/13 "...May take vitamins and keep at bedside...."</p> <p>On 2/10/15 at 2:30 P.M. RN #1 was observed to review Resident #136's chart for assessments and was unable to find a Self Administration of Medications Assessment form for the resident.</p> <p>On 2/10/15 at 2:30 P.M. an interview with RN #1 indicated a Self Administration of Medications Assessment Form for Resident #136 should have been done prior to allowing the resident to keep the medications in the residents room.</p> <p>The policy for Self Administration of Medications by Residents dated 2/12/02 received from RN #1 on 2/10/15 at 2:45 P.M., indicated "Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility."</p> <p>On 2/11/15 at 8:31 A.M. an interview with the Director of Nursing Service (DNS) indicated the nurses were</p>		and report to QA monthly for 12 months and on-going. Staff will be educated on Self Administration Assessment and Care Planning. DON responsible QA to monitor monthly for 12 months.				

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F000282 SS=D	<p>responsible for assessing the resident prior to self administration of medications and keeping the medications in the resident's room. The DNS indicated after the initial assessment for self administration of medication, the resident was then reviewed every time the Minimum Data Set assessment was done at least every 3 months and if there was a significant change in the residents condition.</p> <p>3.1-11(a)</p> <p>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 persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders for one of three residents (#40) reviewed for weight loss.</p> <p>Findings include:</p> <p>Resident #40's clinical record was reviewed on 2/10/15 at 9:30 A.M. and indicated the resident was admitted to the facility on 11/20/14. On admission</p>	F000282	Physician orders will be processed and cosigned by 2nd nurse. Facility will initiate new weight policy which includes: Weights taken upon admission, at 72 hours and weekly for 4 weeks. Nurse team leaders will monitor weights for completion, RD will review for changes. RD will report on weights during monthly QA meetings. Nurse team leader responsible RD to monitor weekly and report to QA monthly, QA to monitor for 12 months.	02/28/2015

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F000323 SS=D	<p>Resident #40 had a gastrostomy tube through which she received all nutrition.</p> <p>Review of physician's orders of 11/20/14 indicated to obtain weekly weights and may discontinue if stable after 4 weeks.</p> <p>On 11/20/14, Resident #40's weight was 136#. The next recorded weight was on 12/7/14 and was 131#.</p> <p>An interview with the Registered Dietician (RD) on 2/11/15 at 11:01 A.M. indicated Resident #40 should have had weekly weights on 11/27/14 and 12/4/14.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident</p>				

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	<p>receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record reviews, and interviews, the facility failed to ensure a resident's side rail attached to the bed was secure.</p> <p>This deficiency affected 1 of 1 resident whose side rails were checked in a sample of 19 (Resident #87).</p> <p>Findings include:</p> <p>On 02/06/15 at 2:32 P.M. Resident #87's left side rail on the bed was observed to be loose and wobbly.</p> <p>On 2/6/15 at 2:35 P.M. Resident #87 was interviewed and indicated the side rail on the left side of the bed was loose and she was concerned the side rail would not hold her when she transferred herself to bed. The resident indicated she had noticed this yesterday morning and had not told anyone of the staff the side rail was loose.</p> <p>On 2/6/15 at 2:41 P.M. maintenance man #2 was interviewed and indicated there was no way to tighten the side rail because the side rail was held in place by a pin. The maintenance man #2 further indicated he would replace the bed due to</p>	F000323	<p>The Maintenance policy was reviewed and updated. Bed was replaced by maintenance department on day it was reported. Environmental checks will be completed bi-weekly instead of monthly. A member of maintenance and a member of the QA team will complete these environmental checklist. All side rails were checked on 2/19/2015 to ensure side rails attached to the beds are secure. Each month during Resident Council residents will be asked if they are having any problems with their bed side rails and this will be documented in the Resident Council Meeting Minutes and communicated to maintenance as needed. Maintenance responsible QA to monitor monthly for 12 months.</p>	02/28/2015			

