STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 00 B. WING	12/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE RETIREMENT HOME	4915 CHARLESTOWN RD NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 28, 29, 30, December 1, 2, 6, and 7, 2011 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Survey team: Gloria J. Reisert, MSW/TC Avona Connell, RN (11/28, 11/30, 12/1, 12/2, 12/6 and 12/7) Dorothy Navetta RN (11/30, 12/1, 12/2, 12/6 and 12/7) Census bed type: SNF: 56 SNF/NF: 63 Residential: 08 Total: 127 Census payor type: Medicare: 23 Medicaid: 39 Other: 65 Total: 127 Sample: 24 Residential sample: 5 Supplemental Residential sample: 1	F0000	This plan of correction constitutes Providence Retirement Home's credible allegation of compliance for all cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statues, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	

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

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 12/9/11 Cathy Emswiller RN			
F0247 SS=B	A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure residents received notice of room changes which listed the transfer location and reason for the move prior to the actual move. This deficient practice affected 2 of 4 residents reviewed for room changes in a sample of 24 residents (Resident #14 and 39) Findings include: 1. Review of the clinical record for Resident #14 on 11/30/2011 at 4:10 p.m., indicated the resident was admitted on 11/11/2011 and had diagnoses which included, but were not limited to, depressive disorder, anxiety, and atrial fibrillation.	F0247	1) What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct for Resident # 14 and #39 due to the room moves have already occurred. Social Services will complete a follow up note documentating the date the room occurred, location to what room the resident moved to, the reason for the move and how the resident is adjusting to their new room.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.Medical Records will complete an audit of room moves that have occurred within the past three months for verification of room change notice. If any found out of compliance, Social	01/06/2012

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	Review of the nursing notes for 11/18/2011, included the following entry: "2 p.m. -Res [resident] moved to room [number listed]. Will cont [continue] to monitor." Documentation was lacking of a room change notice which indicated the date of, location to where the resident would be transferred, the reasoning for the transfer and that the resident was oriented to and agreed to the move prior to it occurring. 2. Review of the clinical record for Resident #39 on 11/29/2011 at 11:15 a.m., indicated the resident was admitted on 8/4/2011 and had diagnoses which included, but were not limited to, diabetes mellitus, osteoarthritis and status post dehydration. Review of the Social Service note for 10/5/2011, included the following entry: [Resident's name] moved to room [number listed] this date due to need for [change in pay status]..." Documentation was lacking of a room change notice which indicated the date of, location to where the resident would be transferred, the reasoning for the transfer and that the resident was oriented to and agreed to the move prior to it occurring. During an interview with LPN #3 on		Services will make a follow up not in chart documentating the date the room occurred, location to what room the resident moved to, the reason for the move and how the resident is adjusting to their new room.3) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Social Services and Unit Managers/Supervisors will be in-serviced on the room change notice form and completing this form with any room change.Social Services/Designee will audit for completion of the room change notice monthly for three months, then quarterly for the remainder of the year.4) How will the corrective action/s be monitored to ensure the deficient practice will not recur, ie. what quality assurance program will be put into place?Social Service/Designee will audit for completion of the room change notice monthly for three months, then quarterly for the remainder of the year. Findings will be reported to the Quality Assurance committee.	

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	11/30/11 at 4:00 p.m., she indicated she was not aware there were specific forms to be filled out when a resident was to be transferred to a different room as she thought the Notice of Transfer Discharge was the one the unit nurses were supposed to complete whenever a change in rooms occurred. She also indicated she assumed Social Services notified the resident and/or responsible party of the move. During an interview with Social Worker #1 on 12/7/2011 at 2:30 p.m., she indicated that she did not usually complete any specific Notice of Room Change as she just made a note in her section of the chart when a room change occurred. On 12/7/2011 at 1:32 p.m., the Administrator present a copy of the facility's current policy on "Notification of Changes." Review of this policy at this time included, but was not limited to: "Policy: Admissions, Social Services, or Nursing shall promptly notify the resident, or legal representative, and his or her attending physician, when indicated, of changes in the resident's condition and/or status including:...A change in room or roommate assignment..." 3.1-3(v)(2)			

