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	05/16/2025

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 a State Residential Licensure Survey. Survey dates: May 9, 12, 13, 14, 15, and 16, 2025 Facility number: 003624 Provider number: 155802 AIM number: 200429840 Census Bed Type: SNF/NF: 61 Residential: 34 Total: 95 Census Payor Type: Medicare: 11 Medicaid: 34 Other: 16 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 27, 2025.	F 0000	Providence Health Care is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. This Plan of Correction constitutes Providence Health Care's written credible allegation of compliance for the deficiencies noted to demonstrate our ongoing commitment to compliance with federal and state regulations.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care A. Based on interview and record review, the facility failed to prevent a delay in treatment after a fall with fracture for 1 of 3 residents reviewed for accidents (Resident 27). B. Based on record review and interview, the facility failed to ensure a treatment order was stopped or clarified after 60 days for 1 of 5	F 0684	It is the facility's policy to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including accurate assessment and	06/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandy Lynch	Administrator	06/11/2025

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	residents reviewed for unnecessary medications (Resident 30). Findings include: A. During an interview, on 5/12/25 at 9:40 a.m., Resident 27's Health Care Representative indicated the resident fell in December 2024 and fractured her hip. They thought the resident was not injured, so she was not sent to the hospital right away. The Health Care Representative indicated she normally placed the resident's walker next to her bed before she left in the evening, but the day the resident fell she had not ensured the walker was next to the resident's bed before she left. The Health Care Representative indicated since the resident's fall she always made sure the resident's walker was next to her bed before leaving for the evening. Resident 27's record was reviewed on 5/15/25 at 9:11 a.m. A significant change Minimum Data Set (MDS) Assessment, dated 3/14/25, indicated the resident had a severe cognitive impairment and had occasional urinary incontinence. Diagnoses on the resident's profile included, but were not limited to, unspecified fracture of the left femur (thigh bone). A Progress Note, dated 12/1/24 at 4:33 a.m., indicated the nurse was called to the resident's room after the resident was found on the floor on her back. The resident was alert with confusion and had not used her walker. The resident was assessed and had no open areas or bruising. As the staff moved her to bed, the resident indicated her hip and knee hurt. The resident's leg had no shortening, swelling, or disfigurement. The staff placed the resident in bed. The note indicated,		documentation. Corrective Action Taken Related to this Finding: A Resident 27 underwent evaluation by the interdisciplinary team, and all required medical care and services have been promptly initiated. B The deficiency related to Resident 30 was rectified immediately upon its discovery during the survey by the Director of Nursing. I Other residents with Potential to be Affected by this Finding will be Identified by: A comprehensive audit of all residents at risk for similar concerns was conducted by the nursing administration team on May 19, 2025. Residents with comparable conditions or needs were evaluated to ensure that appropriate care and services were being delivered as necessary. Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: On May 28, 2025, the Staff Development nurse conducted in services with all nursing staff including a policy review that emphasized documentation standards and the importance of early identification and physician notification regarding changes in residents' conditions. Additionally,	

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	"This nurse will pass on the info to [physician name] and the next shift." The record lacked documentation the physician was notified of the resident's fall or left hip pain on 12/1/24. An xray report indicated an xray of the resident's left femur and knee was completed on 12/1/24 at 6:09 p.m. The results indicated an acute fracture of the neck of the resident's left femur. The results were reported to the facility on 12/1/24 at 8:07 p.m. The report did not indicate how the results were communicated to the facility. A Progress Note, dated 12/2/24 at 8:09 a.m., indicated the resident complained of left leg pain during day shift on 12/1/24. The nurse assessed the resident and contacted the physician for an xray order. The xray was ordered, and results came back on night shift of 12/1/24. Upon the return of the day shift nurse, xray results were found, and the resident had a fractured left femur. The nurse contacted the physician, and the resident was sent to the emergency room (ER). Hospital Discharge Instructions, dated 12/6/24, indicated the resident was discharged back to the facility after an open reduction internal fixation (ORIF) (repair) of the left femur. A Progress Note, dated 12/6/24, indicated the resident returned to the facility. During an interview, on 5/15/24 at 10:42 a.m., the Assistant Director of Nursing (ADON) indicated the facility staff should have called the physician when the resident fell, and the conversation and physician's response should have been documented in the resident's medical record.		the staff reviewed the necessity of clarifying physician orders when appropriate and completion of pharmacy recommendation. The interdisciplinary team will review documentation of any reported change in condition. Corrective Actions will be Monitored to Ensure Compliance by: A The Director of Nursing (DON), or a designated representative, will conduct audits of five of residents with high-risk diagnoses or recurring incidents. This will take place weekly for four weeks, followed by biweekly audits for eight weeks, and subsequently monthly for three months. The results will be evaluated in the subsequent four Quality Assurance and Performance Improvement (QAPI) meetings to assess if further actions are necessary. Providence Health Care is committed to regularly reviewing, updating, and amending this corrective action plan as needed to ensure ongoing compliance for a minimum of six months. B Audits will also be conducted to verify that pharmacy recommendations are being addressed in a timely manner. The DON, or her designee, will randomly audit five residents with pending recommendations each week for four weeks, followed by	

