STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155720	A. BUILDING 00 B. WING	06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HOME HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00150893. This visit resulted in a partially extended survey - Immediate Jeopardy. Complaint IN00150893 - Substantiated, Federal/State deficiencies related to the allegations are cited at F224, F225, F226, and F514. Survey dates: June 17, 18, 19, and 20, 2014 Facility number: 000315 Provider number: 155720 AIM number: 100289030 Survey team: Anne Marie Crays RN Census bed type SNF/NF: 38 Total: 38 Census payor type Medicaid: 32 Other: 6 Total: 38 Sample: 5 Extended sample: 2	F000000	July 3, 2014 Ms. Jodi Meyer Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204-3003 RE: Providence HomeComplaint Survey June 17, 18, 19 and 20 of 2014 Dear Ms. Meyer; The Indiana State Department of Health visited our facilityon June 17, 18, 19 and 20 of 2014 to investigate a complaint (IN 00150893). According to the investigation the complaintwas substantiated. By submitting theenclosed material we are not admitting to the truth or accuracy of any specificfindings or allegations. We reserve theright to contest the findings or allegations as part of any proceedings andsubmit these responses pursuant to our regulatory obligations. We respectfully request our plan ofcorrection be considered our allegation of compliance effective June 30th,2014 and respectfully request a timely revisit to validate compliance due to financiallypenalties impose on the facility. If youhave any questions please feel free to contact me at the facility. Respectfully submitted, Dawn Nordhoff BSN, RN Director of Nursing **Abuse Notification and Prevention QA** **F224, F225,**	

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

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 23, 2014 by Jodi Meyer, RN		**F226** **Yes No** 1. Is the subject of abuse/neglect being discussed with all new employees as part of their orientation? 2. Is abuse information part of packets prepared for new employees' orientation? 3. Have employees signed & dated the abuse information contained in their employee packet? 4. Are employees in all departments able to respond to questions about when, what, how, and to whom to report abuse? (ask at least 3 employees from different departments and shifts) Names/Dept: 1) _____ _____ 2) _____ _____ 3) _____ _____ 1) 2) 3) 1) 2) 3) 5. Are employees able to explain how they have been trained to intervene in situations involving residents who are having behavior episodes? 6. Is there documentation in the residents' clinical records that the Administrator has been notified of allegations of abuse immediately if/when they occur? (If any noncompliance is found, detail finding below, aswell as action taken to correct.) **Date Problem Identified**	

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			Action Taken Staff Involved Auditor's Name:_____ _____ Date:_____ **Quality Assurance Tool Neglect** **DIRECTIONS: Through interview of residents and staffmembers answer the questions below. Place a "Y" for Yes or an "N" for No. Review the outcomes to determine the need for additional interventionsor action plan.** # INDICATOR # PATIENTS # COMMENTS **1 2 3 4 5 6 7 8** 1. Have you received the necessary care and services to meet your needs in a professional manner? 2. Does the staff treat you in a professional manner?	

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			3. Does the staff treat you with dignity and respect? 4. Does the staff conduct themselves in a professional manner while providing care to you? 5. Do you feel that the staff neglects you in any manner in the care they provide to you? **INDICATOR STAFF MEMBERS COMMENTS** 1 2 3 4 5 6 7 8 1. Have you observed any resident that you felt was being neglected in any manner? 2. Have you observed any staff member interacting with a resident in an unprofessional manner?	
F000224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure a staff member who was lying in bed with a resident was immediately removed from the bed, and failed to notify the Administrator immediately of the incident, resulting in the resident's psychosocial distress and allegation of	F000224	By submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any proceedings and submit	06/30/2014

