STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00428135. This visit included a State Residential Licensure Survey. Complaint IN00428135 - No deficiencies related to the allegations are cited. Survey dates: March 11, 12, 13, 14, 15, and 18, 2024 Facility number: 003624 Provider number: 155802 AIM number: 200429840 Census Bed Type: SNF: 63 Residential: 34 Total: 97 Census Payor Type: Medicare: 13 Medicaid: 32 Other: 18 Total: 63 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 26, 2024.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to accurately assess and document impairments in skin for 1 of 1 residents reviewed for skin impairments (Resident 15). Finding includes: During an observation, on 3/12/24 at 10:21 a.m., Resident 15 was sitting in her wheelchair in her room. The resident indicated she had a sore area behind her right ear, and it had been there for a "long time." The resident indicated she thought it was caused by her glasses. A couple of scabbed areas were noted behind her right ear underneath where her glasses touched her skin. Excoriated skin tissue was noted as well. The resident also had a scabbed area on her cheek and nose and indicated she was told they were skin cancer spots. Resident 15's record was reviewed on 3/15/24 at 1:36 p.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), disorder of the skin and subcutaneous tissue (medical condition that occurs in the subcutaneous layer), and type II diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy). A quarterly Minimum Data Set (MDS)	F 0684	On 3/18/2024, the DON corrected the deficiency practice for resident 15 by conducting a head-to-toe assessment and updating the care plan to accurately reflect impairments on the resident's skin. The Medical Director also assessed the patient and referred them to a dermatologist on this date. Other residents with Potential to be Affected by this Finding will be Identified by: The Director of Quality and Wound Nurse reviewed the residents' charts to ensure no other resident's charts lacked documentation of skin impairments. The audit was completed on 3/22/2024. Care plans were updated as needed to accurately reflect skin conditions and intervention recommendations from the Wound NP and Medical Director. !--[endif]--="">Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: 1 On March 19th and 20th the Director of Nursing and the Staff Development Coordinator educated all nursing staff on the	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 2/14/24, indicated the resident was cognitively intact and had no open lesions or pressure ulcers. The record lacked a care plan regarding the skin alteration behind the resident's right ear. A weekly skin assessment note, dated 3/12/24, indicated Resident 15 had multiple cancer areas on her face but lacked documentation of the area behind her right ear. A skin sweep progress note, dated 3/7/24, lacked documentation of the resident's skin alteration behind her right ear. During an interview, on 3/15/24 at 1:54 p.m., Resident 15 was sitting up in her wheelchair outside of her room. The resident indicated the nursing staff had not looked at the area behind her ear and had not been treating it with anything. During an interview, on 3/15/24 at 1:56 p.m., Registered Nurse (RN) 8 indicated she was not aware of the area behind Resident 15's ear, but she was aware that she would pick at the sores on her face at times. During an interview on 3/15/24 at 1:57 p.m., Certified Nurse's Assistant (CNA) 20 indicated she was aware of the area on the back of Resident 15's ear and indicated it had been there for a long time. She indicated she had made a note of the area on the shower sheet dated 3/14/24 and it was reported to the nurse. The CNA indicated she thought the area had gotten bigger. During an interview, on 3/15/24 at 2:13 p.m., Director of Nursing (DON) indicated she was not aware of an area of the resident having a skin		requirements to complete accurate skin assessments. Education was also provided to CNAs regarding providing communication to nurses if a new area of concern is noted on a resident's skin. 2 Continual chart audits and care plan reviews will be conducted by the Wound Nurse and MDS Coordinator to ensure appropriate interventions are in place and accurate completion of skin assessments. 3 All residents will be seen by Wound NP on a quarterly basis. If indicated by the Wound NP assessment, a resident will be seen on weekly rounds with the Wound Nurse and Wound NP. !