PRINTED: 10/04/2023
FORM APPROVED

-	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155802	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/21/2023
	PROVIDER OR SUPPLIE		1 SISTE	ADDRESS, CITY, STATE, ZIP COD ERS OF PROVIDENCE RY OF THE WOODS, IN 47876	3
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	I	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 0000					
Bldg. 00	This visit was for t IN00415330 and II	he Investigation of Complaints N00415942.	F 0000		
	_	5330 - Federal deficiencies ations are cited at F622, F626,			
	-	5942 - Federal deficiencies ations are cited at F622, F626,			
	Survey dates: Aug	ust 17, 18, and 21, 2023			
	Facility number: 00 Provider number: 1 AIM number: 2004	155802			
	Census Bed Type: SNF/NF: 58 Total: 58				
	Census Payor Type Medicare: 13 Medicaid: 30 Other: 15 Total: 58	e:			
	These defieciences accordance with 41	reflect State Findings cited in 10 IAC 16.2-3.1.			
	Quality review cor	npleted on August 31, 2023.			
F 0622 SS=D Bldg. 00	§483.15(c) Trans §483.15(c)(1) Fac	(2)(i)-(iii) charge Requirements fer and discharge- cility requirements- st permit each resident to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Mandy Lynch Administrator 09/30/2023

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UDU611 Facility ID: 003624 If continuation sheet Page 1 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155802		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/21/2023	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
PROVIDE	ENCE HEALTH CA	RE CENTER		ERS OF PROVIDENCE RY OF THE WOODS, IN 4787	76
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
		ity, and not transfer or dent from the facility			
	unless-	dent from the facility			
		r discharge is necessary for			
		are and the resident's			
	needs cannot be r				
	(B) The transfer o	r discharge is appropriate			
	because the resid	ent's health has improved			
	•	resident no longer needs			
	the services provide	-			
		ndividuals in the facility is			
	_	o the clinical or behavioral			
	status of the resid	ent, individuals in the facility			
	would otherwise b	_			
		as failed, after reasonable			
	, ,	otice, to pay for (or to have			
		are or Medicaid) a stay at			
	·	yment applies if the			
	resident does not	submit the necessary			
	paperwork for third	d party payment or after the			
		ng Medicare or Medicaid,			
		and the resident refuses to			
		stay. For a resident who			
	_	or Medicaid after admission			
	· ·	cility may charge a resident arges under Medicaid; or			
	(F) The facility cea	_			
		y not transfer or discharge			
		the appeal is pending,			
		.230 of this chapter, when a			
		his or her right to appeal a			
	transfer or dischar	ge notice from the facility			
		.220(a)(3) of this chapter,			
		to discharge or transfer			
	•	ne health or safety of the			
		ndividuals in the facility.			
	_	locument the danger that			
	ialiure to transfer (or discharge would pose.			
			I	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611 Facility ID: 003624

If continuation sheet

Page 2 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155802		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/21/2023	
	PROVIDER OR SUPPLIEF		1 SIST	ADDRESS, CITY, STATE, ZIP COD ERS OF PROVIDENCE RY OF THE WOODS, IN 4787	6
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	§483.15(c)(2) Doo When the facility to resident under any specified in parage of this section, the the transfer or dist the resident's media information is combealth care institut (i) Documentation record must include (A) The basis for to (c)(1)(i) of this section, the specificannot be met, fact resident needs, and the receiving facility (ii) The documentation (c)(2)(i) of this section, the specificannot be met, fact resident needs, and the receiving facility (iii) The documentation (c)(2)(i) of this section. (juii) A physician who necessary under provider must including this section. (iii) Information proprovider must including (A) Contact inform responsible for the (B) Resident representation (C) Advance Direct (C) Advance Direct (D) All special instongoing care, as a (E) Comprehensive (F) All other neces a copy of the resident representation of the resi	cumentation. ransfers or discharges a y of the circumstances raphs (c)(1)(i)(A) through (F) e facility must ensure that charge is documented in dical record and appropriate emunicated to the receiving tion or provider. in the resident's medical de: the transfer per paragraph etion. paragraph (c)(1)(i)(A) of this fic resident need(s) that cility attempts to meet the find the service available at ty to meet the need(s). action required by paragraph etion must be made by- physician when transfer or essary under paragraph (c) dis section; and finen transfer or discharge is coaragraph (c)(1)(i)(C) or (D) discovided to the receiving under a minimum of the fination of the practitioner fine care of the resident. essentative information formation civic information formations or precautions for			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611 Facility ID: 003624