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	<p>not being able to adjust the side rail on the bed the resident was currently using at this time.</p> <p>The quarterly Minimum Data Set assessment dated 11/24/14 indicated Resident #87 was not cognitively impaired and was interviewable.</p> <p>The Side Rail Evaluation Tool dated 11/24/14 indicated Resident #87 used side rails while in bed and was independent in transfers.</p> <p>On 2/10/15 at 2:51 P.M. RN #1 indicated if side rails were observed to be loose she would notify maintenance of the loose side rail. RN #1 indicated she was unsure why Resident #87 did not notify staff that the side rail was loose.</p> <p>On 2/11/15 at 9:00 A.M. the Director Nursing Service was interviewed and indicated the Maintenance Director stated the side rails were checked every month with the environmental inspection.</p> <p>The policy titled "Maintenance" last reviewed on 10/2013 was received from the Administrator on 2/11/15 at 9:15 P.M. and indicated all of the side rails were checked once a month</p> <p>On 2/11/15 at 9:15 A.M. interview with the Administrator indicated all the side</p>						

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F000325 SS=D	<p>rails on all the beds were checked every month by maintenance and the last inspection was 1/22/15.</p> <p>3.1-45(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview the facility failed to ensure the facility followed physician orders for obtaining weekly weights, failed to ensure a significant weight loss was addressed and reported to the physician, and failed to ensure the care plan was updated to address the weight loss. This affected 1 of 3 residents reviewed for weight loss,</p>	F000325	Facility will initiate new weight policy. Weights will be upon admission, at 72 hours and weekly for 4 weeks. Staff will be educated on new weight policy. Nurse team leaders will monitor for weight completion and RD will review for changes. RD reviewed weights on all current residents to ensure no other resident was negatively impacted by the	02/28/2015

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	<p>Resident #40.</p> <p>Findings include:</p> <p>Resident #40's clinical record was reviewed on 2/10/15 at 9:30 A.M. and indicated the resident was admitted to the facility on 11/20/14. On admission Resident #40 had a gastrostomy tube through which she received all nutrition.</p> <p>Review of physician's orders of 11/20/14 indicated to obtain weekly weights and may discontinue if stable after 4 weeks.</p> <p>On 11/20/14, Resident #40's weight was 136#. The next recorded weight was on 12/7/14 and was 131#. On 12/8/14, Resident #40's weight was 128#, a 5.8% weight loss since admission.</p> <p>Record review did not indicate the Physician was notified of a significant weight change and Resident #40's care plan was not updated to address a significant weight change.</p> <p>A policy was provided by the Director of Nursing on 2/11/15 at 3:00 P.M., with the subject of "Resident Weights", dated 2/1/08. The policy indicated all residents admitted to the facility were to have weights obtained, at minimum: "weekly for the first 4 weeks following admission</p>		<p>deficient practice. Team leaders to update physicians with weight loss/gains per RD. Interim care plans will be initiated within 24 hours and care plans will be reviewed quarterly and with change of conditions. Team leaders responsible. RD to monitor weights upon admission, at 72 hours and weekly weights for 4 weeks through completion. RD to report to QA monthly for 12 months.</p>				

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	<p>and significant weight change." The policy stated under XI: "Weight changes are calculated by the clinical dietary professional within 48 hours of obtaining body weights." The policy stated under XIII: "The clinical dietary professional assesses each resident with a significant weight change, makes appropriate recommendations to physicians and updates the resident's plan of care." The policy stated under XIV: "The resident physician is notified of any significant weight changes and dietary recommendations to address weight changes."</p> <p>An interview with the Registered Dietician (RD) on 2/11/15 at 11:01 A.M. indicated the resident's weight completed on 12/7/14 was a routine monthly weight which is done for all residents and was a 5# weight loss since admission. The RD indicated the weight on 12/8/14 was the first weekly weight done on Resident #40 and the weight of 128# was a 5.8% weight loss since admission 18 days previous. The RD indicated she did not recognize the 128# weight done on 12/8/14 as a significant change. The RD indicated the 5.8% weight loss was a significant change since admission and should have been addressed. The RD also indicated weekly weights should have been completed on 11/27/14 and 12/4/14</p>						

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R000000	<p>per physician's orders and the facility policy for resident's newly admitted to the facility.</p> <p>3.1-46(a)(1)</p> <p>Presence Sacred Heart Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p>	R000000	<p>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</p>	

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