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	On 5/15/25 at 11:14 a.m. the ADON provided the following documentation of the physician notification of the resident's fall and pain. a. A text message thread included an undated and untimed message to the physician which indicated, "...We had three falls last night...." The text message indicated the resident had some pain in the left hip and knee but no shortening, and she was able to lay on it. The resident seemed weak and did not walk well. There was no response from the physician. The next text message in the thread was on 12/1/24 at 3:13 p.m., and indicated the resident was "still complaining of pain in the left leg," and requested an order for an xray of the resident's femur and knee. The physician responded, "Yes." b. A fall report, dated 12/1/24, indicated the resident fell. The report indicated the physician was notified on 12/1/24 at 4:32 a.m., however, the Progress Note, reviewed above, was written one minute later than the report and indicated the physician would be notified at a later time. During an interview, on 5/15/25 at 11:14 a.m., the ADON acknowledged the fall report indicated the physician was notified one minute before the Progress Note was written which stated the physician would be notified at a later time. She was unable to provide further information regarding the notification of the resident's physician of the fall or the resident's reported pain. The ADON indicated when the physician was contacted, by text message or other means, the nurse should have documented the physician notification and the response in the resident's medical record. The reported time on the resident's xray report was the date and time the facility was		three residents per week for the next four weeks, then two residents per week for an additional four weeks, and finally one resident per week for the last four weeks. The outcomes of these audits will be reviewed in the next four QAPI meetings to determine if any further actions are warranted. Providence Health Care will continuously review, update, and modify this plan of correction as necessary to maintain compliance for no less than six months.	

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	notified of the results. The xray company faxed results and did not call the facility. The staff should have addressed the resident's fracture immediately when the report was received. During an interview, on 5/15/24 at 11:30 a.m., Certified Nurse Aide (CNA) 14 indicated if a resident fell the CNA called for help and waited for a nurse assessment before the resident was moved. If the resident complained of pain they should have notified the nurse. During an interview, on 5/15/24 at 11:32 a.m., Registered Nurse (RN) 9 indicated if there were signs or symptoms of a fracture after a resident fell they should not have moved the resident until Emergency Medical Services (EMS) arrived. If the nurse assessed the resident and assisted the resident to move, but the resident complained of pain when moving then the staff should have stopped moving the resident and sent them to the hospital. On 5/13/24 at 2:15 p.m., the Director of Nursing (DON) provided an undated document titled, "Fall Risk and Post Fall Assessment," and indicated it was the policy currently being used by the facility. The policy indicated, "...4. Conduct Physical and Mental Status Assessment...d. Assess limb strength and motion by asking the resident if he/she has pain and the location...e. If you suspect any injury to bone/joints, don't move until seen by a physician or transported to an acute care setting...." On 5/15/24 at 11:55 a.m., the ADON provided a document titled, "Diagnostic Services," updated on 2/23/18, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: To ensure that appropriate			

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	diagnostic services are available to the residents and to outline the responsibilities of provider services and facility staff...11. Licensed nurses are responsible for documenting the performance of laboratory tests and test results if performed in-house, and physician notification in the nurses's notes...14. Upon notification by the diagnostic service, the nurse in charge will notify the attending physician of abnormal lab and/or radiology results...."B. Resident 30's record was reviewed on 5/12/25 at 1:57 p.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease that affects the central nervous system [brain and spinal cord]). A quarterly Minimum Data Set (MDS) assessment, dated 2/11/25, indicated the resident was at risk for skin issues. A physician's order, dated 12/13/24, indicated to apply Ammonium Lactate External Cream 12 % (used to treat dry or scaly skin in adults and children) to both feet topically (on the skin) at bedtime for skin integrity protection for 60 days. The order lacked a specific stop date for the treatment. A pharmacy recommendation, dated 4/17/25, indicated to discontinue (DC) the treatment order, since it had been active for longer than 60 days. The order history lacked documentation that an order had been written to DC the treatment order. During an interview, on 5/13/25 at 11:50 a.m., the Director of Nursing (DON) indicated she had assumed that the order was an as needed (PRN) order. The pharmacy recommendation should have been addressed. The Pharmacist should have caught this around the time of the 60 days,			