If continuation sheet Page 3 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/21/2023 155802 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1 SISTERS OF PROVIDENCE PROVIDENCE HEALTH CARE CENTER ST MARY OF THE WOODS. IN 47876 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and any other documentation, as applicable, to ensure a safe and effective transition of Based on interview and record review, the facility F 0622 08/30/2023 The facility disagrees with the failed to honor a resident's request to be deficiency cited below. This transferred to the hospital related to increased individual was not involuntarily pain of a right femur fracture and without her discharged or transferred. The signing a document saying the transfer was resident's attending physician was against medical advice (AMA) and without being not willing to provide an order for informed her AMA transfer may result in the the transfer to the hospital facility not allowing her to return for 1 of 3 because he believed the risks of residents reviewed for transfer and discharge sending the resident for treatment (Resident B). of an old fracture that was already healing outweighed the benefits of Findings include: treatment and would not increase the resident's quality of life. Even During a confidential phone interview, on 8/17/23 though the hospital treated the at 8:55 a.m., Resident B's friend indicated she had fracture it did not improve the visited the resident on 8/15/23 at the facility. The resident's ability to bear weight resident informed her friend that she had a due to paralyzed lower fractured right femur. She was unable to explain extremities. how the fracture happened. The friend indicated The resident voluntarily left the the facility had always called her with any facility against medical advice condition changes until this one. She was not (AMA) and signed an notified of the fracture. She observed the acknowledgment that included our resident's external rotation to her right leg during AMA policy, which states that this visit. The friend indicated the rotation had residents who leave AMA may not never been noted before. The friend had just been be allowed to return. When the in the facility at the end of July 2023, and it was hospital was ready to discharge not seen at that time. the resident, the resident's prior attending physician would not During an interview, on 8/17/23 at 11:44 a.m., RN 3 provide an order for the resident to indicated she was working day shift on the day of return to the facility, hence we 7/30/23 and she noticed Resident B's right foot could not readmit the resident was rotated out. She had never noticed it before. without orders from a physician. She forgot to notify the oncoming night shift At the time the fracture was nurse, nor did she document any of her findings discovered, we also notified the in the resident's medical record. She didn't notice resident's sister, who was the any swelling or redness at that time. She resident's designated messaged the night shift nurse at approximately representative at that time. We

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611

Facility ID: 003624

If continuation sheet

Page 4 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/21/2023 155802 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1 SISTERS OF PROVIDENCE PROVIDENCE HEALTH CARE CENTER ST MARY OF THE WOODS. IN 47876 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 3:00 a.m. via text message about the resident's explained that the attending foot. The record lacked documentation related to physician and orthopedic the potential injury by the nurse. specialist wanted to wait for further X-ray results in the coming weeks. During an interview, on 8/17/23 at 2:45 p.m., The resident representative and Resident B indicated she had increased pain in her the patient agreed to that plan of right leg related to a fracture and she wanted to be care and did not want to seek transferred to the hospital for further assistance. treatment at the hospital. Notwithstanding, it is the policy of During an interview, on 8/17/23 at 3:00 p.m., the PHC to ensure residents' transfers Administrator indicated Resident B was going to will be conducted in accordance be sent out to the hospital against medical advice with resident rights, and (AMA) because it was her request to be sent out physician's orders, and in such a to the hospital. She indicated the Medical Director manner as to maintain continuity did not feel her transfer was medically necessary. of care of the resident. Corrective Action Taken Related During an interview, on 8/18/23 at 3:15 p.m., the to this Finding: Administrator indicated staff understood Resident The resident was discharged to B was requesting and had the right to be seen in the hospital per her request. the emergency room due to pain and wanting a Other residents with Potential to second opinion of her fracture, but the Medical be Affected by this Finding will be Director said it was not necessary, the facility had Identified by: her sign an against medical advice (AMA) form. No other resident was affected. Having the resident sign the AMA did not Measures and Systemic indicate the facility would not take her back. Her Changes put into place to assure return would depend on rather the Medical deficient practices do not recur are Director wanted to continue caring for her. as follows: All nursing Staff were educated at Resident B's record was reviewed on 8/17/23 at mandatory in-service on 8-29 and 10:50 a.m. The profile indicated the resident's 8-30-23 regarding the transfer and diagnoses included, but were not limited to, discharge policy. All transfers and quadriplegia (paralysis of all four limbs), discharges will be authorized by respiratory failure unspecified with hypoxia the Administrator or Director of (happens when you don't have enough oxygen in Nursing. your blood, and epilepsy (a disorder in which Corrective Actions will be nerve cell activity in the brain is disturbed causing Monitored to Ensure Compliance seizures). The resident required a mechanical ventilator (type of breathing apparatus that DON/designee will audit resident provides mechanical ventilation by moving transfers/discharges to ensure breathable air into and out of the lungs). proper paperwork is

