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	11/10/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00393738 and IN00391864. Complaint IN00393738-Substantiated. Federal deficiencies related to the allegation were cited at F657. Complaint IN00391864-Substantiated. No deficiencies related to allegations were cited. Survey dates: November 9 and 10, 2022 Facility number: 003624 Provider number: 155802 AIM number: 200429840 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 12 Medicaid: 35 Other: 10 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 21, 2022.	F 0000		
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion			

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

Mandy Lynch | Administrator | 12/02/2022

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

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	of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, record review, and interview, the facility failed to ensure fall care plans were revised and/or developed for 2 of 3 residents reviewed for accidents (Resident B and Resident D). Findings include: 1. Resident B was observed on 11/9/22 at 12:30 p.m. sitting in a wheelchair in the dining room wearing tube socks without shoes. On 11/9/22 at 11:30 a.m., Resident B's medical record was reviewed. Resident B's progress notes indicated that Resident B experienced a fall on the	F 0657	It is the policy of PHC to ensure care plans are updated timely and revised to accurately address the resident needs by the interdisciplinary team. I. Corrective Action Taken Related to this Finding: On 11/11/2022, resident B and resident D were reviewed by IDT consisting of the Director of Nursing, Unit Managers, AIT, and Administrator, to ensure appropriate fall interventions are in place based on root causes of prior falls and fall care plans were	11/18/2022

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	following dates: 9/27/22, 10/1/22, 10/5/22, 10/10/22, 10/24/22, 10/27/22 and 10/29/22. A review of the fall care plan indicated as an intervention that the facility was to ensure Resident B was wearing proper footwear, dated 12/14/21. The care plan did not include interventions for the falls from 9/27/22, 10/01/22, 10/5/22, 10/10/22, 10/27/22 or 10/29/22. On 11/10/22 at 9:10a.m., during an interview the Administrator indicated that the care plans had not been updated due to a vacancy in the facility staff and the care plan should have been updated with an intervention after each fall. 2. Resident D's record was reviewed on 11/9/22 at 2:13 p.m. Resident D was admitted to the facility, on 10/5/22, with the diagnoses included, but were not limited to fracture of second lumbar vertebra subsequent encounter for fracture with routine healing (spinal fracture), other displaced fracture of upper end of right humerus subsequent encounter for fracture with routine healing (right arm fracture), muscle weakness, and difficulty in walking. An admission Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the resident had a moderate cognitive impairment, required physical help in part of bathing of one person, had an upper extremity impairment on one side, and had a fall with a fracture in the last month prior to admission to the facility. An ADL (activities of daily living) care plan, dated 10/13/22, indicated Resident D needed assistance of one staff member when providing patient care. A progress note, dated 10/18/22 at 1:30 p.m., indicated Resident D was bathing in the shower		updated/developed to reflect current interventions related to falls. II. Other residents with the potential to be affected by this Finding will be identified by: The care plans of all residents currently residing in the facility were reviewed and revised by the IDT, as needed, to ensure appropriate fall interventions are care planned based on the resident's fall risk and root causes of prior falls and to ensure all fall care interventions are implemented per the plan of care. This audit was completed on 11/18/2022. III. Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: All nursing Staff was educated at mandatory in-service on 11/16/2022 and 11/17/2022 regarding the requirement to ensure that immediate interventions are implemented following each fall, and to validate those fall interventions are implemented for residents as indicated in the plan of care. The IDT team will review all falls the next business day during the daily clinical meeting to ensure the fall care plan is updated and includes appropriate interventions based on the root cause of the fall. IV. Corrective Actions will be	

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	room and assisted by a Certified Nursing Assistant (CNA). Resident D had requested privacy, so the curtain in the shower room was pulled closed. CNA indicated to Resident D to let her know when she was finished bathing. When Resident D indicated she was finished, the CNA reached for a towel and went to open the shower curtain and heard a thump. When the shower curtain was pulled back, the CNA observed Resident D had fallen onto the shower floor with a skin tear on the right shin area. A post fall risk assessment, dated 10/18/22, indicated Resident D was a moderate risk for falls. The medical record lacked documentation an at risk for falls care plan was developed for Resident D. On 11/10/22 at 10:49 a.m., the Administrator (ADM) indicated, Resident D was at risk for falls and should have had a fall care plan developed. On 11/9/22 at 3:00 p.m., the ADM provided and identified an undated document as a current facility policy, titled "RESIDENT CARE PLAN POLICY." The policy indicated, " ...Purpose: To provide an individualized plan of care for each resident ...Policy: It is the policy of Providence Health Care that a comprehensive plan of care will be provided for each resident the includes measurable objectives and time frames to meet the medical, nursing, mental and psychosocial needs that are identified in the interdisciplinary assessments ...Standards: ...2. Resident care services provided or arranged by the facility must meet professional standards of practice and be provided by qualified persons in accordance with the resident's care plan ...9. The care plan is initiated following admission assessments and		Monitored to Ensure Compliance by: The Director of Nursing, or her designee, will be conducting random fall care plan audits (see attached) to ensure each one includes all appropriate interventions documented in resident charts in accordance with the IDT recommendations and that those fall interventions are implemented per the plan of care. 5 residents x per week times 4 weeks, then 3 x per week x 4 weeks, then 2 x per week x 4 weeks, then 1 x per week x 3 months. 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.	

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	shall be completed within twenty-one (21) days of admission or within seven (7) days of the completion of a Comprehensive MDS Assessment. The goals shall be specific and relative to the resident's current condition, measurable and related to specific time frames ...10. Additions and modifications will be made by each disciplinary team member to assist facility personnel in meeting the needs of the resident. Plans will be reviewed at least quarterly and revised at any time the condition of the resident changes or the resident exercises rights including the right to refuse treatment or after each assessment or assessment review where change has occurred which would alter the plan of care. Nurses on each shift are responsible for revising and updating the resident care plan whenever the resident's condition changes. All disciplines are responsible for updating the plan of care to assure the plan represents the resident's current status ...." This Federal tag relates to Complaint IN00393738. 3.1-35(c)(1) 3.1-35(c)(2)			