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F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based record review and interview, the facility failed to provide social service monitoring of a resident's well-being when a family member became verbally frustrated with a confused resident. This deficient practice affected 1 of 1 resident reviewed for conflict between a resident and family member in a sample of 24 residents. (Resident #32) Finding includes: Review of the clinical record for Resident #32 on 12/6/2011 at 12:30 p.m., indicated the resident had diagnoses which included, but were not limited to, toxic encephalopathy, Alzheimer disease, episodic mood disorder, and dementia with behavior disturbance. Review of the nursing notes dated 11/16/2011 indicated the following entry: "11:30 a.m.:...Alert to self - pleasantly confused. Sitting [up] in chair with eyes closed...Voices [no] c/o [complaints] or concerns - Although [family member] states 'I don't know why she won't open her eyes. Something isn't right.' resident sits in w/c [wheelchair] [with] eyes closed every day. Resident was able to follow	F0250	1) What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? Social Services will meet with resident #32 and family member to offer support services as needed and document this visit.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions/will be taken.Social Services will audit 24 hour reports for last three months to identify if there are any other psychosocial needs/support that hasn't been addressed.3) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Licensed staff will be in-serviced on reporting psychosocial concerns to social services.Social Services will be in-serviced on documentating follow up to any psychosocial needs identified.Social Services/Designee will audit documentatation of follow up on psychosocial needs monthly for three months, then quarterly for the remainder of the year.4) How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?Social	01/06/2012

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	simple commands & tell me her name. Staff overheard [family member] fussing at resident - stated 'I've been taking care of you for ten years & and I'm not putting up with this. You are going to open your eyes!'..." Review of the Social Service notes between July and November 30, 2011 indicated documentation was lacking of Social Services having spoken with the resident and family member to provide support as needed. During the daily exit meeting on 12/6/2011 at 1:50 p.m. with the Administrator and the Director of Nursing, the Administrator indicated this was the normal pattern of interaction between the resident and family member and that the family member had been spoken to before about his frustration during interaction with the resident. She also indicated there was documentation of this discussion and would go and get it. No documentation of the conversation was presented up through the time of the final exit meeting with the facility. Review of the signed Job Description for both Social Service personnel - Social Worker #1 on 3/28/2011 and Social Worker #2 on 3/22/2011 - as presented by the Business Office Manager on		Service/Designee will audit documentation of follow up on psychosocial needs monthly for three months, then quarterly for the remainder of the year. Findings to be reported to Quality Assurance committee.	

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	12/7/2011 at 11:30 a.m., included, but was not limited to: ...Accountability:...5. Addresses psychosocial needs of residents and families. meets with individual residents and families to facilitate discussion regarding issues and emotional needs with empathy and concern..." 3.1-34(a)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a care plan which addressed the needs of a resident on strict 800 cc [cubic centimeters] fluid restrictions. This deficient practice affected 1 of 1 resident reviewed for fluid restrictions in a sample of 24 residents. (Resident #7)	F0279	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?Unable to correct due to resident was discontinued from fluid restrictions on 11/21/11.2) How other residents having the potential to be affected by the same deficient practice will be	01/06/2012

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	Finding includes: Review of the clinical record for Resident #7 on 12/2/2011 at 12:05 p.m., indicated the resident was admitted from the hospital on 11/16/2011 and had diagnoses which included, but was not limited to, hyponatremia [low sodium], anxiety, and gastroesophageal reflux disease. Review of the admitting orders to the facility from the hospital indicated the resident had the following orders: Fluid restriction 800 cc/day as follows - 240 cc [with] meals TID [3 times a day] and 40 cc [with] 6 am and HS [evening] med pass." Review of the care plans for the resident failed to locate a care plan which addressed the resident's diagnosis of hyponatremia and the needs and risks associated with following fluid restrictions. A single Preliminary Care Plan dated 11/16/2011 noted only 1 care plan - "Problem - Resident requires assist with ADLs [activities of daily living]. Goal - Resident will participate in ADLs as tolerated and within limits of safety thru the next 30 days. " Interventions included, but were not limited to: "7. Provide diet as ordered: Mech [mechanical] soft 800 ml [milliliters]/day		identified and what corrective action/s will be taken.Director of Nursing/Designee will audit all residents receiving fluid restrictions to verify a care plan is in place.3) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Licensed nursing staff will be in-serviced on implementing fluid restriction care plan at admission or when they receive an order for fluid restrictions.Director of Nursing/Designee will audit fluid restriction care plans weekly for one month, monthly for three months, then quarterly for the remainder of the year.4) How will the corrective action/s be monitored to ensure the deficient practice will not recur, i. e. what quality assurance program will be put into place?Director of Nursing/Designee will audit fluid restriction care plans weekly for one month, monthly for three months, then quarterly for the remainder of the year. Findings will be reported to the Quality Assurance committee.	