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	and requested that an end date for the treatment be obtained. During an interview, on 5/13/25 at 1:44 p.m., the DON indicated the recommendation was not designated for the physician to address, but was for the nursing staff to address. The Pharmacist should have provided an specific end date for the cream when the order was originally sent to the Pharmacy, but had failed to do so. On 5/13/25 at 1:38 p.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." 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review, the facility failed to ensure that staff assessed a resident with a pressure ulcer and implemented treatments which resulted in harm due to the pressure ulcer worsening from a stage 1 (non-blanchable red intact skin) to a stage 3 (full thickness skin loss where fat tissue may be visible) before pressure ulcer assessments and treatments were started for 1of 2 residents reviewed for pressure ulcers (Resident 16). Findings include: On 5/12/25 at 11:23 a.m., during an initial	F 0686	It is the policy of Providence Health Care to ensure that residents receive wound care, consistent with professional standards of practice, to prevent pressure ulcers and that residents with pressure ulcers receive necessary treatment to promote healing. I Corrective Action Taken Related to this Finding: On May 14, 2025, Resident 16 underwent evaluation by the interdisciplinary team; wound treatment orders were reviewed	06/06/2025

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	observation and interview Resident 16 indicated he had a sore area on his bottom. On 5/14/25 at 8:46 a.m., the medical record of Resident 16 was reviewed. The resident was admitted to the facility on 3/25/25, diagnosis included but were not limited to myocardial infarction type 2 (occurs when there's an imbalance between the heart's oxygen supply and demand, leading to injury or death of heart muscle tissue), chronic respiratory failure with hypoxia (the lungs are unable to adequately transfer oxygen into the blood over a long period, leading to low oxygen levels in the blood and tissues), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), and pressure ulcer of sacral region (tail bone). A warm handoff form (a form used to receive patient information including medical conditions at the time of the discharge from the hospital), from admission on 3/25/25, indicated the resident was discharged from the hospital with a stage 1 wound to the coccyx, (stage 1 wound indicated the skin was red, no broken skin). The medical record lacked evidence of an assessment of the pressure wound on the coccyx area at time of admission on 3/25/25, until the resident was seen by wound care services on 4/1/25. The record lacked evidence of a physician order to treat the wound on the coccyx from 3/25/25 to 4/1/25. The medical record indicated when the resident's wound was assessed by the wound care nurse 7 days after admission to the facility the wound had increased from a stage 1 to a stage 3.		and revised as needed. Wound care was continued per physician orders. II Other residents with Potential to be Affected by this Finding will be Identified by: On May 19, 2025, a facility wide full skin integrity audit was conducted for all residents to identify any residents with existing pressure ulcers. All identified residents were assessed by the wound care nurse and no additional unaddressed pressure injuries were found. Wound treatments were reviewed and updated to ensure they were appropriate and in line with evidence-based practice and individualized interventions. III Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: On May 28, 2025, the nursing staff underwent education regarding the policy which emphasized documentation standards and the importance of treatment protocols and expectations. Additionally, the wound nurse will round promptly after each resident admits validating documentation and orders received if indicated. The interdisciplinary team will review at each clinical meeting all residents and monitor status of residents with impaired skin integrity. IV Corrective Actions will be	