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	sexual abuse, for 1 of 7 residents reviewed for abuse/neglect, in a sample of 7. (Resident A) The Immediate Jeopardy began on 5/25/14 when a staff member was observed in bed with a resident, the staff member was not removed and/or the Administrator was not notified immediately. The Administrator and Director of Nursing were notified of the Immediate Jeopardy at 4:40 P.M. on 6/18/14. The immediate jeopardy was removed on 6/20/14, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. On 6/17/14 at 10:00 A.M., the Administrator provided an "Indiana State Department of Health" Incident Report Form regarding Resident A. The report included: "Initial Report, Date: 5/26/14, Incident Date: 5/25/14, Incident Time: 9:45 PM, Resident Name: [Resident A]...Brief Description of Incident: CNA [CNA # 1] was found on the floor in [room number] beside [Resident A's] bed. She had BM on both hands. She was not responsive to name being called. EMT's called and [CNA # 1] taken to		theseresponses pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective 06-30-14 to the alleged finding ofthe complaint survey conducted onJune 17, 18, 19 and 20, 2014. F – 224 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident A has been evaluated by his physician and a psychologistand has been found to have suffered no Physical harmor psychosocial distress as it relates to the event identified in the survey. The resident has and will continue to beassessed by social services at least weekly for the next month and willdocument results of these assessments in progress notes. The LPN identified asLPN #1 initially received a very stern verbal counseling on her	

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	hospital. When asked what happened [Resident A] stated that [CNA # 1] had been in bed with him...." A Follow-Up report, dated 5/30/14, indicated, "...At approximately 4:00 am [Resident A] told [LPN # 1] that [CNA # 1] touched him in an inappropriate sexual manner...Immediate Action Taken: Administrator notified immediately. Staff instructed to begin investigation. [CNA # 1] suspended and removed from schedule...Preventive measures taken: All staff inservice scheduled on abuse and the elder care act...." A written statement by LPN # 1, dated 5/26/14, indicated, "9:45 PM. On 5/25/14, I found [CNA # 1] on the floor face down beside [Resident A's] bed...Before I found her on the floor, she was laying in bed [with] her arm draped over the resident. He was not upset, but had been earlier in the shift. I thought she was consoling him from earlier. It did not seem inappropriate bx [behavior], I thought she was helping. 5/26/14 0400 [4:00 A.M.] I believe I called [Administrator] to tell him the following that [Resident A] told me @ first. He stated the CNA was on top of him, holding him down, kissing his face & calling him 'baby, sexy bunny, sexy...'...I was told to get his statement...."		failure toaddress the CNA's inappropriate and unprofessional behavior at the initialreporting of the allegation. Thefacility has now put that counseling in writing as a final written warning inLPN #1's personnel file. The nurse hasalso received one on one education on the definition of neglect and abuse onprofessional and ethical conduct of all health care workers in the work place andfacility's standards and practices of acceptable behavior/interactions withresidents. The CNA identified as CNA #1was immediately removed from the work schedule and now has been terminated. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* at the time of the allegation all residents wereassessed physically and emotionally. Noother residents were found to have any signs or symptoms of neglect or abuse ofany nature.	

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	An additional written statement by LPN # 1, written on 5/27/14, indicated, "When I re-entered the room to tell [CNA # 1] to go ahead & get started on bed check she was face down on the floor...I asked [Resident A] 'what happened' he said 'she fell off the bed.'...." A written statement by CNA # 2, dated 5/26/14, indicated, "I walked in the door and saw [CNA # 1] laying on the floor...Later on I found [CNA # 1's] shoes in [room number of Resident A]. I asked and [Resident A] replied [CNA # 1] removed them before climbing in bed." On 6/17/14 at 11:30 A.M., during an interview with LPN # 1, she indicated she was working on 5/25/14. She indicated at approximately 9:30 P.M., she was passing medications, and entered Resident A's room to give his roommate medication. She indicated she saw CNA # 1 laying in bed with Resident A with her arm over him. She indicated Resident A had been upset earlier in the shift, and "some of the new aides had been lying with residents to console them." She indicated it did not look inappropriate, so she didn't say anything. She indicated the resident did not appear upset. She indicated CNA # 1 did not speak. She indicated she did not know if CNA # 1's		The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has conducted amandatory in-service for all staff members on the definition of abuse and neglectand their responsibility of immediately reporting to the Administrator anysigns and symptoms or allegations of abuse or neglect. In addition the in-service included the standards and expectation of allstaff members to conduct themselves in a professional and ethical manner in allinteractions with the residents. Thein-service also included the facility handbook as it relates to appropriatebehavior in the workplace (standards of conduct). The Abuse/Neglect policy was also reviewed withthe staff during this mandatory in-service. The DON also went into deep conversation in regards to being in bed witha resident and what measures to take if this	

