STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а. вип	LDING	00	COMPLE	ETED
		155720	B. WIN			06/20/2	2014
NAME OF B	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIED	X		520 W 9	9TH ST		
PROVIDE	ENCE HOME HEAL	_TH CARE CENTER		JASPEI	R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY 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
F000000							
F000000	Complaint IN00 resulted in a par Immediate Jeopa Complaint IN00 Federal/State de	2150893 - Substantiated, efficiencies related to the effic	F00	0000	July 3, 2014 Ms. Jodi Meye Indiana State Department of Health 2 North Meridian Stree Indianapolis, IN 46204-3003 RE: Providence HomeCompla Survey June 17, 18, 19 and 20 2014 Dear Ms. Meyer; The Indiana State Department of Health visited our facilityon Ju 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 n admitting to the truth or accura of any specificfindings or allegations. We reserve theriot to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We respectfully request our plan ofcorrection be considered our allegation of compliance effect June 30th,2014 and respectfur request a timely revisit to valid compliance due to financiallypenalties impose on facility. If youhave any questic please feel free to contact me the facility. Respectfully submitted, Dawn Nordhoff BSN, RN Director of Nursing Abuse Notification and	aint of of ne ot acy ght tive lly iate the ons at	
	Sample: 5 Extended sampl	e: 2			F224, F225,		
			I				

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLETED
		155720	B. WING			06/20/2014
NAME OF S	DDOWNED OF GLERN IEE		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		1	520 W 9	9TH ST	
		TH CARE CENTER			R, IN 47546	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		es reflect state findings			F226	
	cited in accordar	nce with 410 IAC 16.2.				
					Yes No 1. Is the subject of	
	Ouality review c	completed on June 23,			abuse/neglect being discussed	d
	2014 by Jodi Meyer, RN				with all new employees as par	
					their orientation?	
					Is abuse information part of the control of th	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 t	.
					questions about when, what, h	II
					and to whom to report abuse?	•
					(ask at least 3 employees fron	II
					different departments and shif	
					Names/Dept: 1)	
					2)	
					3)	
						2)
					3) 1) 2) 3)	2)
					5. Are employees able to exp	olain
					how they have been trained to	
					intervene in situations involvin	
					residents who are having	-
					behavior episodes?	
					6. Is there documentation in	
					residents' clinical records that	
					Administrator has been notifie	
					allegations of abuse immediat	еіу
					if/when they occur? (If any noncompliance is four	nd
					detail finding below, aswell as	
					action taken to correct.)	
					Date Problem Identified	

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Event ID:

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155720	A. BUILDING B. WING (X3) DAT COMI 00 06/2			
	PROVIDER OR SUPPLIER	TH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RECTION HOULD BE APPROPRIATE DA	
				Auditor's Name:	te: pol Neglect ough s and r the ce a "Y" mes to or nsor R the ervices to professional	

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Event ID:

9LGQ11

Facility ID: 000315

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155720	B. WING		06/20/2014	
NAME OF D	DOLUDED OD CLIDDLIED		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		520 W	9TH ST		
		TH CARE CENTER		ER, IN 47546		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	3. Does the staff treat you wi	DATE	
				dignity and respect?	ui	
				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 bein	9	
				neglected in any manner?		
				2. Have you observed any st	aff	
				member interacting with a		
				resident in an unprofessional manner?		
				manner!		
F000224	483.13(c)					
SS=J	PROHIBIT					
		NEGLECT/MISAPPROP				
	RIATN The facility must d	evelop and implement				
	_	d procedures that prohibit				
	mistreatment, neg					
	residents and misa	appropriation of resident				
	property.					
		ew and record review,	F000224	By submitting the	06/30/2014	
	•	to ensure a staff		enclosedmaterial we are not		
		s lying in bed with a		admitting the truth or accura	acy	
		nediately removed from		of any specific findings		
	the bed, and faile	ed to notify the		orallegations. We reserve the	ne	
	Administrator im	mediately of the		right tocontest the findings	or	
	incident, resultin	g in the resident's		allegations as part of any		
	psychosocial dist	tress and allegation of		proceedings and submit		
			1	1	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155720	B. WIN	NG		06/20/2	014
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DD 6) (ID)		THE CARE OF MEET			9TH ST		
	ENCE HOME HEAL	_TH CARE CENTER		JASPEI	R, IN 47546		
(X4) ID		TATEMENT OF DEFICIENCIES		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 APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		r 1 of 7 residents		1710	theseresponses pursuant to o	nur	DATE
	· ·	use/neglect, in a sample			regulatory obligations. The		
	of 7. (Resident A)				facility request the plan of		
	or /. (Resident 11)				correctionbe considered our		
	The Immediate	Jeopardy began on			allegation of compliance		
	5/25/14 when a staff member was				effective 06-30-14		
	observed in bed with a resident, the staff				to the alleged finding ofthe		
	member was not removed and/or the				complaint survey conducted		
	Administrator was not notified				onJune 17, 18, 19 and 20,		
	immediately. The Administrator and				2014.		
	Director of Nursing were notified of the						
	Immediate Jeopardy at 4:40 P.M. on				F – 224		
		nmediate jeopardy was					
		0/14, but noncompliance			The corrective action takent	for	
		lower scope and severity	those residents found to have				
	of isolated, no a	ctual harm with potential			been affected by the deficien	nt	
	for more than m	inimal harm that is not			practice isthat the		
	immediate jeopa	ardy.			residentidentified as residen	t A	
					has been evaluated by his		
	Findings include				physician and a		
					psychologistand has been		
	1. On 6/17/14 at	10:00 A.M., the			found to have suffered no		
	_	rovided an "Indiana State			Physical harmor psychosoci	ial	
		Health" Incident Report			distress as it relates to the		
		Resident A. The report			event identified in the surve	y.	
		l Report, Date: 5/26/14,			The resident has and will		
		/25/14, Incident Time:			continue to beassessed by		
	•	ent Name: [Resident			social services at least week	ly	
	_	iption of Incident: CNA			for the next month and		
		found on the floor in			willdocument results of thes		
	-	beside [Resident A's]			assessments in progress not		
		If on both hands. She was			The LPN identified asLPN	I	
	_	o name being called.			initially received a very ster	n	
	EMT's called an	d [CNA # 1] taken to			verbal counseling on her		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	LDING	00	COMPL	ETED
		155720	B. WIN			06/20/	2014
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		520 W 9			
PROVIDI	ENCE HOME HEAL	TH CARE CENTER	JASPER, IN 47546				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		asked what happened			failure toaddress the CNA's		
		ted that [CNA # 1] had			inappropriate and		
	been in bed with him"				unprofessional behavior at t	he	
					initialreporting of the		
		port, dated 5/30/14,			allegation. Thefacility has		
	,	approximately 4:00 am			now put that counseling in		
	[Resident A] told [LPN # 1] that [CNA #				writing as a final written		
	1] touched him in an inappropriate sexual				warning inLPN #1's person	nel	
	mannerImmediate Action Taken:				file. The nurse hasalso		
	Administrator notified immediately. Staff				received one on one educati	on	
	instructed to begin investigation. [CNA #				on the definition of neglect	and	
	1] suspended and removed from				abuse onprofessional and		
	schedulePreventive measures taken: All				ethical conduct of all health		
	staff inservice so	cheduled on abuse and			care workers in the work pla	ace	
	the elder care ac	t"			andfacility's standards and		
					practices of acceptable		
	A written statem	ent by LPN # 1, dated			behavior/interactions		
		ed, "9:45 PM. On			withresidents. The CNA		
	· · · · · · · · · · · · · · · · · · ·	[CNA # 1] on the floor			identified as CNA #1was		
	face down besid	-			immediately removed from	the	
		und her on the floor, she			work schedule and now has		
		d [with] her arm draped		been terminated.			
		t. He was not upset, but					
		in the shift. I thought she			The corrective action taken	for	
		im from earlier. It did not			the other residentshaving th	~	
		ate bx [behavior], I			potential to be affected by the		
		helping. 5/26/14 0400			same deficient practice is the		
	[4:00 A.M.] I be	1 0			at the time of the allegation		
					residents wereassessed	all	
		to tell him the following					
	_] told me @ first. He			physically and emotionally.	ا ا	
		was on top of him,			Noother residents were four		
	_	vn, kissing his face &			to have any signs or sympto	ms	
		y, sexy bunny, sexy'I			of neglect or abuse of any		