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	A care plan, dated 3/27/25, indicated the resident had the potential for pressure wounds. The record lacked documentation indicating a care plan was initiated for an actual pressure wound with interventions. An admission Minimum Data Set Assessment (MDS), dated 4/1/25, indicated the resident was cognitively intact and required assistance for daily care needs. A Physician order, dated 4/2/25, indicated to cleanse area on coccyx, apply collagen to area and cover with bordered gauze daily and PRN (as needed) every night shift for a stage 3 pressure ulcer (a full thickness ulcer that might involve subcutaneous fat). A physician order, dated 4/8/25, indicated every night shift to cleanse area on coccyx, apply Medihoney to area and cover with a ABD pad (large absorbent dressing) and do not secure with tape for stage 3 pressure ulcer. On 5/13/25 at 9:55 a.m., during an interview Registered Nurse (RN) 5 indicated the resident was admitted with a wound on the coccyx. She acknowledged the report from the hospital indicated the resident had a stage 1 pressure area on the coccyx. She indicated the resident refused to allow the nurse to assess the wound at admission. She did not know why treatment orders were not obtained on the day of admission or until 4/1/25. On 5/13/25 at 2:11 p.m., during an interview the Director of Nursing (DON) indicated if a resident was admitted with a wound it should be assessed at the time of admission. If the resident refused to allow an assessment they would continue to		Monitored to Ensure Compliance by: Audits will also be conducted to verify skin assessment, wound documentation, and orders received if indicated. The DON, or her designee, will audit five residents each week for four weeks, followed by three residents per week for the next four weeks, then two residents per week for an additional four weeks, and finally one resident per week for the last four weeks. The outcomes of these audits will be reviewed in the next four QAPI meetings to determine if any further actions are warranted. Providence Health Care will continuously review, update, and modify this plan of correction as necessary to maintain compliance for no less than six months.	

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	attempt to assess the wound. She acknowledged the nurse would call the physician and obtain wound care orders at the time of admission. She indicated the wound care provider visits weekly and assesses wounds. On 5/14/25 at 2:11 p.m., during an interview Registered Nurse (RN) 9 indicated she would look at the resident's skin at admission. If the resident refused she would pass the information onto the next shift and ask the nurse to assess the resident's skin. She indicated she would assess the resident from head to toe at admission. She would call physician if there were no treatment orders in the admission discharge hospital orders. If the resident had a pressure wound she would assess the wound but would not measure it or stage it. She would wait for the wound nurse to measure the wound. On 5/13/2025 at 1:37 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, "...1. A skin assessment and Braden Scale will be performed on admission ...8. The nurse shall document in the Nurse Progress note that a skin abnormality was identified, the physician and legal representative notification and any new orders ...." 3.1-40			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure a root cause analysis was completed and an intervention put in place after falls for 1 of 3 residents reviewed for accidents	F 0689	It is the policy of Providence Health Care to ensure that care plans are updated promptly from a root cause analysis, thereby	06/03/2025

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	(Resident 27). Findings include: During an interview, on 5/12/25 at 9:40 a.m., Resident 27's Health Care Representative indicated the resident fell in December 2024 and fractured her hip. They thought the resident was not injured, so she was not sent to the hospital right away. The Health Care Representative indicated she normally placed the resident's walker next to her bed before she left in the evening, but the day the resident fell she had not ensured the walker was next to the resident's bed before she left. The Health Care Representative indicated since the resident's fall she always made sure the resident's walker was next to her bed before leaving for the evening. Resident 27's record was reviewed on 5/15/25 at 9:11 a.m. A significant change Minimum Data Set (MDS) Assessment, dated 3/14/25, indicated the resident had a severe cognitive impairment and had occasional urinary incontinence. Diagnoses on the resident's profile included, but were not limited to, unspecified fracture of the left femur (thigh bone). A Progress Note, dated 12/2/24 at 4:33 a.m., indicated the nurse was called to the resident's room when the staff found the resident on the floor on her back. The resident was alert but confused and was not using her walker. The resident was assessed, and there were no open areas or bruising. When the staff moved the resident she complained of pain to the left hip and knee. There was no shortening, swelling, or disfigurement in the resident's leg. The resident was put in bed. The note lacked documentation an		fostering a safe environment devoid of accidents. The interdisciplinary team is responsible for revising care plans to accurately reflect the needs of residents. Corrective Action Taken Related to this Finding: On May 16, 2025, the facility corrected the deficiency practice for Resident 27, by completing a root cause analysis related to her past falls. Interdisciplinary team determined a contributing factor was the visitor who has since been educated on the residents individualized plan of care and interventions. Other residents with Potential to be Affected by this Finding will be Identified by: The facility acknowledges that all residents may be at risk. This concern has been addressed through the systems outlined below. Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: All nursing staff participated in a mandatory in-service on May 28, 2025, focusing on fall prevention and the critical nature of documentation. The interdisciplinary team will review all fall incidents on the next	