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	fluid restrictions." During an interview with RN #1 on 12/2/2011 at 1:12 p.m., she indicated that depending on what the problem was would determine if an initial care plan should be written before the comprehensive care plans were finished. She indicated that Resident 7 should have had a care plan to address his strict fluid restrictions and recent hospitalization for hyponatremia. During an interview with Minimum Data Set [MDS] coordinator #1 on 12/6/2011 at 9:20 a.m., she indicated there should have been an initial care plan to specifically address his hyponatremia and his fluid restrictions indicating how much he was to have and when. On 12/6/2011 at 10:00 a.m., the Administrator presented a copy of the facility's current policy on "Care Plans - Preliminary". Review of this policy at this time included, but was not limited to: "Policy Statement: A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission..1. To assure that the resident's immediate care needs are met and maintained, a preliminary care plan will be developed within twenty-four (24)			

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	hours of the resident's admission. 2. The Interdisciplinary team will review the Attending Physician's orders (e.g. dietary needs, medications, and routine treatments, etc.), and implement a nursing care plan to meet the resident's immediate care needs. 3. The preliminary care plan will be used until the staff can conduct and develop an interdisciplinary care plan." 3.1-35(a) 3.1-35(b)(1)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician orders were followed for monitoring of strict fluid restrictions for 1 of 1 resident reviewed for fluid restrictions in a sample of 24 residents (Resident #7) Finding includes: Review of the clinical record for Resident #7 on 12/2/2011 at 12:05 p.m., indicated the resident was admitted from the hospital on 11/16/2011 and had diagnoses which included, but was not limited to, hyponatremia [low sodium], anxiety, and	F0282	1) What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?Unable to correct for Resident # 7. Physician discontinued the order for fluid restrictions on 11/21/11.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.All charts will be reviewed to verify physician orders for fluid restrictions are being followed. The physician will be notified if any concerns are identified.3) What measure will be put into place or what systemic changes	01/06/2012

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	gastroesophageal reflux disease. Review of the admitting orders to the facility from the hospital indicated the resident had the following orders: Fluid restriction 800 cc/day as follows - 240 cc [with] meals TID [3 times a day] and 40 cc [with] 6 am and HS [evening] med pass." Review of the November 2011 Monthly Meal Percentage form noted the resident's strict 800 cc fluid restriction was not monitored and the resident received more than the allotted amount on the following days: - 11/18: total intake was 1440 cc = 7-3 encouraged fluids was 240 cc, 3 -11 encouraged fluids was 240 cc, 11 -7 encouraged fluids was 120 cc. Breakfast fluids was 120 cc, Lunch fluids was 240 cc and Supper fluids was 480 cc. - 11/19: total intake was 1560 cc = 7-3 encouraged fluids was 240 cc, 3 -11 encouraged fluids was 240 cc, 11 -7 encouraged fluids was 120 cc. Breakfast fluids was 120 cc, Lunch fluids was 360 cc and Supper fluids was 480 cc. - 11/20: total intake was 1140 cc = 3 -11 encouraged fluids was 240 cc, 11 -7 encouraged fluids was 120 cc. Breakfast fluids was 60 cc, Lunch fluids was 480 cc		will be made to ensure that the deficient practice does not recur? Licensed nursing staff will be in-serviced on following physician orders obtained regarding fluid restrictions.Director of Nursing/Designee will audit 10% of the resident population for physician orders related to fluid restrictions being followed weekly for one month, monthly for three months, then quarterly for the remainder of the year.4) Director of Nursing/Designee will audit 10% of the resident population for physician orders related to fluid restrictions being followed weekly for one month, monthly for three months, then quarterly for the remainder of the year. Findings will be reported to the Quality Assurance committee.	

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	and Supper fluids was 240 cc. Review of the November 2011 MAR [Medication Administration Record] noted the physician's order for the specific fluid restrictions and how they were to be divided during the day, but documentation was lacking of how much fluids were being administered during the medication passes. During an interview with LPN #4 on 12/2/2011 at 12:55 p.m., she indicated there should be an I & O [intake and output] sheet in front of the MARs for anyone on fluid restriction. Documentation was lacking of an I & O record. A new physician order was received on 11/21/2011 to discontinue the fluid restrictions due to constipation. On 12/7/2011 at 7:00 a.m., the Administrator presented a copy of the facility's current policy on "Encouraging and Restricting Fluids". Review of this policy included, but was not limited to: "Purpose: The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids...General Guidelines:...2. Be accurate when recording fluid intake.			

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	3. Record fluid intake on the intake side of the intake and output record. record fluid intake in mls [milliliters]...8. Be sure an intake and output record is maintained in the Resident's room." 3.1-35(g)(2)			
R0000	The following residential deficiency is cited in accordance with 410 IAC 16.2	R0000	This plan of correction constitutes Providence Retirement Home's credible allegation of compliance for all cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statues, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to initiate an evaluation of the resident's needs prior to admission for 3 of 5 residents reviewed for pre-admission assessments in a sample of 5 residential residents. (R #1, R #2, R #3)	R0214	1) What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct for R#1, R#2 and R#3 since they have already been admitted to residential care. A current evaluation will be completed on R#1, R#2 and	01/06/2012

