STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESENCE SACRED HEART HOME	**515 N MAIN ST AVILLA, IN 46710**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure 1 of 1 resident (Resident 43) who had a [DIAGNOSES REDACTED]. Findings include: On 3/9/20 at 9:01 A.M., the Clinical Record of Resident 43 was reviewed and indicated [DIAGNOSES REDACTED]. Resident 43 had resided in the facility's Assisted Living (AL). On 7/9/19 the resident was then admitted to the facility's nursing home. Notice of PASRR Level 1 Screen outcome dated 8/14/18 indicated a Level 2 PASRR was not required because the resident did not have a mental illness. On 3/10/20 at 11:07 A.M., an interview was conducted the Social Service Director (SSD) indicated the following: When Resident 43 had admitted to the facility's AL residence the director of the facility's AL had requested a Level 1 PASRR Screen but had not included the resident's [DIAGNOSES REDACTED]. The resident had discharged to another facility in 2018 and when the resident admitted to Presence Sacred Heart Nursing facility in July 2019 a PASRR Screen should had been requested. The PASARR (Pre-Admission Screening & Resident Review) policy dated 8/2017 and revised on 7/2018 was received from Director of Nursing Service on 3/10/20 at 11:15 A.M. The policy indicated, but was not limited to the following: The purpose of this policy is to outline the screening of residents with a history of serious mental illness and developmental disability. The community will not admit any new resident who is suspected of having: A serious mental illness unless: The state mental health authority determines that the physical and mental condition of the individual requires the level of services provided by the facility; The state mental health authority determines whether or not the individual requires specialized savvies for mental illness; and These determinations are based on an independent . physical and mental evaluations that is performed prior to admission. 3.1-31(f)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure care plan meetings occurred quarterly for 1 of 1 residents reviewed (Resident 27). Findings include: The clinical record for Resident 27 was reviewed on 3/3/20 at 10:03 A.M. [DIAGNOSES REDACTED]. Resident 27 was interviewed on 3/3/20 at 11:40 A.M. During the interview Resident 27 indicated he had not had a care plan meeting in a long time. There was no documentation to indicate Resident 27 had a care plan meeting from 4/19/19 to 12/19/19. The Social Service Director (SSD) was interviewed on 3/6/20 at 11:16 A.M. During the interview the SSD indicated care plan meetings should occur quarterly. She also indicated Resident 27 did not have a quarterly care plan meeting between 4/19/19 to 12/19/20 and he should have. A policy, dated 7/2018, was provided by the SSD on 3/6/20 at 12:06 P.M., titled Care Planning- Interdisciplinary Team. The policy indicated .C. The resident and the resident representative are encouraged to participate in the development of and revisions to the resident's care plan. Attendees are documented. D. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. 3.1-35(d)(2)(B)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure adaptive eating utensils were provided for 1 of 2 observations of Residents needing adaptive equipment. (Resident 9) Findigns include: 1. During observation of lunch on 3/4/2020 at 12:00 P.M., Resident 9 was observed feeding self with regular silverware. During observation of breakfast on 3/9/2020 at 9:09 A.M., Resident 9 was observed attempting to feed herself with regular silverware. The record of Resident 9 was reviewed on 03/03/20 at 2:32 P.M. [DIAGNOSES REDACTED]. The record contained an order for [REDACTED]. The Care Plan dated as last reviewed on 2/6/2020 indicated need for adaptive equipment at meals and the Resident fluctuated with needing feeding assistance at meals. During an interview on 3/09/20 at 12:04 P.M., the Director of Nursing Services indicated that built up foam utensils was an order 6/14/19, and the last time she served back there (on the unit) they had them on her tray. The facility policy titled Restorative Nursing-Eating/Swallowing Program, # 1, dated 12/2019 stated Procedure . C. Care plan includes, but is not limited to: . 2. Specific interventions may include, but are not limited to: . d. Use of assistive device(s) (e.g., build up utensils, scoop plates, long straws, dycem, tippee cup); 3.1-46