	was told to get h	is statement"			nature.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155720	A. BUILDING B. WING		06/20/2014	
NIANCE OF	DOWNER OF COM-	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	ROVIDER OR SUPPLIEI	К	520 W	9TH ST		
PROVIDE	ENCE HOME HEAI	LTH CARE CENTER	JASPE	ER, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	An additional	witten statement 1 I DNI 4				
		ritten statement by LPN #		The measures that have		
	-	27/14, indicated, "When I		The measures that have		
		oom to tell [CNA # 1] to		beenput into place to ensure		
	go ahead & get started on bed check she			that the deficient practice de		
	was face down on the floorI asked			not recur is that the facility	nas	
	[Resident A] 'what happened' he said 'she			conducted amandatory		
	fell off the bed.'			in-service for all staff	\r	
	A written statement by CNA # 2, dated			members on the definition of)1	
				abuse and neglectand their		
	5/26/14, indicated, "I walked in the door and saw [CNA # 1] laying on the			responsibility of immediately		
	_			reporting to the Administrat	ЮГ	
		I found [CNA # 1's] shoes		anysigns and symptoms or		
	-	er of Resident A]. I asked		allegations of abuse or		
	-] replied [CNA # 1]		neglect. In addition the		
	removed them b	before climbing in bed."		in-service included the	C	
	0 (4544)	1.20 4.35 1 .		standards and expectation o		
		1:30 A.M., during an		allstaff members to conduct		
		LPN # 1, she indicated she		themselves in a professiona	1	
	_	5/25/14. She indicated at		and ethical manner in		
		2:30 P.M., she was		allinteractions with the		
	1 0	ions, and entered		residents. Thein-service als		
		om to give his roommate		included the facility handbo	ook	
		indicated she saw CNA		as it relates to		
		d with Resident A with		appropriate behavior in the		
		n. She indicated Resident		workplace (standards of		
	-	et earlier in the shift, and		conduct). The Abuse/Negle	ect	
		w aides had been lying		policy was also reviewed		
		console them." She		withthe staff during this		
		not look inappropriate, so		mandatory in-service. The		
		ything. She indicated the		DON also went into deep		
		appear upset. She		conversation in regards to		
	indicated CNA	# 1 did not speak. She		being in bed with aresident	and	
	indicated she did	d not know if CNA # 1's		what measures to take if thi	s	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155720	B. WIN			06/20/2014	
NAME OF I	DROVIDED OD GUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	X		520 W	9TH ST		
PROVIDI	ENCE HOME HEAI	_TH CARE CENTER		JASPE	R, IN 47546		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		Ν
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATE	
		or not, because her hair			was ever observed. The DO		
		LPN # 1 indicated that			also questioned staff during		
	CNA # 1 soon came out to the desk, a				thein-service, if anyone had		
	call light went off, and CNA # 1				ever educated or encourage	d	
		ent A's light. She			climbing into bed with		
		d not see CNA # 1 doing			aresident as an appropriate		
		e went to check on her,			intervention. The DON		
		n the floor beside			discussed		
	Resident A's bed, BM (bowel movement)				appropriate/inappropriate		
	was observed on the CNA's hands and				interventions with staffwhe	n	
	forearms. She indicated she asked				caring for residents. In		
	Resident A what happened, and he told				additionthe DON mandated		
		out of bed." LPN # 1			that this in-service be provi	ded	
	indicated she the	en took care of sending		to all employees andvolunteers			
	CNA # 1 to the	hospital, and when she		working within the facility.			
	checked on Resi	ident A, approximately 45					
	minutes later, he	e was sleeping. She					
	indicated that w	hen the resident awoke at					
	4:00 A.M., she	went in to talk with him			The corrective action taken	to	
	and ask him wh	at had happened. The			monitor to assurecomplian	ce	
	resident was ass	essed at that time. She			is that a QualityAssurance t	ool	
	indicated that is	when the resident told			has been developed and		
	her the CNA sex	cually abused him, and			implemented to ensure that		
	she called the A	dministrator at that time.		residents are provided the			
					necessary goods and service	e	
	On 6/17/14 at 1:	45 P.M., during an			which are necessary to avoi	d	
	interview with the	he Social Services			physicalharm, mental angui	sh	
	Director (SSD),	she indicated she was			or mental illness. The tool v	vill	
	aware of a CNA	who had laid with a			also assess that the resident		
	resident. She inc	dicated she would not be			receives these services in		
	comfortable wit	h that, but that she was			aprofessional manner in		
		n what the evening and			conjunction with the facility	7	
		do. The SSD indicated			practices in accordancewith		
	the resident tend				the standards set forth in the	·	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720		LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/20/	ETED	
	PROVIDER OR SUPPLIER	TH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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)		(X5) COMPLETION DATE	
	psychologist and visited with him. On 6/17/14 at 3:1 interview with the (DON), she indicated of CNA # Resident B, because pain. She indicated she tollying down with practice. She indicated she tollying down with practice. She indicated she tollying down with practice. She indicated she tollying down with practice would be a common be a common practice with the DON, the Admin the common practice down with was only 1 previous and Resident E with CNA # 1 ar was lying crosswiped.	200 P.M., during an the Director of Nursing cated that lying in bed was not appropriate dicated she had first 3 lying down with the Resident B had back and that CNA # 3 was set trying to help. She did the CNA and nurse that residents was not a good icated she had stand-up lay with her staff, and then that lying down with the inappropriate. The			facility handbook. This too will be completed by the Administrator and/or designee 3 times weekly for the first month, then weekly the 2nd month. After 2nd month, goes to monthly on anongoing base. The outcor of this tool will be reviewed the Quality Assurance meeti to determine if any addition action is warranted.	rfor ne I at ng		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	A. BUI	LDING	NSTRUCTION 00	COMI	E SURVEY PLETED 0/2014