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	eyes were open or not, because her hair was in her face. LPN # 1 indicated that CNA # 1 soon came out to the desk, a call light went off, and CNA # 1 answered Resident A's light. She indicated she did not see CNA # 1 doing bed check, so she went to check on her, and found her on the floor beside Resident A's bed, BM (bowel movement) was observed on the CNA's hands and forearms. She indicated she asked Resident A what happened, and he told her, "She rolled out of bed." LPN # 1 indicated she then took care of sending CNA # 1 to the hospital, and when she checked on Resident A, approximately 45 minutes later, he was sleeping. She indicated that when the resident awoke at 4:00 A.M., she went in to talk with him and ask him what had happened. The resident was assessed at that time. She indicated that is when the resident told her the CNA sexually abused him, and she called the Administrator at that time. On 6/17/14 at 1:45 P.M., during an interview with the Social Services Director (SSD), she indicated she was aware of a CNA who had laid with a resident. She indicated she would not be comfortable with that, but that she was not familiar with what the evening and night shift staff do. The SSD indicated the resident tends to be "an		was ever observed. The DON also questioned staff during thein-service, if anyone had ever educated or encouraged climbing into bed with aresident as an appropriate intervention. The DON discussed appropriate/inappropriate interventions with staffwhen caring for residents. In additionthe DON mandated that this in-service be provided to all employees andvolunteers working within the facility. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance tool has been developed and implemented to ensure that residents areprovided the necessary goods and service which are necessary to avoid physicalharm, mental anguish or mental illness. The tool will also assess that the resident receives these services in aprofessional manner in conjunction with the facility practices in accordancewith the standards set forth in the	

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	attention-seeker," and that both the psychologist and primary physician had visited with him. On 6/17/14 at 3:00 P.M., during an interview with the Director of Nursing (DON), she indicated that lying in bed with a resident was not appropriate behavior. She indicated she had first heard of CNA # 3 lying down with Resident B, because Resident B had back pain. She indicated that CNA # 3 was new, and was just trying to help. She indicated she told the CNA and nurse that lying down with residents was not a good practice. She indicated she had stand-up meetings every day with her staff, and informed them then that lying down with residents would be inappropriate. The DON indicated she had no documentation of that inservice. On 6/17/14 at 3:45 P.M., during an interview with the Administrator and DON, the Administrator indicated it was not common practice for a staff member to lie down with a resident, and that there was only 1 previous incident with CNA # 3 and Resident B prior to the incident with CNA # 1 and Resident A. CNA # 3 was lying crossways in that resident's bed. The clinical record of Resident A was		facility handbook. This tool will be completed by theAdministrator and/or designee 3 times weekly for the first month, then weeklyfor the 2nd month. After 2nd month, goes to monthly on anongoing base. The outcome of this tool will be reviewed at the QualityAssurance meeting to determine if any additional action is warranted.	

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	reviewed on 6/17/14 at 1:30 P.M. Diagnoses included, but were not limited to, borderline mental retardation, anxiety state, and schizoaffective disorder. A Minimum Data Set (MDS) assessment, dated 5/21/14, indicated the resident scored a 15 out of 15 for cognition, indicating no memory impairment. The MDS assessment indicated the resident required limited assistance of one person for bed mobility and transfer, and extensive assistance of two+ staff for toilet use. The resident was assessed as frequently incontinent of bladder, and always continent of bowel. Documentation regarding the resident's allegation of 5/25/14 was not found in the clinical record. 2. On 6/19/14 at 12:05 P.M., the Director of Nursing provided the current facility policy on "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property," dated February 2014. The policy included: "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, and physical abuse...Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is			

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	provided as needed by the residents...Prevention:...Staff...will be monitored and supervised by their respective supervisors to ensure that the residents receive appropriate care and services to meet their needs and to prevent the potential of neglect and/or abuse...Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse...are reported to the Administrator immediately...." The immediate jeopardy that began on 5/25/14 was removed on 6/20/14 when the facility began inservicing staff on the inappropriateness of lying with residents, and to immediately report such incidents to the Administrator immediately, but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all employees had not been inserviced. This Federal tag relates to Complaint IN00150893. 3.1-28(a)			

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F000225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further			