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE SURVE	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155802	B. W	'ING		08/21/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			ERS OF PROVIDENCE		
PROVIDE	ENCE HEALTH CA	RE CENTER			RY OF THE WOODS, IN 47876		
			<u> </u>		<u> </u>	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		PLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	-	TAG			DATE
	D ' CM I' '	· Alitical Doll			completed. Conducting audits		
		ion Administration Record			per week times 4 weeks, then		
		n the month of August 2023,			per week x 4 weeks, then 2 x	per	
		nplained of pain at a scale of 5 7 days reviewed and required			week x 4 weeks, then 1 x per week x 3 months. The outcom	o of	
	-	ication to be administered in			the audit will be reviewed at the		
	-	lent's routine pain medication.					
	addition to the resid	iem s routine pain inedication.			Quality Assurance meetings to determine if any additional act		
	Review of hed hold	policy, dated 8/17/23,			is warranted. Providence Hea		
		en a bed hold policy and			Care will review, update, and		
	_	nt was being transferred to the			changes to this plan of correct		
		arked as a transfer or discharge			as needed for sustaining	1011	
	was necessary to meet the resident's welfare and				compliance for no less than si	, l	
	the resident's needs cannot be met in the facility.				months.	`	
	 1001401110 110040				monare.		
	Review of transfer	or discharge request for					
		ated Resident B's name on the					
	_	date and no resident					
	representative signa						
	-						
	Review of an orthor	pedic note, dated 8/18/23 at					
	2:54 p.m., the Ortho	opedic doctor indicated he had					
	reviewed an x-ray t	hat was completed on 8/1/23.					
	The x-ray indicated	Resident B had a					
	non-displaced, suba	cute (a condition between					
	acute and chronic) t	to chronic (long term)					
		nanteric hip fracture with					
	evidence of healing	. The orthopedic doctor					
		nued non-operative treatment					
	_	ent was not having significant					
	_	ting transfers and positioning.					
		esident had transferred to a					
	local hospital per pa	atient request.					
		pital records included a					
	-	ography (CT) of the low right					
		hospital, dated 8/17/23. The CT					
		B had a subacute to chronic					
		uted (a bone that is broken in					
	at least 2 places) rig	tht femur intertrochanteric					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611 Facility ID: 003624

If continuation sheet Page 6 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155802		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/21/2023		
	ROVIDER OR SUPPLIEF			1 SISTE	DDRESS, CITY, STATE, ZIP COD ERS OF PROVIDENCE BY OF THE WOODS, IN 47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	A hospital note incl consultation note, d consulted due to Re orthopedic doctor a resident had a subac proximal (situated r the point of attachm old. The physician pure the operating room (used to treat proximal fracture fixation (stroken bones by resident B had a prunstable fracture of operation was an opfixation (put pieces using surgery) of the 120-degree Stryker interlocking (metall of traumatic long be splint.	duded an Orthopedic physician lated 8/18/23. They were esident B's fracture. The the hospital indicated the cute fracture to the right nearer the center of the body or nent) femur, likely 2 to 6 weeks planned to take Resident B to on 8/19/23 for a gamma nail mal femoral fractures) and abilize extremely misaligned esetting). The note, dated 8/19/23, indicated reoperative diagnosis of an of the right proximal femur. The pen reduction and internal of a broken bone into place the right proximal femur with gamma nail with proximal distallic implants used for the repair one fractures) and a long leg					
	the Case Manager f resident wanted tran second opinion on h resident's injury did	from the hospital indicated the insferred to the hospital for a ner fractured leg. The require surgical intervention hospital. Her surgery was					
	Cross reference F62	26 and F684.					
	provided a document 1/15/23, titled, "Tra	p.m., the Administrator nt, with a revised date of unsfer and Discharge," and policy currently being used					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $UDU611 \qquad {\tt Facility \, ID:} \quad 003624$

If continuation sheet

Page 7 of 20

PRINTED: 10/04/2023 FORM APPROVED

ENTERS FOR MEDICARE & MEDICAID SERVICES							IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO ЛLDING	INSTRUCTION 00	(X3) DATE COMPI	
		155802	B. W	ING		08/21	/2023
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ERS OF PROVIDENCE		
PROVIDI	ENCE HEALTH CA	RE CENTER			RY OF THE WOODS, IN 4787	6	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION DATE
ino		policy indicated, "2. Resident		mo			DATE
	I .	tative(s), if known have the					
		in decisions regarding					
		ge and to request or agree to					
		e facility or to another facility					
	or home 5. The state mandated notice must be						
	given to the resident or resident representative at least 30 days before the transfer or discharge14.						
	In the event of an emergency transfer, the state						
	form shall be sent with the resident to the hospital						
	for a resident review	w as soon as possible and					
	provided to other re	equired individuals"					
	This Federal tag rel and IN00415942.	ates to Complaints IN00415330					
	3.1-12(a)(6)(B)						
F 0626 SS=D Bldg. 00	483.15(e)(1)(2) Permitting Reside §483.15(e)(1) Per facility. A facility must est policy on permittir facility after they a on therapeutic lead for the following. (i) A resident, who therapeutic leave period under the Stacility to their pre immediately upon in a semi-private r (A) Requires the stacility; and (B) Is eligible for Macility services or nursing facility serial.						