--[endif]--="">Corrective Actions will be Monitored to Ensure Compliance by: Chart audits will be conducted to ensure skin assessments are being completed accurately, and that care plans are updated accordingly. The DON, or her designee, will randomly audit five residents per week x 4 weeks, then three residents per week x 4 weeks, then two residents per week x 4 weeks, and then one resident per week x 4 weeks. The outcome of the audit tool will be reviewed at the Quality Assurance and Performance Improvement meetings to determine if any additional action is warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	issue behind her ear. During an interview, on 3/15/24 at 2:37 p.m., DON indicated the wound nurse had noted areas on the resident's face but not behind her ear on the skin assessments. The DON further indicated she had reviewed progress notes and was not able to find any notes regarding the area behind the resident's right ear. The DON assessed the area and noted the scabbing and a small open area behind the ear. A head to toe assessment should be completed by the wound nurse when conducting skin sweeps. On 3/15/24 at 2:32 p.m., the DON provided an undated document titled, "Skin Condition and Pressure Ulcer Assessment," and indicated it was the policy currently being used by the facility. The policy indicated, " ...2. Resident's identified by the Braden Scale as being at risk of a skin breakdown, will have a care plan customized and initiated to address the at risk individual's skin care needs. 3. All areas of each resident's skin shall be inspected by his or her nurse and documented at least every seven days ...9. The Director of Nursing will be notified of any new skin abnormality ...." 3.1-37		Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to address a significant weight discrepancy for 1 of 2 residents reviewed for nutrition (Resident 57). Finding includes: Resident 57s record was reviewed on 3/15/24 at 9:08 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified protein-calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food) and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). An admission Minimum Data Set assessment, dated 2/21/24, indicated the resident required supervision or touching assist with eating, and had no swallowing or nutrition disorders noted. The assessment lacked documentation of weight gain or loss. A physician's order, dated 2/14/24, indicated	F 0692	!--[endif]--="">Corrective Action Taken Related to this Finding: The Director of Quality corrected the deficiency practice for resident 57 by obtaining a reweight and reviewing this resident's chart for any other significant changes or discrepancies in charting on 3/18/2024. Other residents with Potential to be Affected by this Finding will be Identified by: As of 3/22/2024 the DON and Director of Quality ensured all physician's orders for weight monitoring were accurate and that no other record lacked documentation or indicated significant discrepancies in resident weights. Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: 1. DON and the Staff Development	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	weekly weights and to review weights and report significant changes to physician. A physician's order, dated 2/16/24, indicated the resident was to have a regular diet with mechanical soft texture (a modified diet with a texture soft for people with difficulty swallowing or chewing). Review of the resident's weights indicated he weighed 108.0 pounds (lbs) upon admission on 2/14/24. Subsequent weights included, but were not limited to the following: a. On 3/9/24 at 1:52 p.m., the resident had been weighed by Certified Nursing Aide (CNA) 18. His weight was measured at 104.8 pounds (lbs). b. On 3/9/24 at 2:54 p.m., the resident had been weighed by CNA 17. His weight was measured at 127.2 lbs. c. On 3/10/24 at 12:44 p.m., the resident had been weighed by CNA 17. His weight was measured at 127.5 lbs. d. On 3/11/24 at 5:59 p.m., the resident had been weighed by CNA 17. His weight was measured at 104.4 lbs. The record lacked documentation that the significant discrepancies in the resident's weights between 3/9/24 at 1:52 p.m., and 3/11/24 at 5:59 p.m., had been addressed by the facility. A nurse progress note, completed by Licensed Practical Nurse (LPN) 11, on 3/6/24 at 2:24 p.m., indicated the resident had been weighed on 3/5/24 at 5:56 p.m., sitting on the scale. His weight was measured at 104.2 lbs.		Coordinator conducted a review of PHC's weight monitoring policy and the importance of reporting significant changes in weight on March 19th and 20th. Nursing staff signed an acknowledgment of understanding of the policy. Nursing staff are made aware upon hire importance of call light etiquette. 2. Individual education provided to CNAs by the Director of Quality and Director of Human Resources on proper reporting of significant weight changes to nurses. Corrective Actions will be Monitored to Ensure Compliance by: Weight audits will be conducted to ensure weights are being obtained and documented in resident's charts in accordance with physician's orders and any significant weight changes will be reviewed during the Nutrition at Risk weekly meeting. The DON, or her designee, will randomly audit five residents per week x 4 weeks, then three residents per week x 4 weeks, then two residents per week x 4 weeks, and then one resident per week x 4 weeks. The outcome of the audit tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			than six months.	