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	potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure a staff member who was lying in bed with a resident was immediately removed from the bed, and failed to notify the Administrator immediately of the incident, resulting in the resident's psychosocial distress and allegation of sexual abuse, for 1 of 7 residents reviewed for abuse/neglect, in a sample of 7. (Resident A) The Immediate Jeopardy began on 5/25/14 when a staff member was observed in bed with a resident, the staff member was not removed and/or the Administrator was not notified immediately. The Administrator and Director of Nursing were notified of the Immediate Jeopardy at 4:40 P.M. on 6/18/14. The immediate jeopardy was removed on 6/20/14, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential	F000225	F – 225 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident A has been evaluated by his physician and a psychologistand has been found to have suffered no physical harmor psychosocial distress as it relates to the event identified in thesurvey. The resident has and willcontinue to be assessed by nursing in accordance with his plan of care. The LPN identified as LPN #1 initially receiveda very stern verbal counseling on her failure to address the CNA'sinappropriate and unprofessional behavior at the	06/30/2014

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	for more than minimal harm that is not immediate jeopardy. Findings include: 1. On 6/17/14 at 10:00 A.M., the Administrator provided an "Indiana State Department of Health" Incident Report Form regarding Resident A. The report included: "Initial Report, Date: 5/26/14, Incident Date: 5/25/14, Incident Time: 9:45 PM, Resident Name: [Resident A]...Brief Description of Incident: CNA [CNA # 1] was found on the floor in [room number] beside [Resident A's] bed. She had BM on both hands. She was not responsive to name being called. EMT's called and [CNA # 1] taken to hospital. When asked what happened [Resident A] stated that [CNA # 1] had been in bed with him...." A Follow-Up report, dated 5/30/14, indicated, "...At approximately 4:00 am [Resident A] told [LPN # 1] that [CNA # 1] touched him in an inappropriate sexual manner...Immediate Action Taken: Administrator notified immediately. Staff instructed to begin investigation. [CNA # 1] suspended and removed from schedule...Preventive measures taken: All staff inservice scheduled on abuse and the elder care act...."		initial reporting of theallegation. The facility has now putthat counseling in writing as a final written warning in LPN #1's personnelfile. The nurse has also received one onone education on the definition of neglect, on professional and ethical conductof all health care workers in the work place and has been educated on thefacilities standards and practices of acceptable behavior/interactions withresidents. The CNA identified as CNA #1was immediatly removed from the work schedule and now has been terminated. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* at the time of the allegation all residents wereassessed physically and emotionally. Noother residents were found to have any signs or symptoms of neglect or abuse ofany nature.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155720	A. BUILDING 00 B. WING	06/20/2014

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	A written statement by LPN # 1, dated 5/26/14, indicated, "9:45 PM. On 5/25/14, I found [CNA # 1] on the floor face down beside [Resident A's] bed...Before I found her on the floor, she was laying in bed [with] her arm draped over the resident. He was not upset, but had been earlier in the shift. I thought she was consoling him from earlier. It did not seem inappropriate bx [behavior], I thought she was helping. 5/26/14 0400 [4:00 A.M.] I believe I called [Administrator] to tell him the following that [Resident A] told me @ first. He stated the CNA was on top of him, holding him down, kissing his face & calling him 'baby, sexy bunny, sexy...'...I was told to get his statement...." An additional written statement by LPN # 1, written on 5/27/14, indicated, "When I re-entered the room to tell [CNA # 1] to go ahead & get started on bed check she was face down on the floor...I asked [Resident A] 'what happened' he said 'she fell off the bed.'...." On 6/17/14 at 11:30 A.M., during an interview with LPN # 1, she indicated she was working on 5/25/14. She indicated at approximately 9:30 P.M., she was passing medications, and entered Resident A's room to give his roommate		The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has conducted amandatory in-service for all staff members on the definition of neglect andtheir responsibility of immediately reporting to the Administrator any signsand symptoms of neglect. In addition thein-service included the standards and expectation of all staff members toconduct themselves in a professional and ethical manner in all interactionswith the residents. The in-service alsoincluded the facility handbook as it relates to appropriate behavior in theworkplace (standards of conduct). TheAbuse/Neglect policy was also reviewed with the staff during this mandatoryin-service. The DON also went into deepconversation in regards to being in bed with a resident, what measures to takeif this was ever observed. The DON alsoquestioned staff during the	