FORM CMS-2567(02-99) Previous Versions Obsolete

resident who was transferred with an

Event ID:

UDU611

Facility ID: 003624

If continuation sheet

Page 8 of 20

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155802	B. WI	NG		08/21	/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ERS OF PROVIDENCE		
PROVIDI	ENCE HEALTH CA	RE CENTER			RY OF THE WOODS, IN 47876		
TITOVIDI	·	- CENTER		01 1017 (1	THE WOODS, 114 47070		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	urning to the facility, cannot					
		ty, the facility must comply					
	-	ents of paragraph (c) as					
	they apply to disc	harges.					
	- ' ' ' '	admission to a composite					
		en the facility to which a					
	resident returns is a composite distinct part (as defined in § 483.5), the resident must be						
	-	n to an available bed in the					
	particular location of the composite distinct						
	part in which he or she resided previously. If a						
	bed is not available in that location at the time of return, the resident must be given the						
		-					
	availability of a be	that location upon the first					
	1	and record review, the facility	F 06	526	It is the policy of PHC to ensu	ro	08/30/2023
		esident back from the hospital	1 00	020	residents' transfers will be	16	06/30/2023
	_	ischarge notice for 1 of 3			conducted in accordance with		
	_	for transfer and discharge			resident rights, and physician'		
	(Resident B).	for transfer and discharge			orders, and in such a manner		
	(resident 2).				to maintain continuity of care		
	Findings include:				the resident.	5 1	
	8				Corrective Action Taken Relat	ed to	
	During an interview	v, on 8/17/23 at 2:45 p.m.,			this Finding:		
	_	ed she had increased pain in her			For any facility-initiated		
		a fracture and she wanted to be			transfers/discharges, resident	s will	
	transferred to the h	ospital for further assistance.			be permitted to return to the		
					facility.		
	Cross reference F62	22 and F684.			Other residents with Potentia	l to_	
					be Affected by this Finding wil	l be_	
	_	v, on 8/17/23 at 3:00 p.m., the			Identified by:		
	Administrator indicated Resident B was going to				No other resident was affecte	d.	
	be sent out to the hospital against medical advice				Measures and Systemic Char	<u>iges</u>	
	(AMA) because it was her request to be sent out.				put into place to assure deficie	<u>ent</u>	
		tor did not feel her transfer was			practices do not recur are as		1
	medically necessary.				follows:		
					All nursing Staff were educate		
		v, on 8/17/23 at 4:05 p.m.,			mandatory in-service on 8-29		
	Resident B's emerg	ency contact individual			8-30-23 regarding the transfer	· and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG	00	COMPLETED 08/21/2023	
		155802	B. WING			08/21/	2023
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
					RS OF PROVIDENCE		
PROVIDE	ENCE HEALTH CA	RE CENTER		WAK	Y OF THE WOODS, IN 47876		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		ot made aware of the resident	TAC	j		a.a.d	DATE
		or return to facility once			discharge policy. All transfers discharges will be authorized by		
	_	•			the Administrator or Director o	-	
	discharged from the hospital by any facility personnel when the resident was sent to the				Nursing.		
	hospital per the resident's request.				Corrective Actions will be		
					Monitored to Ensure Complian	nce	
	During an interview, on 8/18/23 at 3:15 p.m., the				by:	_	
	Administrator indicated staff understood Resident				DON/designee will audit reside	ent	
		nd had the right to be seen in			transfers/discharges to ensure	;	
		n due to pain. Having the			proper paperwork is		
	resident sign the AMA did not indicate the				completed. Conducting audits		
	facility would not take her back. Her return would				per week times 4 weeks, then		
	depend on if the medical director wanted to continue caring for her.				per week x 4 weeks, then 2 x p	per	
	continue caring for	ner.			week x 4 weeks, then 1 x per week x 3 months. The outcom	o of	
	Resident R's record	was reviewed on 8/17/23 at			the audit will be reviewed at th		
		file indicated the resident's			Quality Assurance meetings to		
	-	but were not limited to,			determine if any additional act		
	-	ysis of all four limbs),			is warranted. Providence Heal		
		inspecified with hypoxia			Care will review, update, and r		
		don't have enough oxygen in			changes to this plan of correct		
		lepsy (a disorder in which			as needed for sustaining		
		n the brain is disturbed causing			compliance for no less than six	x	
		ent required a mechanical			months.		
	ventilator (type of b	oreathing apparatus that					
	provides mechanica	al ventilation by moving					
	breathable air into a	and out of the lungs).					
		port completed on 8/1/23 at 4:55					
		icated Resident B had an "old					
	or nearing" intertroo	chanteric right femoral fracture.					
	Review of hed hold	policy, dated 8/17/23,					
		en a bed hold policy and					
	_	nt was being transferred to the					
		arked as a transfer or discharge					
	_	eet the resident's welfare and					
		cannot be met in the facility.					
		-					
	Review of transfer	or discharge request for					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155802		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/21/2023	
	PROVIDER OR SUPPLIEF		1 SIST	ADDRESS, CITY, STATE, ZIP COD ERS OF PROVIDENCE RY OF THE WOODS, IN 47876	3
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL U.S.C. IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	REGULATORY OF hearing form, indicate form, there was no representative signate. Review of case man hospital, dated 8/18 Case Manager spok long-term care facil B had signed an AM emergency room for Administrator indicate not feel as though the hospital and her facility. The Administrator case Manager with resident could return discharge. Review of physician at 7:01 p.m., the Morpatient was transfer medical advice. Give resident's non-compute to the During an interview Administrator indicate the resident wanted she "wasn't happy here wasn't happy here was not case the side of the control of the resident wanted she "wasn't happy here wasn't happy here.	CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION ated Resident B's name on the date and no resident ature on the form. Inagement note from the /23 at 4:35 p.m., indicated the e with Administrator from the ity and she indicated Resident // A form to come to the revaluation and treatment. The ated the Medical Director did not patient needed to come to needs could be met at the istrator did not provide the an answer on rather the into the facility post In progress note, dated 8/18/23 edical Director indicated the red to the hospital against ven the facility policy and the oliant behavior, the Medical was necessary to deny		(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
	the Case manager fi Administrator from denied Resident B's facility from the ho indicated she was n	erview, on 8/22/23 at 9:45 a.m., from the hospital indicated the the long-term care facility had re-admittance back to the spital. The case manager of provided a 30-day on the facility for the resident.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611 Facility ID: 003624