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure stat laboratory results were reported timely to the physician resulting in a delay in treatment for 1 of 3 residents reviewed (Resident B). Findings include: The clinical record for Resident B was reviewed on 3/9/20 at 11:21 A.M. [DIAGNOSES REDACTED]. A nursing progress note dated 2/10/20 at 7:43 A.M., indicated Resident B was not feeling well, had dark urine, a blood pressure of 90/46, a temperature of 101.0, and a pulse of 88. The Nurse Practitioner was notified of these findings and a stat BMP (basic metabolic panel) and CBC (complete blood count) were ordered. A nursing progress note dated 2/10/20 at 10:02 A.M., indicated the facility was waiting for the results of the ordered stat laboratory tests and the NP would be notified when they were available. A signed, untimed, Nurse Practitioner (NP) 9 rounding provider note dated 2/10/20, indicated Resident B was noted to have fever, chills, and a low blood pressure. A stat BMP and CBC were ordered. A lab report faxed to the facility on [DATE] at 6:05 P.M., included Resident B's stat BMP and CBC results had been received. The lab report indicated Resident B had an elevated of BUN of 30 (normal range is 7-25 mg/dL) and an elevated creatinine level of 2.5 (normal range is 0.6- 1.3 mg/dL). BUN and creatinine laboratory tests indicate kidney function. A written order dated 2/11/20 at 8:45 P.M., indicated Resident B was to receive normal saline intravenously at 100 milliliters per hour (2 liters total) for dehydration and acute kidney failure. A nursing progress note dated 2/11/20 at 10:23 P.M., indicated Nurse Practitioner 9 was notified of Resident B's lab results and a new order was received to start normal saline intravenously at 100 milliliters per hour (2 liters total). NP 9 was interviewed on 3/11/20 at 10:00 A.M. During the interview NP 9 indicated she had not been aware Resident B's stat BMP and CBC results until a nurse reported them to her on the evening of 2/11/20. She indicated she would have ordered normal saline intravenously at 100 milliliters per hour (2 liters total) when she was made aware of the results. She also indicated she would expect stat labs to be reported to her soon after they were reported to the facility. The Director of Nursing Services (DNS) was interviewed on 3/11/20 at 11:03 A.M. During the interview the DNS indicated when stat labs are ordered it is expected that the results would be reported to the Nurse Practitioner as soon as the facility received them. The BMP and CBC results should have been reported soon after the facility received them on 2/10/20 at 6:05 P.M. This deficiency is related to Complaint IN 887. 3.1-49(j)(2)

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

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F 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0809 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** Based on observation, interview, and record review, the facility failed to provide a nourishing snack between the evening meal and breakfast for 9 of 9 residents observed. Findings include: On 3/3/20, breakfast was observed to be served at 10:15 A.M. 9 residents were in the E section dining room to receive breakfast. On 3/3/20 at 10:44 A.M., in an interview, CNA 1 indicated supper was served at 5:30 P.M. Breakfast was served at 10:15 A.M. because the get up list was so long. On 3/3/20 at 10:48 A.M., in an interview, CNA 2 and CNA 3 indicated residents had the right to eat what they want, when they want to eat it regardless of the time. In an interview on 3/3/2020 at 11:00 A.M., the Dietary Manager (CDM) indicated the facility had been having trouble with the staff being able to get the residents up in time to eat. The facility knew it was a problem, but it was hard to keep breakfast at the appropriate time on that unit. She indicated breakfast was scheduled to be served between 7:30 A.M. and 7:45 A.M. She also indicated residents do not receive a substantial snack between the evening meal and breakfast, only light crackers and milk or juice was scheduled to be served. A Review of the POS [REDACTED]. and 7:45 A.M. Resident 47's family member indicated breakfast meals were always between 9:45 A.M. and 10 A.M. Resident 47's family member indicated he knew of no evening snacks being provided. Resident 15's family member indicated meal times are usually on time except breakfast when it seemed meals came down the hall at the discretion of the staff, sometimes 30 minutes before lunch was to be served. In an observation on 3/3/20 at 12:00 P.M., the Unit was ready to serve lunch. Lunch was served. 6 residents identified during breakfast were observed to consumed less than 50%. 3.1-21(c)