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	medication. She indicated she saw CNA # 1 laying in bed with Resident A with her arm over him. She indicated Resident A had been upset earlier in the shift, and "some of the new aides had been lying with residents to console them." She indicated it did not look inappropriate, so she didn't say anything. She indicated the resident did not appear upset. She indicated she did not know if CNA # 1's eyes were open or not, because her hair was in her face. LPN # 1 indicated that CNA # 1 soon came out to the desk, a call light went off, and CNA # 1 answered Resident A's light. She indicated she did not see CNA # 1 doing bed check, so she went to check her, and found her on the floor beside Resident A's bed, BM was observed on hands and forearms of the CNA. She indicated she asked Resident A what happened, and he told her, "She rolled out of bed." LPN # 1 indicated she then took care of sending CNA # 1 to the hospital, and when she checked on Resident A, approximately 45 minutes later, he was sleeping. She indicated that when the resident awoke at 4:00 A.M., she went in to talk with him and ask him what had happened. She indicated that is when the resident told her the CNA sexually abused him, and she called the Administrator then. On 6/17/14 at 3:45 P.M., during an		in-service, if anyone had ever educated orencouraged climbing into bed with a resident as an appropriateintervention. The DON discussedappropriate/inappropriate interventions with staff when caring forresidents. In addition the DON mandatedthat this in-service be provided to all employees and volunteers working withinthe facility. *The corrective action taken to monitor to assurecompliance is that* a QualityAssurance tool has been developed and implemented to ensure that residents areprovided the necessary goods and service which are necessary to avoid physicalharm, mental anguish	

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	155720	A. BUILDING 00 B. WING	06/20/2014

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	interview with the Administrator and DON, the Administrator indicated it was not common practice for a staff member to lie down with a resident, and he did not know why LPN # 1 did not ask CNA # 1 to get out of the resident's bed or notify him. 2. On 6/19/14 at 12:05 P.M., the Director of Nursing provided the current facility policy on "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property," dated February 2014. The policy included: "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, and physical abuse...Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents...Prevention:...Staff...will be monitored and supervised by their respective supervisors to ensure that the residents receive appropriate care and services to meet their needs and to prevent the potential of neglect and/or abuse...Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse...are reported to the Administrator immediately...."		or mental illness. The tool will also assess that the resident receives these services in aprofessional manner in conjunction with the facility practices in accordancewith the standards set forth in the facility handbook. This tool will be completed by the Administratorand/or designee 3 times weekly for the first month, then weekly for the 2ndmonth. After 2nd month, goes to monthly on an ongoing base. The outcome of this tool will be reviewed atthe Quality Assurance meeting to determine if any additional action iswarranted.	

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	The immediate jeopardy that began on 5/25/14 was removed on 6/20/14 when the facility began inservicing staff on the inappropriateness of lying with residents, and to immediately report such incidents to the Administrator immediately, but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all employees had not been inserviced. This Federal tag relates to Complaint IN00150893. 3.1-28(c)			
F000226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit			

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	mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policy in that a staff member who was lying in bed with a resident was not immediately removed from the bed, and failed to notify the Administrator immediately of the incident, resulting in the resident's psychosocial distress and allegation of sexual abuse, for 1 of 7 residents reviewed for abuse/neglect, in a sample of 7. (Resident A) The Immediate Jeopardy began on 5/25/14 when a staff member was observed in bed with a resident, the staff member was not removed and/or the Administrator was not notified immediately. The Administrator and Director of Nursing were notified of the Immediate Jeopardy at 4:40 P.M. on 6/18/14. The immediate jeopardy was removed on 6/20/14, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. On 6/17/14 at 10:00 A.M., the Administrator provided an "Indiana State	F000226	F – 226 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the residentidentified as resident A has been evaluated by his physician and a psychologistand has been found to have suffered no physical harmor psychosocial distress as it relates to the event identified in thesurvey. The resident has and willcontinue to be assessed by nursing in accordance with his plan of care. The LPN identified as LPN #1 initially receiveda very stern verbal counseling on her failure to address the CNA'sinappropriate and unprofessional behavior at the initial reporting of theallegation. The facility has now putthat counseling in writing as a final written warning in LPN #1's personnelfile. The nurse has also received one onone	06/30/2014