A nutritional at risk (NAR) meeting note, dated 3/7/24, indicated the resident had lost 2 lbs. He was reported to eat 26-50% of his meals and had been provided a nutrient-rich caloric drink supplement with B-vitamins to help convert food to energy, two times daily.

A nurse progress note, completed by Registered Nurse (RN) 14, on 3/8/24 at 10:36 a.m., lacked documentation of the resident's weight.

A nurse progress note, completed by LPN 11, on 3/9/24 at 2:58 p.m., indicated the resident had been weighed on 3/9/24 at 2:54 p.m., sitting on the scale. His weight was measured at 127.2 lbs.

A nurse progress note, completed by LPN 15, on 3/10/24 at 11:40 p.m., lacked documentation of the resident's weight.

A nurse progress note, completed by RN 16, on 3/11/24 at 7:50 p.m., indicated the resident had been weighed on 3/11/24 at 5:59 p.m., sitting on the scale. His weight was measured at 104.4 lbs.

A NAR meeting note, dated 3/14/24, indicated the resident consumed about 50 % of his meals, was on a regular diet, and was being weighed daily. He continued on his drink supplement and his weights had remained stable since admission. The plan was to discontinue being followed by the NAR committee at that time. The note lacked documentation of the weight discrepancies from 3/9/24 at 1:52 p.m., through 3/11/24 at 5:59 p.m.