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	Findings include: 1. Review of the clinical record for Residential Resident #1 on 12/7/2011 at 10:00 a.m., indicated the resident was admitted on 7/12/2011 and had diagnoses which included, but were not limited to, osteoporosis, status post cerebral vascular accident without residual, and leukopenia. Documentation was lacking of a pre-admission assessment having been completed before the resident was admitted to the residential unit from the skilled rehabilitation side of the nursing center. 2. Review of the clinical record for Residential Resident #2 on 12/7/2011 at 8:50 a.m., indicated the resident was admitted on 11/23/2011 and had diagnoses which included, but was not limited to, history of kyphoplasty, kyphosis, osteoporosis, and anemia. Documentation was lacking of a pre-admission assessment having been completed before the resident was admitted to the residential unit from the skilled rehabilitation side of the nursing center.		R#3.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.A Pre-Admission form will be implemented and utilized on all potential residents to residential care prior to admission.Unable to correct on current residents, but will verify each residential resident has a current evaluation completed.3) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Unit Managers, Supervisors & Admission staff will be in-serviced on the need for all potential residential residents to have an evaluation of their needs completed prior to admission to residential care.Director of Nursing/Designee will complete an audit for pre-admission evalution forms monthly for three months and then quarterly for the remainder of the year.4) How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?Director of Nursing/Designee will complete an audit for pre-admission evalution forms monthly for three months, then quarterly for the remainder of the year. Findings will be reported to the Quality Assurance committee.	

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	155668	A. BUILDING 00 B. WING	12/07/2011

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	3. Review of the clinical record for Residential Resident #3 on 12/7/2011 at 10:45 a.m., indicated the resident was admitted on 10/29/2011 and had diagnoses which included, but were not limited to, chest pain with shortness of air, chronic back pain, and esophageal stricture. Documentation was lacking of a pre-admission assessment having been completed before the resident was admitted to the residential unit from the skilled rehabilitation side of the nursing center. During an interview with RN #1 on 12/7/2011 at 2:30 p.m., she indicated that because the resident was only transferring from the skilled section of the nursing center to assisted living section, she did not think a pre-admission evaluation had to be completed. On 11/28/2011 at 9:30 a.m., the Administrator presented a copy of the facility's current policy on "Residential Assessment". Review of this policy indicated: "Purpose: Assessment of residents in Residential Care is essential to identifying the needs of that resident. Policy: It is the policy of [name of facility] to thoroughly assess all residents admitted to residential Care at periodic			

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	intervals. Procedure: 1. Prior to admission to residential Care, candidates will be assessed by the Admissions manager or designee..."			
R0406	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review and interview the facility failed to ensure that standards of nursing practice for infection control were followed when the nurse picked up a dropped medication off of the floor, and did not wash hands before administration of other medications to resident. This deficient practice affected 1 of 1 residents during a random nursing observation. (Resident # R4) Findings include: On 11/30/2011 at 4:00 p.m., Licensed Practical Nurse (LPN) # 1 was preparing medications for administration for Resident # R4 when it was observed that LPN # 1 dropped a green pill on the floor and then picked the green pill up off the floor and disposed of it. LPN # 1 then opened the medication drawer and took a	R0406	1) What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct for #R4.2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken. All residents have the potential to be affected.3) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?All licensed nursing staff will be in-serviced on washing their hands if they drop medication to the floor prior to dispensing additional medication.Director of Nursing/Designee will audit for proper infection control by monitoring medication pass on four separate occassions monthly for three months, then quarterly for the remainder of the year.4) How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e. what	01/06/2012

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	white bottle out and emptied another green pill into her hand and then gave the green pill to Resident # R4. The resident swallowed the pill along with 2 other pills the resident had in hand. No hand washing or antibacterial gel was observed to have been used after LPN # 1 picked the pill up off of the floor and prior to the administration of the new pill. On 12/01/2011 at 12:00 p.m., in an interview with LPN # 2 she indicated that if you drop something on the floor and pick it up, you should wash your hands before touching anything else. On 12/07/2011 at 2:30 p.m., record review of LPN # 1 orientation record dated 10/14/2011 indicated, but is not limited to; "follow infection control standard operating procedures...". Review of LPN # 1 employee orientation checklist dated 10/11/2011 indicated, but is not limited to; infection control and universal precautions as being completed and a "INFECTION PREVENTION AND CONTROL-ALL STAFF REVIEW" post-test was given. On 12/07/2011 at 2:45 p.m., review of the "INFECTION CONTROL POLICY 483.65 indicated, but is not limited to; "Infection control. The facility has established and maintains an infection		quality assurance program will be put into place?Director of Nursing/Designee will audit for proper infection control	

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	control program designed to provide a safe, sanitary, and comfortable environment. The infection control program is designed to help prevent development and transmission of disease and infections" On 12/07/2011 at 3:30 p.m., review of the facility's infection control manual on handwashing and when personnel should always wash their hands the policy indicated, but is not limited to; under bullet 7 " + after touching inanimate [not living] sources that are likely to be contaminated with virulent [highly infective] or epidemiologically [causes of disease] important microorganisms"			