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	Department of Health" Incident Report Form regarding Resident A. The report included: "Initial Report, Date: 5/26/14, Incident Date: 5/25/14, Incident Time: 9:45 PM, Resident Name: [Resident A]...Brief Description of Incident: CNA [CNA # 1] was found on the floor in [room number] beside [Resident A's] bed. She had BM on both hands. She was not responsive to name being called. EMT's called and [CNA # 1] taken to hospital. When asked what happened [Resident A] stated that [CNA # 1] had been in bed with him...." A Follow-Up report, dated 5/30/14, indicated, "...At approximately 4:00 am [Resident A] told [LPN # 1] that [CNA # 1] touched him in an inappropriate sexual manner...Immediate Action Taken: Administrator notified immediately. Staff instructed to begin investigation. [CNA # 1] suspended and removed from schedule...Preventive measures taken: All staff inservice scheduled on abuse and the elder care act...." A written statement by LPN # 1, dated 5/26/14, indicated, "9:45 PM. On 5/25/14, I found [CNA # 1] on the floor face down beside [Resident A's] bed...Before I found her on the floor, she was laying in bed [with] her arm draped over the resident. He was not upset, but		education on the definition of neglect, on professional and ethical conductof all health care workers in the work place and has been educated on thefacilities standards and practices of acceptable behavior/interactions withresidents. The nurse has also receivedone on one education of the up-dated Abuse and Neglect policy. The CNA identified as CNA #1 was immediatelyremoved from the work schedule and has been terminated. *The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* at the time of the allegation all	

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	had been earlier in the shift. I thought she was consoling him from earlier. It did not seem inappropriate bx [behavior], I thought she was helping. 5/26/14 0400 [4:00 A.M.] I believe I called [Administrator] to tell him the following that [Resident A] told me @ first. He stated the CNA was on top of him, holding him down, kissing his face & calling him 'baby, sexy bunny, sexy...'...I was told to get his statement...." An additional written statement by LPN # 1, written on 5/27/14, indicated, "When I re-entered the room to tell [CNA # 1] to go ahead & get started on bed check she was face down on the floor...I asked [Resident A] 'what happened' he said 'she fell off the bed.'...." A written statement by CNA # 2, dated 5/26/14, indicated, "I walked in the door and saw [CNA # 1] laying on the floor...Later on I found [CNA # 1's] shoes in [room number of Resident A]. I asked and [Resident A] replied [CNA # 1] removed them before climbing in bed." On 6/17/14 at 11:30 A.M., during an interview with LPN # 1, she indicated she was working on 5/25/14. She indicated at approximately 9:30 P.M., she was passing medications, and entered Resident A's room to give his roommate		residents wereassessed physically and emotionally. Noother residents were found to have any signs or symptoms of neglect or abuse ofany nature. The Abuse/Neglect policy hasbeen reviewed and will be strictly enforced in accordance with the facilitydisciplinary process.	

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	medication. She indicated she saw CNA # 1 laying in bed with Resident A with her arm over him. She indicated Resident A had been upset earlier in the shift, and "some of the new aides had been lying with residents to console them." She indicated it did not look inappropriate, so she didn't say anything. She indicated the resident did not appear upset. She indicated she did not know if CNA # 1's eyes were open or not, because her hair was in her face. LPN # 1 indicated that CNA # 1 soon came out to the desk, a call light went off, and CNA # 1 answered Resident A's light. She indicated she did not see CNA # 1 doing bed check, so she went to check her, and found her on the floor beside Resident A's bed. She indicated she asked Resident A what happened, and he told her, "She rolled out of bed." LPN # 1 indicated she then took care of sending CNA # 1 to the hospital, and when she checked on Resident A, approximately 45 minutes later, he was sleeping. She indicated that when the resident awoke at 4:00 A.M., she went in to talk with him and ask him what had happened. She indicated that is when the resident told her the CNA sexually abused him, and she called the Administrator then. On 6/17/14 at 3:45 P.M., during an interview with the Administrator and		The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has conducted amandatory in-service for all staff members on the definition of neglect andtheir responsibility of immediately reporting to the Administrator any signsand symptoms of neglect. In addition thein-service included the standards and expectation of all staff members toconduct themselves in a professional and ethical manner in all interactionswith the residents. The in-service alsoincluded the facility handbook as it relates to appropriate behavior in theworkplace (standards of	