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	immediate intervention was put in place to prevent another fall. A Post Fall Evaluation Note, dated 12/2/24 at 4:54 a.m., indicated the resident had an unwitnessed fall in her room, and the reason for the fall was toileting. The note indicated there were no injuries. The note lacked documentation of why the resident had not used her walker when attempting to ambulate to the bathroom or an intervention put in place to prevent further falls. A Progress Note, dated 12/2/24 at 8:09 a.m., indicated the resident complained of left leg pain during day shift on 12/1/24. The nurse assessed the resident and requested an order for an xray from the physician. The xray results came back on night shift on 12/1/24. Upon return of day shift, on 12/2/24, the xray results showed the resident had a fractured left femur. The physician was notified, and the resident was sent to the emergency room (ER). A Progress Note, dated 12/6/24, indicated the resident returned to the facility. A care plan, initiated on 12/18/24, indicated the resident had a left femur fracture related to a fall. Interventions included anticipate and meet the resident's needs, ensure the call light is within reach and respond promptly, change surgical incision dressing as ordered and as needed, encourage deep breathing and relaxation techniques, follow the physician's orders for weight bearing status, and modify the environment as needed to meet the resident's current needs. The care plan lacked resident-specific interventions to address the root cause of the resident's fall.		business day during daily clinical meetings to ensure that a root cause analysis is conducted and that care plans are updated to reflect the appropriate interventions based on the identified root cause. Corrective Actions will be Monitored to Ensure Compliance by: Documentation audits will be conducted by the Administrator, or a designated representative, to ensure root cause analysis is completed in the clinical meeting with the interdisciplinary team and care plans are updated appropriately. These audits will occur three times weekly for four weeks, followed by two times weekly for four weeks, and then once weekly for eight weeks. The outcomes will be reviewed at the next four Quality Assurance and Performance Improvement (QAPI) meetings to determine if any further actions are warranted. Providence Health Care will regularly review, update, and amend this plan of correction as necessary to ensure ongoing compliance for no less than six months.	

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	A Progress Note, dated 12/20/24, indicated the resident's sitter came to the nurse's station and reported the resident was on the floor. The nurse entered the room, and the resident was sitting on the floor leaning towards her right hip. The resident said she wanted to "scoot to the bathroom." The resident's sitter indicated the resident did not fall, and when the sitter woke up the resident said she was going to the bathroom then "lowered herself gently to the floor." The resident was assisted to the bathroom and back to bed. The note lacked documentation of an intervention put in place to prevent further falls. A care plan, last revised on 4/3/25, indicated the resident was at risk for falls related to requiring assistance with activities of daily living (ADLs), decreased mobility, unsteady balance, history of falls, cognitive deficit, behaviors, incontinence, pain, shortness of breath, and the use of multiple medications. Interventions were reviewed and were dated on, or before, 1/5/23. There were no updated or revised interventions with the falls on 12/1/24, 12/20/24, or 5/4/25, included on the fall care plan. A Post Fall Evaluation Note, dated 5/4/25 at 4:19 p.m., indicated the resident had an unwitnessed fall in her room. The resident stated she was just standing in her room. The resident was found siting on her bottom in the doorway, with no apparent injuries. The root cause analysis questions were answered, but the note lacked documentation of an intervention put in place to prevent further falls. A Progress Note, dated 5/4/25 at 4:33 p.m., indicated the resident had an unwitnessed fall, in her room, around 3:45 p.m. The resident was found sitting up on the floor in her doorway. The			

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	resident stated she went down "gracefully" and did not hurt herself. The note lacked documentation of an intervention put in place to prevent further falls. During an interview, on 5/15/15 at 11:14 a.m., the Assistant Director of Nursing (ADON) indicated a root cause analysis should have been completed with each fall, and an intervention should have been put in place to prevent further falls. On 5/15/25 at 1:37 p.m., the ADON provided documentation from therapy the resident was evaluated as an intervention for the resident's fall on 5/4/25. At the same time, the ADON indicated the intervention should have been documented in an interdisciplinary team (IDT) note after the fall, but a note was not completed. The ADON indicated she was unable to find an intervention put in place for the falls on 12/1/24 and 12/20/24. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to ensure a resident's indwelling urinary catheter (a semi-flexible plastic tube with one end inserted into the bladder) which is attached to a urinary drainage bag (a bag that collects urine) did not touch the floor for 1 of 1 residents reviewed for catheter care (Resident 52). Findings include: On 5/9/25 at 11:18 a.m., during an initial observation and interview Resident 52 indicated he was not sure why he had a catheter, but he	F 0690	It is the policy of Providence Health Care to ensure that residents who have an indwelling catheter will receive appropriate treatment and services to ensure compliance with **infection control** and **quality of care standards**. I Corrective Action Taken Related to this Finding: On May 13, 2025, the catheter drainage bag that was observed touching the floor was immediately removed and replaced using aseptic technique. Resident 52	06/06/2025