During an interview, on 3/15/24 at 9:51 a.m., the Director of Nursing (DON) indicated if a significant discrepancy of a resident's weight was discovered, the resident should be re-weighed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	confirm the accuracy of the measured weight. During an interview, on 3/15/24 at 10:49 a.m., CNA 19 indicated if there was a significant weight discrepancy she would re-weigh the resident to make sure the weight was accurate. She would then inform the nurse and double check for any significant changes with the resident's health that could be causing the weight change. On 3/15/24 at 10:42 a.m., the DON provided an undated document titled, "Certified Nursing Assistant (CNA) Rehab/LTC Orientation Checklist," and stated it was the orientation and annual competency checklist for the CNA's. The form lacked documentation of any competency measurement on weighing residents. On 3/15/24 at 10:42 a.m., the DON provided a document, dated 9/22/21, titled, "Weighing Residents," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...4. A licensed nurse evaluates weight changes to determine if there is a 5% or greater weight loss/gain in one month and notifies the physician of unanticipated or undesired weight loss/gain...Rationale/Amplification: ...A re-weigh should be taken with the licensed nurse present as soon as possible after an unanticipated weight reading is noted and prior to calling the physician...." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure a nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) mask was stored properly when not in use and an self administration assessment was completed for 1 of 2 residents reviewed for respiratory care (Resident 113), and failed to ensure oxygen orders were in place for 1 of 2 residents reviewed for respiratory care (Resident 39). Findings include: 1. During the initial pool observation, on 3/11/24 at 11:24 a.m., Resident 113's nebulizer mask was observed un-bagged and sitting on his bedside table. At the same time, the resident indicated he had used the nebulizer earlier that morning and that it should have been placed into a bag, but the nurse had not been in since he had used the nebulizer. During a random observation, on 3/14/24 at 10:09 a.m., the resident's nebulizer mask was observed un-bagged and sitting on his bedside table. During a random observation, on 3/14/24 at 1:42 p.m., the resident's nebulizer was sitting, un-bagged on his bedside table. At the same time, the resident indicated that he had just used it right after lunch. He doubted it would not be placed in	F 0695	!--[endif]--="">Corrective Action Taken Related to this Finding: The DON corrected the deficiency practice for resident 113 by completing a self-administration assessment and properly storing nebulizer equipment on 3/14/2024. The DON corrected the deficiency practice by obtaining a physician's order for the use of oxygen for resident 39 on 3/13/2024. Other residents with Potential to be Affected by this Finding will be Identified by: 1. The DON and Director of Quality ensured no residents' chart was lacking physician's orders for oxygen if indicated and ensured self-administration of nebulizer assessments were completed if indicated. This audit was completed on 3/25/2024. 2. Rounding was completed by DON and Administrator to ensure proper storage of all nebulizer equipment on 3/14/2024. !--[endif]--="">Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows:	03/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a bag by the nurse, until the next shift, if they put it in the bag at all. Resident 113's record was reviewed on 3/14/24 at 10:21 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems), unspecified respiratory failure (a condition in which the blood doesn't have enough oxygen or has too much carbon dioxide), and pleural plaque with presence of asbestos (areas of thickened tissue that form in the lining of the lungs caused by significant asbestos exposure). A baseline care plan, dated 3/11/24, indicated the resident had been admitted with a diagnosis of pneumonia (an infection of one or both of the lungs caused by bacteria, viruses, or fungi). A physician's order, dated 3/8/24, indicated albuterol sulfate inhalation solution (medicine that is used for the relief of bronchospasms [the tightening and swelling of the muscles around the airways]), 2.5 milligrams (mg)/3 milliliters (ml) 0.083%. Inhale 3 ml orally via nebulizer in the afternoon for COPD. A physician's order, dated 3/8/24, indicated ipratropium (used to prevent wheezing, shortness of breath, coughing, and chest tightness in people)-albuterol inhalation solution 0.5-2.5 (3) mg/3 ml. Inhale 3 ml orally via nebulizer every 6 hours as needed for COPD. The record lacked documentation of an assessment to determine the independent use of the nebulizer by the resident.		