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	DON, the Administrator indicated it was not common practice for a staff member to lie down with a resident, and he did not know why LPN # 1 did not make CNA # 1 get out of the bed. 2. On 6/19/14 at 12:05 P.M., the Director of Nursing provided the current facility policy on "Resident Mistreatment, Neglect, Abuse & Misappropriation of Property," dated February 2014. The policy included: "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, and physical abuse...Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents...Prevention:...Staff...will be monitored and supervised by their respective supervisors to ensure that the residents receive appropriate care and services to meet their needs and to prevent the potential of neglect and/or abuse...Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse...are reported to the Administrator immediately...." The immediate jeopardy that began on 5/25/14 was removed on 6/20/14 when		conduct). TheAbuse/Neglect policy was also reviewed with the staff during this mandatoryin-service. The DON also went into deepconversation in regards to being in bed with a resident, what measures to takeif this was ever observed. The DON alsoquestioned staff during the in-service, if anyone had ever educated orencouraged climbing into bed with a resident as an appropriateintervention. The DON discussedappropriate/inappropriate interventions with staff when caring forresidents. In addition the DON mandatedthat this in-service be provided to all employees and volunteers working withinthe facility. All staff members wereadvised that failure to follow the facility policies and procedures on Abuseand Neglect will result in serious disciplinary action, up to and includingdischarge in accordance with the facility disciplinary process.	

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	the facility began inservicing staff on the inappropriateness of lying with residents, and to immediately report such incidents to the Administrator immediately, but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all employees had not been inserviced. This Federal tag relates to Complaint IN00150893. 3.1-28(a)		*The corrective action taken to monitor to assurecompliance is that* a QualityAssurance tool has been developed and implemented to ensure that residents areprovided the necessary goods and service which are necessary to avoid physicalharm, mental anguish or mental illness. The tool will also assess that the resident receives these services in aprofessional manner in conjunction with the facility practices in accordancewith the standards set forth in the facility handbook. This tool will be completed by theAdministrator and/or designee 3 times weekly for the first month, then weeklyfor the 2nd month. After 2nd month, goes to monthly on anongoing base. The outcome of this tool will be reviewed at the QualityAssurance meeting to determine if any additional action is warranted.	

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure documentation of alleged abuse against a staff member was complete in the clinical record, for 1 of 3 residents reviewed for documentation, in a sample of 7. (Resident A) Findings include: 1. On 6/17/14 at 10:00 A.M., the Administrator provided an "Indiana State Department of Health" Incident Report	F000514	F – 514 The corrective action takenfor those residents found to have been affected by the deficient practice isthat the clinicalrecord of the resident identified as resident A has been amended to include theinformation related to the allegation of abuse.	06/30/2014

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	Form regarding Resident A. The report included: "Initial Report, Date: 5/26/14, Incident Date: 5/25/14, Incident Time: 9:45 PM, Resident Name: [Resident A]...Brief Description of Incident: CNA [CNA # 1] was found on the floor in [room number] beside [Resident A's] bed. She had BM on both hands. She was not responsive to name being called. EMT's called and [CNA # 1] taken to hospital. When asked what happened [Resident A] stated that [CNA # 1] had been in bed with him...." A Follow-Up report, dated 5/30/14, indicated, "...At approximately 4:00 am [Resident A] told [LPN # 1] that [CNA # 1] touched him in an inappropriate sexual manner...Immediate Action Taken: Administrator notified immediately. Staff instructed to begin investigation. [CNA # 1] suspended and removed from schedule...Preventive measures taken: All staff inservice scheduled on abuse and the elder care act...." A written statement by LPN # 1, dated 5/26/14, indicated, "9:45 PM. On 5/25/14, I found [CNA # 1] on the floor face down beside [Resident A's] bed...Before I found her on the floor, she was laying in bed [with] her arm draped over the resident. He was not upset, but had been earlier in the shift. I thought she		*The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that* changes in resident condition or status, includingallegations of abuse/neglect, will be documented in the involved resident'sclinical records as per facility policy. *The measures that have been put into place to ensurethat the deficient practice does not recur is that* a mandatory in-service has been conducted for alllicensed nurses on the accepted professional standards and practices and facilitypolicies that related in residents clinical records of changes and conditionand status, including allegations of abuse and neglect. The facility hasdeveloped and implemented a protocol that the clinical record of any residentinvolved in an allegation of abuse will be reviewed by the DON and/or herdesignee the same day or next business day to ensure that the allegation ofabuse/neglect has been	