If continuation sheet

Page 11 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155802	ì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/21 /	ETED
	PROVIDER OR SUPPLIER			1 SISTE	DDRESS, CITY, STATE, ZIP COD ERS OF PROVIDENCE RY OF THE WOODS, IN 47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	signing an AMA for to the facility. The resident or a semanager indicated hintervention while surgery was perform. On 8/18/23 at 1:15 document, with a result of the policy currently. The policy indicated representative(s), if participate in decision discharge and to recein the facility or to a The state mandated resident or resident before the transfer coff an emergency transent with the resident.	p.m., the ADM provided a vised date of 1/15/23, titled, harge," and indicated it was being used by the facility. d,"2. Resident or resident known have the right to ons regarding transfers or quest or agree to transfers with another facility or home 5. notice must be given to the representative at least 30 days or discharge14. In the event unsfer, the state form shall be not to the hospital for a resident possible and provided to other					
	and IN00415942.	ates to Complaints IN00415330					
F 0684 SS=D Bldg. 00	applies to all treatifacility residents. Ecomprehensive as facility must ensur treatment and care	a fundamental principle that ment and care provided to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611 Facility ID: 003624

If continuation sheet Page 12 of 20

PRINTED: 10/04/2023 FORM APPROVED

CENTERS FOI	ENTERS FOR MEDICARE & MEDICAID SERVICES						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155802		ILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/21/	ETED
	PROVIDER OR SUPPLIEI			1 SISTI	ADDRESS, CITY, STATE, ZIP COD ERS OF PROVIDENCE RY OF THE WOODS, IN 47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	comprehensive per and the residents' Based on interview failed to assess and new injury, failed to orders and treatment timely on an extern resulting in the delar reviewed for quality. Findings include: During a confident at 8:55 a.m., Resident visited the resident resident resident informed by fractured right femphow the fracture has the facility had alword condition changes an ontified of the fract resident's external in this visit. The friender been noted by in the facility at the not seen at that time. During an interview indicated she was well in the resident's meany swelling or red messaged the night.	erson-centered care plan, choices. and record review, the facility document a baseline for a coreport an unknown injury for int, and failed to follow up all rotation of the right leg may of care for 1 of 3 residents by of care (Resident B). The friend indicated she had on 8/15/23 at the facility. The mater friend that she had a cur. She was unable to explain pened. The friend indicated and any called her with any until this one. She was not the true of the friend had just been are end of July 2023, and it was be end of July 2023, and it was end of July 2023,	F 06		It is the policy of PHC to ensure residents receive comprehens assessment and appropriate treatment timely. Corrective Action Taken Related to this Findings: On 8-29-23, the IDT consisting Director of Nursing, Unit Managers, Director of Quality, Social Services, and therapy reviewed all orders and treatments. Other residents with Potential be Affected by this Finding will Identified by: On 8-29-23, the IDT reviewed residents' care plans to ensure timely physician notification ar follow-up of any change in condition. Measures and Systemic Changes put into place to assideficient practices do not recuras follows: All nursing Staff were educated mandatory in-service on 8-29-8-30-23 regarding the resident assessment policy and change condition policy, as well as education on proper documentation of notification of appropriate personnel and prodocumentation of change of condition.	ted_ g of, to_ l be_ all and ure_ r are_ ed at and te of	08/30/2023
	3:00 a.m. via text n	nessage about the resident's			Corrective Actions will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