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	thought it may be due to prostate cancer. Observed the resident sitting in a wheelchair in the main dining area. The catheter bag was attached to the bar under the wheelchair and was touching the floor. On 5/9/25 at 12:11 p.m., observed Resident 52 propelling self in wheelchair. Observed catheter bag dragging on the floor under the wheelchair. On 5/13/25 at 9:52 a.m., during interview with Registered Nurse (RN) 5 she indicated the catheter bag should never touch the floor and when she was positioning a drainage bag she would ensure the bag was not touching the floor. On 5/14/25 at 11:35 a.m., reviewed the medical record of Resident 52. The resident was admitted to the facility on 4/14/25. Admitting diagnosis included but not limited to retention of urine (a condition in which you are unable to empty all the urine from your bladder), malignant neoplasm of prostate (a tumor within the prostate gland), and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland, often causing urinary problems). A care plan dated 4/15/25, indicated the resident had an Indwelling Catheter related to urinary retention. Intervention included but not limited to, prevent kinks in catheter tubing. An admission Minimum Data Set Assessment (MDS) dated 4/21/25, indicated the resident was cognitively intact and had an indwelling catheter since admission to the facility. On 5/13/25 at 1:37 p.m., the Director of Nursing (DON) provided an undated document, titled, "Urinary Catheter Care," and indicated it was the		was immediately assessed by the nursing team for signs and symptoms of infection; none were present at the time of assessment. I Other residents with Potential to be Affected by this Finding will be Identified by: A facility-wide review of residents with Indwelling catheters was conducted on May 13, 2025, to ensure all catheter drainage bags were appropriately secured and not in contact with the floor. No other residents were identified with drainage bags touching the floor. Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: On May 28, 2025, all staff received education on proper catheter care, including correct positioning of drainage bags, per the new facility policy and CDC/CMS guidance. All staff were instructed to report any improperly placed catheter bags during rounds. Special dignified wheelchair storage bags were purchased to hold the drainage bag. These were applied to all residents currently requiring catheters in the facility. The facility's policy and procedure guidelines were updated to include special dignified wheelchair storage bags while ina wheelchair for all future residents requiring catheters.	

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	policy currently being used by the facility. The policy indicated, " ...Standards ...7. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor ...." 3.1-41(a)(1)		Corrective Actions will be Monitored to Ensure Compliance by: Audits will also be conducted to ensure proper care and infection control practices. The DON, or her designee, will audit five residents with indwelling catheters each week for four weeks, followed by three residents per week for the next four weeks, then two residents per week for an additional four weeks, and finally one resident per week for the last four weeks. The outcomes of these audits will be reviewed in the next four QAPI meetings to determine if any further actions are warranted. Providence Health Care will continuously review, update, and modify this plan of correction as necessary to maintain compliance for no less than six months.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure proper cleaning and storage of respiratory equipment for 2 of 4 residents reviewed for respiratory care (Residents 50 and 270). Findings include: 1. During an observation, on 5/15/25 at 8:53 a.m., Registered Nurse (RN) 8 administered a breathing treatment to Resident 50. The nurse removed the	F 0695	It is the policy of Providence Health Care to ensure that nebulizer kits, complete with mouthpieces, are stored in plastic bags alongside the nebulizer tubing, following proper cleaning protocols. Corrective Action Taken Related to this Finding: On May 16, 2025, the unit manager discarded the disposable	05/29/2025

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	breathing treatment mask from the resident at 9:08 a.m., she opened the chamber (this holds the liquid medication) and dumbed out the remaining medication left in the chamber into the trash can and returned the respiratory mask and tubing to a clear plastic bag. Resident 50's record was reviewed on 5/15/25 at 11:07 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a lung disease characterized by airflow obstruction, making it difficult to breathe) with acute exacerbation (a period where COPD symptoms worsen significantly beyond the usual day-to-day experience) and unspecified asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe). An admission Minimum Data Set (MDS) assessment, dated 4/16/25, indicated the resident was cognitively intact and received respiratory therapy. A physician's order, dated 4/9/25, indicated ipratropium-albuterol solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier) 0.5-2.5 milligrams (mg)/3 milliliters (ml) inhale orally via nebulizer four times a day for COPD. A care plan, dated 4/10/25, indicated the resident had COPD and asthma. Interventions included, but were not limited to, give aerosol or bronchodilators (a drug that causes widening of the bronchi) as ordered, give oxygen therapy as ordered by physician, and head of bed to be elevated.		nebulizer kits and tubing and replaced them with new equipment for Residents 50 and 270. These residents were assessed by nursing unit manager for any signs or symptoms of respiratory infection. No adverse outcomes were identified. II Other residents with Potential to be Affected by this Finding will be Identified by: On May 16, 2025, a full audit of all resident rooms and respiratory supply storage areas was conducted to identify any additional instances of improperly stored nebulizer equipment. No other improper storage was identified. Any nebulizer devices in current use were confirmed to be individually assigned, labeled, and properly stored in accordance with infection control standards. Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: On May 28, 2025, the Director of Nursing and the Staff Development Coordinator conducted a review of the Oxygen Therapy Policy and the Nebulized Mist Inhalation Treatment Policy with all licensed nursing staff. Corrective Actions will be Monitored to Ensure Compliance by:	