1 On March 19th and 20th Director of Nursing and Staff Development Coordinator reviewed with all nursing staff the Oxygen Therapy Policy and Nebulized Mist Inhalation Treatment policy. 2 Nursing staff also educated on the Self-Administration of Nebulizer treatments and ensuring that physician's orders and self-administration assessment is completed on a routine basis. u="">Corrective Actions will be Monitored to Ensure Compliance by: 1 The DON, or her designee, will randomly audit five residents per week x 4 weeks, then three residents per week x 4 weeks, then two residents per week x 4 weeks, and then one resident per week x 4 weeks for accuracy for oxygen orders as indicated and self-administration of nebulizer assessments as indicated. The outcome of the audit tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months. 2 Rounding audits will be conducted by the DON, or her designee, to ensure that nebulizers and oxygen equipment are being stored appropriately. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 3/14/24 at 1:57 p.m., Licensed Practical Nurse (LPN) 11 indicated she would set up the resident's nebulizer, but he used it himself. She was not aware of any assessment that had been completed to determine if the resident was able to use his nebulizer independently. During an interview, on 3/14/24 at 2:16 p.m., the Director of Nursing (DON) indicated the resident should have had an assessment to use the nebulizer independently. The nebulizer masks should be placed in plastic bags when not in use. On 3/14/24 at 2:25 p.m., the DON provided a document, dated 9/25/21, titled, "Licensed Nurse or Respiratory Therapist Procedure Nebulized Mist Inhalation Treatment," and indicated it was the procedural documentation on the proper use of nebulizer equipment for the facility. The document indicated, "...Procedure...Disassemble the nebulizer and place in plastic bag with nebulizer tubing...."2. During an interview, on 3/12/24 at 9:21 a.m., Resident 39 indicated he used oxygen therapy per nasal cannula (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) during the nighttime. During an observation, on 3/12/24 at 9:21 a.m., an oxygen concentrator was in Resident 39's room and had a nasal cannula attached to it. The resident was not using oxygen at the time of the observation. Resident 39's record was reviewed on 3/13/24 at 10:02 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a disease in which the immune system eats away at the protective covering of		DON, or her designee, will conduct rounding on all resident rooms three times per day x 4 weeks, then two times per day x 4 weeks, and then one time per day x 8 weeks. The outcome of the audit tool will be reviewed at the next four QAPI meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nerves resulting in nerve damage), dependence on supplemental oxygen (used to keep your organs or tissues healthy), and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). A quarterly Minimum Data Set (MDS) assessment, dated 2/20/24, indicated Resident 39 was cognitively intact and was not marked as using oxygen therapy. A care plan, dated 6/17/21, with a revised date of 11/28/23, indicated resident had oxygen therapy related to ineffective gas exchange and chronic respiratory failure (occurs when a person's blood has too much carbon dioxide and not enough oxygen) and dyspnea (shortness of breath). Interventions included but were not limited to, oxygen 2L(liters) per nasal cannula during the night. The record lacked documentation of a physician order for the oxygen therapy at night. Review of a hospice clarification fax sent to the facility, dated 3/13/24, indicated the hospice company had requested an order for Resident 39 to have Oxygen therapy 3L as needed. The order was dated 1/31/24 but was not implemented into the resident's electronic health record. The March Medication Administration Record (MAR) lacked documentation of oxygen being used at night or as needed. Review of vital signs note, dated 2/5/24 at 7:07 a.m., indicated Resident 39's oxygen saturation was 100% on oxygen via nasal cannula.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Review of vital signs note, dated 2/4/24 at 7:56 p.m., indicated Resident 39's oxygen saturation was 99% on oxygen via nasal cannula.