foot. The record lacked documentation related to

the potential injury by the nurse.

Event ID:

UDU611

Facility ID: 003624

If continuation sheet

Monitored to Ensure Compliance

The Director of Nursing, or her

Page 13 of 20

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155802	B. W	ING		08/21/	/2023
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ERS OF PROVIDENCE		
DBU/\IDI	ENCE HEALTH CA	DE CENTED			RY OF THE WOODS, IN 47876		
FROVIDI	LINGE ITEALITICA	IL CENTER		OT WAR			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		sage, dated 7/31/23 at 3:28 a.m.,			designee, will be conducting		
		essage to the night shift nurse			audits 5x per week times 4		
	and indicated she forgot to mention to her about				weeks, then 3 x per week x 4		
	Resident B's right lower extremity was turned				weeks, then 2 x per week x 4		
	outward and should probably have an x-ray. The				weeks, then 1 x per week x 3		
	nurse receiving the text message responded she				months. The outcome of the a	udit	
	had noticed it as well and would notify the Unit				will be reviewed at the Quality		
		ronic medical record lacked			Assurance meetings to detern	nine	
		documentation of the nurses'			if any additional action is		
	findings.				warranted. Providence Health		
					will review, update, and make		
		erview, on 8/18/23 at 11:45 a.m.,			changes to this plan of correct	tion	
		or indicated he was notified on			as needed for sustaining		
		al rotation to Resident B's right			compliance for no less than si	X	
	_	aking rounds at the facility. A			months.		
		completed on 8/1/23 and the					
		as notified of the results on					
		d an orthopedic doctor					
		results. The orthopedic doctor					
		mine the age of the fracture					
	•	ages were not clear due to them					
		ble machine. The orthopedic					
		medical director to obtain					
		e week. The orthopedic doctor					
		r leg as stable as possible					
		repositioning and no					
		sfers. The Medical Director					
		nt's increased pain could be					
		id medications that she					
	already took routine	ery for pain.					
	Dumin a. a.: : '	on 9/19/22 at 12,22 II!					
		v, on 8/18/23 at 12:32 p.m., Unit					
	_	d she was told about					
		al rotation on Monday, 7/31/23					
	1 -	Manager spoke with the					
		n Tuesday 8/1/23 when he was					
		ng his rounds. She indicated the					
	_	aced an order for the resident					
	_	ray done on the right femur.					
	i i ne Medical Direct	or was not notified of the	1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611 Facility ID: 003624

If continuation sheet Page 14 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X2)			X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>00</u> COM			ETED			
		155802	B. W	B. WING			08/21/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF PROVIDER OR SUPPLIER									
PROVIDENCE HEALTH CARE CENTER				1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876					
TROVIDI	LINGE HEALTH OF	THE CENTER		OT WA	(1 01 111E WOODS, IN 47878				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		e day that staff notified the							
		indicated the x-ray was							
		as ordered but she did not get							
		ne computer system until							
		ed she had missed a day of							
		d she obtained the results when							
		ork on 8/4/23. The Unit							
		not all nursing staff had							
	access to pull the r	eport from the system.							
	D 11 . DI								
		d was reviewed on 8/17/23 at							
	_	file indicated the resident's							
	-	l, but were not limited to,							
		ysis of all four limbs),							
		unspecified with hypoxia							
	(happens when you don't have enough oxygen in								
	your blood, and epilepsy (a disorder in which								
	nerve cell activity in the brain is disturbed causing								
		dent required a mechanical							
		breathing apparatus that							
	provides mechanical ventilation by moving breathable air into and out of the lungs).								
	Review of Medication Administration Record								
		in the month of August 2023,							
		mplained of pain at a scale of 5							
		17 days reviewed and required							
	-	dication to be administered in							
	_	dent's routine pain medication.							
	dudition to the resi	dent's routine pain incarcation.							
	Review of shower	sheet, dated 7/28/23, indicated							
		ven a bed bath and external							
	rotation was not no								
	l	J							
	Review of shower	sheet, dated 7/31/23, indicated							
	Resident B was given a shower at 11:53 a.m. The								
	_	d any documentation of the							
		eing noted by staff. Resident B							
		mechanical lift for her shower							
	_	Director of Nursing (DON).							
	1 - 1		1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $UDU611 \qquad {\tt Facility \, ID:} \quad 003624$