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	During an interview on 5/15/25 at 10:25 a.m., Registered Nurse (RN) 9 indicated the nebulizer mouthpiece and medication chamber was to be rinsed out after use and once dried it should be placed in a bag until used again. 2. On 5/9/25 at 2:11 p.m., during initial observation the resident was sleeping in bed. Observed a clear storage bag next to the resident's bed. The storage bag was dated 5/9/25. A nebulizer unit, (a reservoir for holding the liquid for nebulization), and a tracheostomy (an opening surgically created through the neck into the trachea to allow air to fill the lungs) mask which adapts nebulizers for patients who have had a tracheostomy to receive inhalation therapy which the medication aerosol is inhaled and the nebulizer tubing was inside of the bag. The reservoir was observed to have clear liquid inside. Observed suction canister (a container used in medical procedures to collect body fluids and debris removed during treatment through suction pressure), was next to the bed. The canister was half full of green liquid. The suction tubing (suction tubing is used to remove fluids, secretions, or debris from the body, during procedures like suctioning the airway) was observed with green and white colored debris throughout the inside of the tubing. The suction tubing was placed inside of the bag with the nebulizer administration set. On 5/12/25 at 9:48 a.m., observed nebulizer equipment inside of a clear storage bag next to the resident's bed. The storage bag observed with clear fluid in the interior of the bag. The nebulizer administration set was wet and stored inside of the bag. On 5/13/25 at 9:45 a.m., observed nebulizer administration set in a clear bag next to the bed. The inside of the bag was wet, and the nebulizer		Rounding audits will be conducted by the DON, or a designated representative, to ensure proper cleaning and storage of nebulizers. These audits will occur three times daily for four weeks, followed by two times daily for four weeks, and then once daily for eight weeks. The outcomes will be reviewed at the next four Quality Assurance and Performance Improvement (QAPI) meetings to determine if any further actions are warranted. Providence Health Care will regularly review, update, and amend this plan of correction as necessary to ensure ongoing compliance for no less than six months.	

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	administration set was wet. On 5/13/25 at 9:51 a.m., during an interview Registered Nurse (RN) 5 indicated after she completed a nebulizer treatment she rinsed the equipment and allowed it to dry and placed the equipment in the storage bag. On5/13/25 at 1:59 p.m., during an interview the Director of Nursing (DON) indicated the suction canister was a closed system and the suction tubing from the machine must be cleaned after use and stored in a clean bag separate from other equipment. She acknowledged the nebulizer equipment should be clean and dry before being placed in a clean bag. On 5/14/25 at 2:08 p.m., during interview Registered Nurse (RN) 9 indicated she would clean the nebulizer administration set and place it in the designated bag. If it was very soiled she would wash the equipment and allowed to air dry, before placing it into storage bag. On 5/14/25 2:15 p.m., the medical record of Resident 270 was reviewed. The record indicated the most recent admission to the facility was on 5/5/25. Admission diagnosis included but was not limited to acute and chronic respiratory failure (a long-term condition where the lungs are unable to adequately exchange oxygen and carbon dioxide), traumatic brain injury (a form of acquired brain injury, occurs when a sudden trauma causes damage to the brain), and quadriplegia (a condition characterized by the paralysis or loss of function in all four limbs). A physician order, dated 5/5/25, indicated to administer Ipratropium-Albuterol Solution 0.5-2.5 (3) mg (milligram) 3ML (milliliter) 1 vial via (by way			