Review of vital signs note, dated 2/1/24 at 3:24 p.m., indicated Resident 39's oxygen saturation was 100% on oxygen via nasal cannula.

During an interview, on 3/13/24 at 11:35 a.m., Certified Nurse's Aide (CNA) 7 indicated Resident 39 used oxygen therapy at nighttime
.
During an interview, on 3/13/24 at 11:36 a.m., Registered Nurse (RN) 8 indicated she thought Resident 39 had an order for oxygen to be used as needed.

During an interview, on 3/13/24 at 1:18 p.m., Director of Nursing (DON) indicated Resident 39 should have an order in his chart for the oxygen use but he had been in and out of the hospital, so she wasn't sure if it was missed.

On 3/14/24 at 9:45 a.m., the Administrator provided an undated document, titled, "Oxygen Therapy," and indicated it was the policy currently being used by the facility. The policy indicated, " ...It is the policy of Providence Health Care to administer oxygen in accordance with physician's order and on emergency basis ...5. Initial and ongoing assessments will be documented in the nursing progress notes ...18. Record oxygen therapy on the treatment or special record and nursing notes if prn (as needed), Include type of catheter and liter flow ...."

3.1-47(a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review, observation, and interview, the facility failed to ensure physician orders were followed for 2 of 5 residents reviewed for unnecessary medication review (Residents 35 and 37). Findings include: 1. On 3/13/24 at 11:00 a.m., the medical record of Resident 35 was reviewed. Resident 35's diagnoses on the resident's profile included but were not limited to, type 2 Diabetes Mellitus (a disease that occurs when your blood glucose,	F 0757	!--[endif]-->Corrective Action Taken Related to this Finding: The DON corrected the deficiency practice for resident 35 on 3/13/2024 by adding monitoring of blood pressure to the MAR for each nurse to document prior to administering blood pressure medication based on physician-ordered parameters. The facility corrected the deficiency practice for resident 37 by obtaining A1C labs. Other residents with Potential to	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	also called blood sugar, is too high), Atherosclerosis (a thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery), Hyperlipidemia (high cholesterol) is an excess of lipids or fats in your blood), Atrial Fibrillation (Fibrillation an irregular heart rhythm (arrhythmia) that begins in the upper (atria) of your heart), Hypertension (HTN) (also known as high or raised blood pressure, is a condition in which the blood vessels have persistently raised pressure). Physician Orders include but are not limited to: Lisinopril Tablet 40 mg (milligrams) give 1 tablet by mouth one time a day for HTN hold for Systolic Blood Pressure (SBP) less (<) than 100, 11/30/22. (The systolic blood pressure is the maximum blood pressure during contraction of the ventricles of the heart). Review of the medication administration records from 1/1/24 to 3/13/24 indicated the resident received Lisinopril 40 milligram (mg) by mouth once daily. Record lacked documentation of monitoring of the blood pressure. The weights and vitals summary record documentation indicated, the blood pressure had been assessed and the reading was entered into the summary report 10 days in total from January to March 2024. The most recent quarterly Minimum Data Set (MDS) assessment indicated the resident had a diagnosis of hypertension and orthostatic hypotension (a drop in blood pressure that occurs when moving from a laying down [supine] position to a standing [upright] position). The MDS indicated the resident was cognitively intact.		be Affected by this Finding will be Identified by: As of 03/22/2024, all other residents' charts were checked by DON to ensure that no other record lacked documentation of monitoring of parameters for medication administration as indicated by physician's orders. Chart audits were completed to ensure that no other records lacked labs as indicated per the physician's orders. III Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: 1 On March 19th and 20th the Director of Nursing and the Staff Development Coordinator reviewed with nurses and QMA's the Physician's Order policy and completion of appropriate documentation per physician's order. 2 EMAR was updated to require documentation of blood pressure in relation to parameters of physician's orders. 3 Chart audits were conducted to ensure monitoring of vitals and labs are being completed in accordance with the physician's orders. Chart audits were completed on 03/22/2024. IV Corrective Actions will be Monitored to Ensure Compliance by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan, dated 2/19/21, indicated the resident had a diagnosis of hypertension. Intervention included but were not limited to, blood pressure readings as ordered/per protocol. Report significant abnormalities to medical doctor as needed. On, 3/15/24 at 9:03 a.m., the Director of Nursing (DON) provided an undated document, titled. "Physician's Orders," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Policy: Facility nursing personnel will ensure clear, accurate and complete physician's orders. Procedure: ...5 ...Ensure any follow through is completed ...." 