If continuation sheet Page 15 of 20

CIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/21/2023			
	1 SISTI	STREET ADDRESS, CITY, STATE, ZIP COD 1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876					
FICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE			
as note, dated 8/1/23 at 1:40 p.m., sident B's right lower extremity was ard, Medical Director notified, and beived for x-ray. Tay report, completed on 8/1/23 at 3:40 per indicated Resident B had an "old attertrochanteric (fractures of the nur that occur between the greater and inter) right femoral fracture. Taked a care plan for a fractured femur perigin after diagnosis of x-ray. Taked any assessment documentation are in the electronic medical record to 8/18/23. Taked documentation physical per occupational therapy were assess for positioning or transferring elated to fracture. Tas note, created on 8/7/23 at 10:57 reffective date of 8/4/23, indicated ar 5 spoke with resident about her x-ray. Resident B was unaware of ure could have happened. The eled any falls or rough turning and/or aff. Tas note, created on 8/7/23 at 11:50 reffective date of 8/4/23, indicated ar 5 paged the orthopedic doctor sident B's x-ray of her right femur. The could be resident did did not resident							
TON THE TRANSPORT OF TH	IDENTIFICATION NUMBER 155802 TH CARE CENTER IMARY STATEMENT OF DEFICIENCIE EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION The sident B's right lower extremity was ard, Medical Director notified, and ceived for x-ray. The ray report, completed on 8/1/23 at 3:40 fort indicated Resident B had an "old intertrochanteric (fractures of the nur that occur between the greater and inter) right femoral fracture. The ray report, are plan for a fractured femur origin after diagnosis of x-ray. The received are plan for a fractured femur origin after diagnosis of x-ray. The received are plan for a fractured femur origin after diagnosis of x-ray. The received are of 8/18/23. The received documentation physical for occupational therapy were assess for positioning or transferring related to fracture. The reflective date of 8/4/23, indicated for 5 spoke with resident about her for x-ray. Resident B was unaware of ture could have happened. The field any falls or rough turning and/or aff. The reflective date of 8/4/23, indicated for 5 paged the orthopedic doctor indicated the resident did for	TIPPLIER TH CARE CENTER TH C	INTERMEDIAL STATEMENT OF DEFICIENCIE INTERMEDIAL STATEMENT OF DEFICIENCY INTERMEDIAL STATEMENT OF DEFICIENCY INTERMEDIAL STATEMENT OF THE WOODS, INTERMEDIAL STATEMEN	DENTIFICATION NUMBER 158802 STREET ADDRESS, CITY, STATE, ZIP COD 1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876 STREET ADDRESS, CITY, STATE, ZIP COD 1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876 IMARY STATEMENT OF DEFICIENCIE EFFCIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION us note, dated 8/1/23 at 1:40 p.m., sident B's right lower extremity was ard, Medical Director notified, and ceived for x-ray. asked a care plan for a fractured femurorigin after diagnosis of x-ray. asked a care plan for a fractured femurorigin after diagnosis of x-ray. asked a care plan for a fractured femurorigin after diagnosis of x-ray. asked a care plan for a fractured femurorigin after diagnosis of x-ray. asked a coupational therapy were assess for positioning or transferring related to fracture. us note, created on 8/7/23 at 10:57 or ffective date of 8/4/23, indicated ar 5 spoke with resident about her x-ray. Resident B was unaware of ture could have happened. The ed any falls or rough turning and/or aff. us note, created on 8/7/23 at 11:50 or effective date of 8/4/23, indicated ar 5 paged the orthopedic doctor sident Bx x-ray of her right femur. dic doctor indicated the resident did urgery and did not need to be sent to			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611