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	of) trach (tracheostomy) every 6 hours for respiratory failure and 1 vial via trach every 4 hours as needed for congestion; shortness of breath. A care plan, dated 1/16/20, indicated that the resident had the potential for altered respiratory status/difficulty breathing related to tracheostomy status and diagnosis of acute and chronic respiratory failure. Interventions included but were not limited to, administer breathing medications as ordered and monitor for effectiveness and side effects. A quarterly Minimum Data Set Assessment (MDS), dated 2/19/25, indicated the resident had a tracheostomy which required suctioning and received nebulizer treatments during the review period. On 5/13/2025 at 1:37 p.m., the DON provided an undated document titled, "Nebulizer inhalation device sanitizing," and indicated it was the policy currently being used by the facility. The policy indicated, "...2. Respiratory equipment used with a mini nebulizer will be stored clean and covered between resident uses ...4. The mouthpiece, T-piece nebulizer cup and lid will be washed with warm soapy water, rinsed thoroughly between each use with sterile water or tap water, and disinfected daily. All pieces are then rinsed thoroughly with tap water, drained, air dried in a clean location, then stored in a clean container ...." On 5/13/2025 at 1:37 p.m., the DON provided an undated document titled, "Suction machines cleaning and sanitizing," and indicated it was the policy currently being used by the facility. The policy indicated, ..."Procedure ...4.Suction water or saline solution through tubing into collection			

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	chamber, if needed to clear tubing ...." 3.1-47(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medication was labeled properly and the facility failed to ensure expired medication was disposed of for 2 of 2 medication storage rooms reviewed for medication storage (Resident 49). Findings include: 1. On 5/14/25 at 10:00 a.m., the north hall medication storage room refrigerator contained an opened and undated multi use vial of Aplisol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution. During an interview, on 5/14/25 at 10:02 a.m., Registered Nurse (RN) 7 indicated she was not aware of how long the Aplisol was good for once opened, but she was aware it should be dated once opened. 2. On 5/14/25 at 10:11 a.m., the south hall medication storage room refrigerator contained an opened bottle of Mary's Magic Mouthwash (a compounded oral rinse used to treat mouth sores and pain, often associated with cancer treatment). The bottle contained a label that indicated it was for Resident 49 and was opened on 4/27/25 and had an expiration date of 5/12/25. During an interview, on 5/14/25 at 10:14 a.m., the Assistant Director of Nursing (ADON) indicated the mouthwash should have been discarded two	F 0761	It is the policy of Providence Health Care to ensure all medications will be labeled and stored in accordance with state and federal regulations I Corrective Action Taken Related to this Finding: On May 14, 2025, the opened and undated vial of Aplisol solution was disposed of and the unopened and expired bottle of Mary Magic Mouthwash for resident 49 was discarded. II Other residents with Potential to be Affected by this Finding will be Identified by: On May 14, 2025, all medication rooms and medication carts were inspected to ensure that no expired medication/biologicals were present and that all medications are properly labeled and dated. III.Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: On May 28, 2025, all licensed nursing personnel and QMA's were re-educated at a mandatory in-service on the medication storage and labeling policy and	05/29/2025

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	days ago on 5/12/25. She also indicated the Aplisol solution was good for 30 days once opened and should have been dated when it was opened. On 5/14/25 at 2:52 p.m., the Administrator provided an undated document titled, "Refrigerated Products Expiration Date," and indicated it was the current policy used by the facility. The policy indicated, " ...Aplisol injection discard open vials after 30 days ...." On 5/14/25 at 1:31 p.m., the Administrator provided a document with a revised date of 2/17/25, titled, "Medication Storage Policy," and indicated it was the currently policy used by the facility. The policy indicated, " ...22. No drugs or biological shall be stored which are beyond manufacturer's expiration date or facility established expiration date ...." 3.1-25(j)		given a copy of the policy. IV Corrective Actions will be Monitored to Ensure Compliance by: Rounding audits will be conducted by the DON, or a designated representative, to ensure proper labeling and dating of medications. These audits will occur three times a week for four weeks, followed by two times a week for four weeks, and then once a week for eight weeks. The outcomes will be reviewed at the next four Quality Assurance and Performance Improvement (QAPI) meetings to determine if any further actions are warranted. Providence Health Care will regularly review, update, and amend this plan of correction as necessary to ensure ongoing compliance for no less than six months.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 16, 2025 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	R 0000	Providence Health Care is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. This Plan of Correction constitutes Providence Health Care's written credible allegation of compliance for the deficiencies noted to demonstrate our ongoing commitment to	

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	Residential Licensure Survey. Quality review completed on May 27, 2025.		compliance with federal and state regulations.	