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PROVIDENCE HOME HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was consoling him from earlier. It did not seem inappropriate bx [behavior], I thought she was helping. 5/26/14 0400 [4:00 A.M.] I believe I called [Administrator] to tell him the following that [Resident A] told me @ first. He stated the CNA was on top of him, holding him down, kissing his face & calling him 'baby, sexy bunny, sexy...'...I was told to get his statement...." An additional written statement by LPN # 1, written on 5/27/14, indicated, "When I re-entered the room to tell [CNA # 1] to go ahead & get started on bed check she was face down on the floor...I asked [Resident A] 'what happened' he said 'she fell off the bed.'...." A written statement by CNA # 2, dated 5/26/14, indicated, "I walked in the door and saw [CNA # 1] laying on the floor...Later on I found [CNA # 1's] shoes in [room number of Resident A]. I asked and [Resident A] replied [CNA # 1] removed them before climbing in bed." On 6/17/14 at 11:30 A.M., during an interview with LPN # 1, she indicated she was working on 5/25/14. She indicated at approximately 9:30 P.M., she was passing medications, and entered Resident A's room to give his roommate medication. She indicated she saw CNA		documented in accordance with acceptable professionalstandards and practices. If the DON or designee finds that it has beendocumented satisfactorily, the DON will follow up with the nurse/nursesinvolved and will re-train them on the facility policy at that time. Progressivedisciplinary action will be taken for continued noncompliance. *The corrective action taken to monitor to assurecompliance is that* the DON will bringthe results of the documentation reviews to QA committee meeting for furtherreview and recommendations for improvement. These reviews will continue on anongoing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	# 1 laying in bed with Resident A with her arm over him. She indicated Resident A had been upset earlier in the shift, and "some of the new aides had been lying with residents to console them." She indicated it did not look inappropriate, so she didn't say anything. She indicated the resident did not appear upset. She indicated CNA # 1 did not speak. She indicated she did not know if CNA # 1's eyes were open or not, because her hair was in her face. LPN # 1 indicated that CNA # 1 soon came out to the desk, a call light went off, and CNA # 1 answered Resident A's light. She indicated she did not see CNA # 1 doing bed check, so she went to check on her, and found her on the floor beside Resident A's bed. She indicated she asked Resident A what happened, and he told her, "She rolled out of bed." LPN # 1 indicated she then took care of sending CNA # 1 to the hospital, and when she checked on Resident A, approximately 45 minutes later, he was sleeping. She indicated that when the resident awoke at 4:00 A.M., she went in to talk with him and ask him what had happened. She indicated that is when the resident told her the CNA sexually abused him, and she called the Administrator at that time. On 6/17/14 at 1:45 P.M., during an interview with the Social Services			

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	Director (SSD), she indicated she had contacted the family regarding the incident. The clinical record of Resident A was reviewed on 6/17/14 at 1:30 P.M. Diagnoses included, but were not limited to, borderline mental retardation, anxiety state, and schizoaffective disorder. A Minimum Data Set (MDS) assessment, dated 5/21/14, indicated the resident scored a 15 out of 15 for cognition, indicating no memory impairment. The MDS assessment indicated the resident required limited assistance of one person for bed mobility and transfer, and extensive assistance of two+ staff for toilet use. The resident was assessed as frequently incontinent of bladder, and always continent of bowel. Documentation regarding the resident's allegation of 5/25/14 was not found in the clinical record. On 6/19/14 at 11:15 A.M., during an interview with the Director of Nursing (DON) and Administrator, the DON indicated it was "her fault" that the documentation was not in the clinical record. She indicated, "Whenever something happens, I tell the staff to put it on a piece of paper, and not document			

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	it." 2. On 6/19/14 at 12:05 P.M., the DON provided the current facility policy regarding documentation practices, dated February 2014. The policy included, "Documentation in the nurses' notes is required each shift on any resident who experiences a problem, demonstrates a symptom, or any change of status...Nurses' notes will identify the condition change and will describe any pertinent nursing assessment indicators and interventions taken...." This Federal tag relates to Complaint IN00150893. 3.1-50(a)(1)			