Facility ID: 003624

If continuation sheet

Page 16 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155802		A. BUILDING <u>00</u> B. WING		COMPLETED 08/21/2023	
199002			B. W.	_		08/21	12023
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
PROVIDE	ENCE HEALTH CA	RE CENTER			ERS OF PROVIDENCE RY OF THE WOODS, IN 47870	5 	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e, created on 8/16/23 at 11:31 tive date of 8/11/23, indicated					
		lled the orthopedic doctor's					
	-	Resident B needed to be seen in					
		opedic doctor denied the					
		in his office but would like a					
	repeat x-ray in one						
	A health status note	e, dated 8/17/23 at 3:02 p.m.,					
		ed nurse called the orthopedic					
		ee if he had received the follow					
	up x-ray performed	l on 8/15/23 for Resident B. The					
	nurse at the doctor's office confirmed that they						
	had received but the doctor had not yet reviewed						
	the x-ray.						
	A health status note, dated 8/17/23 at 3:20 p.m.,						
	indicated RN 3 spo	ke with Resident B in her room.					
	Resident B request	ed to go to the hospital for a					
	-	ner right femur fracture					
		a "lot of pain" and wanted to					
	-	d the resident with Ibuprofen					
		medication) 600 mg (milligram)					
	0.5mg by mouth fo	ax (anti-anxiety medication)					
	o.5mg by mount to	i comiuit.					
	A health status not	e, dated 8/17/23 at 4:00 p.m.,					
		B was transported to the					
	hospital via ambula	ance for evaluation per family					
	request.						
	During an interview, on 8/18/23 at 12:58 p.m., the Administrator indicated Resident B had been interviewed by staff to determine a cause for her fracture. Resident B was unable to recall anything out of the ordinary happening. The Administrator						
		g any staff regarding the root					
		e. It was the nurse's judgement					
	on when they should notify the doctor. The						
external rotation on Resident B's leg was not							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UDU611 Facility

Facility ID: 003624

If continuation sheet

Page 17 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155802		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/21/2023						
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION of by the stoff	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION			
	the Wound doctor in facility on 7/27/23 a rotation to the right Review of an orthop 2:54 p.m., the Orthoreviewed an x-ray to the x-ray indicated non-displaced, subal acute and chronic) to appearing intertrock evidence of healing recommended control as long as the reside pain and was toleral. He was aware the relocal hospital per particular to chronic bone that is broken intertrochanteric frame Review of a consult Orthopedic physicial Resident B's fracture to the right center of the body of femur, likely 2 to 6 planned to take Reson 8/19/23 for a gar femoral fractures) a extremely misaligned.	erview, on 8/18/23 at 1:15 p.m., andicated he was last at the and had not noticed an external lower extremity. Deedic note, dated 8/18/23 at opedic doctor indicated he had hat was completed on 8/1/23. Resident B had a necute (a condition between to chronic (long term) nanteric hip fracture with the orthopedic doctor nued non-operative treatment tent was not having significant tent transfers and positioning. The properties of the low right request. Desident had transferred to a natient request.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $UDU611 \qquad {\tt Facility \, ID:} \quad 003624$

If continuation sheet

Page 18 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED		
155802		B. W	B. WING			08/21/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER								
PROVIDENCE HEALTH CARE CENTER				1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876				
TROVIDE		THE CENTER		OT WA	(1 OF THE WOODS, IN 47070			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	eoperative diagnosis of an						
		the right proximal femur. The						
	-	en reduction and internal						
		of a broken bone into place						
		e right proximal femur with						
		gamma nail with proximal distal						
		ic implants used for the repair						
	_	one fractures) and a long leg						
	splint.							
		a.m., the Administrator						
	_	d document, titled, "Guidelines						
	-	cation for Change in Condition						
		icated it was the policy						
	currently being used by the facility. The policy							
	indicated, "1. All significant changes in resident							
	status are thoroughly assessed and physician							
	notification is based on assessment findings and							
		ed int eh medication record2.						
	_	ems are communicated to the						
		in a timely manner, concise,						
	and thorough manner"							
	0 0/10/22 4 0 52	4 1 1 1 1 1 1						
		a.m., the Administrator						
	-	nt dated 2/23/22, titled, sident Change in Condition,"						
		the policy currently being						
		The policy indicated. "1. A immediately inform the						
	resident, consult with the resident's physician, and the resident's representative when:b. A							
		-						
	significant change in the resident's physical, mental, or psychosocial status"							
	mental, or psychoso	ociai siatus						
	On 8/18/23 at 1.15.	p.m., the Administrator						
		d document, titled, "Resident						
	*	ndicated it was the policy						
		d by the facility. The policy						
		se: To gather comprehensive						
	-							
	information as a basis for the identifying resident							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $UDU611 \qquad {\tt Facility \, ID:} \quad 003624$

If continuation sheet Page 19 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155802	B. WI	NG		08/21/	/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	problems/needs and developing or revising an individual plan of care 3. Other assessment monitoring shall be initiated and recorded on facility approved forms or in conjunction with the resident's clinical condition, assessed need and planned interventions4. Other clinical assessments will be performed in conjunction with body systems, with specific problems/complaints" This Federal tag relates to Complaints IN00415330 and IN00415942.						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UDU611 Facility ID: 003624 If continuation sheet Page 20 of 20