2. Resident 37's record was reviewed on 3/13/24 at 10:13 a.m. The profile indicated the resident's diagnoses included, but were not limited to, diabetes type 2 with diabetic chronic kidney disease (diabetes [a disease that occurs when your blood glucose, also called blood sugar, is too high] that isn't well controlled can damage blood vessels in the kidneys that filter waste from the blood). A quarterly minimum data set assessment (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 11/23/23, indicated the resident had severe cognitive deficit and received hypoglycemic (medications that work by stimulating pancreatic insulin secretion, enhancing tissue sensitivity to insulin, or slowing the absorption of glucose in the intestines). A physician's order, dated 9/1/23, indicated glimepiride oral tablet (hypoglycemic medication) 1 milligram (mg). Give 0.5 tablet by mouth one time		1 Chart audits will be conducted to ensure medication parameters will be indicated on the MAR per the physician's order. The DON, or her designee, will randomly audit five residents per week x 4 weeks, then three residents per week x 4 weeks, then two residents per week x 4 weeks, and then one resident per week x 4 weeks. The outcome of the audit tool will be reviewed at the next four QAPI meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months. 2 Chart audits will be conducted to ensure labs are being completed in accordance with the physician's orders. The DON, or her designee, will randomly audit five residents per week x 4 weeks, then three residents per week x4 weeks, then two residents per week x 4 weeks, and then one resident per week x 4 weeks. The outcome of the audit tool will be reviewed at the next four QAPI meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a day for diabetes. A care plan, dated 9/5/23, indicated the resident had a diagnosis of diabetes and received diabetes medications. A care plan, dated 9/5/23, indicated the resident had a diagnosis of chronic kidney disease. Interventions included, but were not limited to, lab/diagnostic work as ordered. A pharmacy recommendation, dated 9/15/23, indicated since the resident received glimepiride, to consider checking the resident's A1C (a simple blood test that measures the average blood sugar levels over the past 3 months) every six months. The physician agreed and signed the recommendation on 9/20/23. A copy of a physician's order, dated 9/20/23, provided by the Director of Nursing (DON), on 3/14/24 at 8:30 a.m., indicated to check the resident's A1C every 6 months. The record lacked documentation of the resident's A1C lab every being completed as ordered. During an interview, on 3/13/24 at 3:11 p.m., the DON indicated she had put the order in on 9/20/23, but the lab had never been completed as ordered. On 3/14/24 at 8:30 a.m., the DON provided an undated document, titled, "Pharmacy Consultation," and indicated it was the policy currently being used by the facility. The policy indicated, "...Standards: ...5. Upon receipt of signed recommendations, orders are noted by the Director of Nursing or designee for implementation...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(a)(3)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure beard restraints were worn in the kitchen serving area (on the skilled unit) and in the main kitchen food prep area for 2 of 2 kitchen observations. Findings include: 1. During an observation in the kitchen serving area (located on the skilled unit), on 3/11/24 at 11:40 a.m., the Dietary Director was placing whip cream on top of the vanilla and chocolate shakes.	F 0812	!--[endif]-->Corrective Action Taken Related to this Finding: The Director of Food Services and Administrator corrected the deficiency practice by monitoring the use of hair and beard restraints in appropriate areas on 3/15/2024. Other residents with Potential to be Affected by this Finding will be Identified by:	03/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Dietary Director was not wearing a beard restraint and his facial hair was exposed. 2. During an observation in the kitchen serving area, on 3/11/24 at 11:43 a.m., the Dietary Director was placing cinnamon pita chips onto 16 dessert plates from a serving pan. The Dietary Director was not wearing a beard restraint and his facial hair was exposed. During an interview, on 3/11/24 at 11:50 a.m., Dietary Director indicated he should have worn a beard restraint while prepping food that was to be served to the residents. During an interview, on 3/11/24 at 11:54 a.m., Dietary aide 5 indicated when you have facial hair it was to be covered with a beard restraint while in the food prep area. 3. During an observation in the kitchen, on 3/14/24 at 10:21 a.m., Dietary aide 9 was in the food prep area and was transferring applesauce and olives into separate containers and placed them in the refrigerator. The dietary aide was also preparing desserts for the lunch time meal, he was not wearing a beard restraint and his facial hair was exposed. On 3/11/24 at 2:20 p.m., the Dietary Director provided a document, with a revised date of 1/24, titled, "Uniform Dress Code," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Associates working with food ...Restrain all facial hair with a beard net/restraint ...." 3.1-21(i)(3)		To ensure no other residents were affected, the Administrator and Director of Food Services observed the kitchen and dining areas and verified the use of proper hair restraints during food services on 3/15/2024. !--[endif]-->Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: 1 On March 19th the Director of Food Services provided reviewed the policy Uniform Dress Code with Food Service team members. Food Service team members signed an acknowledgment of understanding of policy. 2 Dress code and appearance education will be provided upon hire, annually, and as needed to coincide with storing, preparing, and distributing food in accordance with professional standards for food service safety. !--[endif]-->Corrective Actions will be Monitored to Ensure Compliance by: Observation of appropriate dress code audits will be conducted to ensure that the Food Service dress code is followed per policy. The Director of Food Services, or his designee, will monitor food services three times a day x 4 weeks, then two times a day x 4 weeks, then one time a day per week x 8 weeks. The outcome of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the audit tool will be reviewed at the next four monthly QAPI meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure a resident's call light was within reach for the resident to call for staff assistance when needed for 1 of 24 residents rooms observed for call light availability (Resident 34). Findings include: On 3/12/24 at 9:36 a.m., observed the resident lying in bed. The call light was hanging on the wall several feet from the resident. On 3/13/24 at 10:51 a.m., observed the resident sleeping in her bed. The call light was not within reach of the resident. The call light was clipped to the wall several feet from the resident.	F 0919	=" span="">Corrective Action Taken Related to this Finding: The CNA corrected the deficient practice for resident 34 by ensuring her call light was accessible to her at the bedside on 3/13/2024. Other residents with Potential to be Affected by this Finding will be Identified by: The DON and the Director of Quality completed rounding on each unit on 3/19/2024 to ensure that all call lights were within accessible reach of the residents. =" span="">Measures and Systematic Changes put into	03/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/13/24 at 10:58 a.m., during an interview with Certified Nurse Aide (CNA) 10, she indicated she did not know why the call light was not on the bed next to the resident. She acknowledged it should always be within reach for the resident to call for assistance. On 3/13/24 at 11:02 a.m., during an interview with Registered Nurse (RN) 8, she indicated the call light must be within reach. It was the last thing the staff check before they leave the resident's room. On 3/14/24 at 11:34 a.m., observed call light within reach and attached to the side of the bed. On 3/14/24 at 2:00 p.m., Resident 34's medical record was reviewed. Diagnoses on the resident's profile included, but were not limited to, chronic heart failure (CHF)(a condition that develops when your heart doesn't pump enough blood for your body's needs), chronic obstructive pulmonary disease (COPD)(a group of diseases that cause airflow blockage and breathing-related problems), Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), weakness, and age related physical disability. Physician orders included but were not limited to, observe for/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status every day and night shift for dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).		place to assure deficient practices do not recur are as follows: 1 DON and the Staff Development Coordinator conducted a review of PHC's Call Light policy and call light etiquette as it relates to each resident's individual needs with all nursing staff on March 19th and 20th. Nursing staff signed an acknowledgment of understanding of the policy. 2 Nursing staff are made aware upon hire importance of call light etiquette. Corrective Actions will be Monitored to Ensure Compliance by: Rounding audits will be conducted to ensure that all residents have their call light within reach. The DON, or her designee, will conduct rounding on all resident rooms three times per day x 4 weeks, then two times per day x 4 weeks, and then one time per day x 8 weeks. The outcome of the audit tool will be reviewed at the next four QAPI meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A care plan, dated 2/17/21, indicated the resident had an ADL Self Care Performance Deficit related to unsteady balance, incontinence, history of falls, cognitive deficits, pain, SOB, limited ROM, and multiple medication use. Interventions included but were not limited to, encourage her to use call light to call for assistance, and respond promptly.

A care plan, dated 2/25/21, indicated the resident exhibited impaired cognition and was severely impaired cognition and is severely impaired with decision making, intervention included but were not limited to, provide consistent care and routine.

A quarterly Minimum Data Set (MDS), a standardized assessment tool that measures health status in nursing home residents, dated 2/21/24, indicated the resident was not cognitively intact and she required assistance from the staff for all care.

Review of a Resident Council note, dated 2/1/24, indicated, "a resident had a concern that the aids weren't leaving their call light within reach before the staff leaves their room."

On 3/15/2024 at 9:03 p.m., the Director of Nursing (DON) provided an undated document, titled, "Call Light," and indicated it was the policy currently being used by the facility. The policy indicated, "...1. All residents shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside and in the resident's bathroom ...."

3.1-19(u)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00428135. This visit included a Recertification and State Licensure Survey. Complaint IN00428135 - No deficiencies related to the allegations are cited. Survey dates: March 11, 12, 13, 14, 15, and 18, 2024 Facility number: 003624 Residential Census: 34 Providence Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on March 26, 2024.	R 0000		