		133720	B. WIN				0/2014
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CO	DE	
₽₽∩VIDI	ENCE HOME HEAL	TH CARE CENTER		520 W 9	R, IN 47546		
			1	<u> </u>	· , ii		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
	reviewed on 6/17	<u> </u>					
		led, 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						
	•	of 15 for cognition,					
		O ,					
	indicating no memory impairment. The MDS assessment indicated the resident						
	required limited assistance of one person						
	for bed mobility and transfer, and						
	_	nce of two+ staff for					
		sident was assessed as					
		tinent of bladder, and					
	always continent						
	arways continent	of bower.					
	Documentation r	regarding the resident's					
		5/14 was not found in the					
	clinical record.	of I I was not round in the					
	ommour record.						
	2. On 6/19/14 at	12:05 P.M., the Director					
		ded the current facility					
		ent Mistreatment,					
	1 1	& Misappropriation of					
		February 2014. The					
	_ :	"Residents will be free					
		nt, neglect, abuse,					
		of resident funds and					
		mental, sexual, and					
		Neglect occurs when					
		s to monitor and/or					
	_	ivery of resident care					
	and services to a	-					
	and betvices to a	bbail that care is					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720		LDING	NSTRUCTION 00	(X3) DATE COMPL 06/20/	ETED
	PROVIDER OR SUPPLIER	TH CARE CENTER	•	520 W 9	DDRESS, CITY, STATE, ZIP CODE OTH ST R, IN 47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	monitored and so respective supervesidents receive services to meet prevent the poter abuseInvestigatincidents of alleg mistreatment, ne reported to the Administreatmediately" The immediately" The immediate jubic 5/25/14 was remained to immediate to the Administration to the Administration on compliance of scope and severificated harm with minimal harm the jeopardy, because been inserviced.	ntion:Staffwill be apervised by their visors to ensure that the appropriate care and their needs and to ntial of neglect and/or tion: All reported ged violations involving glect or abuseare					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 20/2014
	ROVIDER OR SUPPLIER	TH CARE CENTER	STREET A 520 W 9	ADDRESS, CITY, STATE, Z 9TH ST R, IN 47546	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F000225 SS=J	have been found of neglecting, or mist court of law; or har into the State nurs abuse, neglect, misappropriation of any knowledge it haw against an emindicate unfitness or other facility staregistry or licensing. The facility must eviolations involving abuse, including ir and misappropriat are reported immediadministrator of the officials in accordate through established the State survey at alleged violations.	EPORT IDIVIDUALS of employ individuals who guilty of abusing, treating residents by a we had a finding entered e aide registry concerning streatment of residents or of their property; and report has of actions by a court of ployee, which would for service as a nurse aide ff to the State nurse aide g authorities. Insure that all alleged g mistreatment, neglect, or nijuries of unknown source ion of resident property ediately to the e facility and to other ance with State law and procedures (including to not certification agency).				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155720	B. WING		06/20/2014	
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE		
				9TH ST		
PROVIDE	ENCE HOME HEAL	TH CARE CENTER	JASPE	ER, IN 47546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	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		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	potential abuse wi	hile the investigation is in				
	progress.					
	The results of all in	nvestigations must be				
	reported to the ad					
	-	entative and to other				
	oπicials in accorda (including to the S	ance with State law				
	, ,	cy) within 5 working days of				
	_	f the alleged violation is				
	verified appropriat	te corrective action must				
	be taken.					
		ew and record review,	F000225	F – 225	06/30/2014	
	1	d to ensure a staff			,	
		s lying in bed with a		The corrective action takens		
		mediately removed from		those residents found to hav		
	the bed, and faile	-		been affected by the deficient	nt	
	Administrator in	nmediately of the		practice isthat the		
	incident, resultin	ng in the resident's		residentidentified as residen	t A	
	psychosocial dis	tress and allegation of		has been evaluated by his		
	sexual abuse, for	r 1 of 7 residents		physician and a		
	reviewed for abu	se/neglect, in a sample		psychologistand has been		
	of 7. (Resident A	Λ)		found to have suffered no		
				physical harmor psychosoci	al	
	The Immediate J	Jeopardy began on		distress as it relates to the		
		staff member was		event identified in thesurvey	7.	
		with a resident, the staff		The resident has and		
		removed and/or the		willcontinue to be assessed	by	
	Administrator w			nursing in accordance with	nis	
		ne Administrator and		plan of care. The LPN		
		ing were notified of the		identified as LPN #1 initiall	y	
		ardy at 4:40 P.M. on		receiveda very stern verbal		
	_	mediate jeopardy was		counseling on her failure to		
		0/14, but noncompliance		address the		
		lower scope and severity		CNA'sinappropriate and		
		ctual harm with potential		unprofessional behavior at t	he	
	or isolated, no at			r		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUII	A. BUILDING 00		COMPLETED	
		155720	B. WIN			06/20/2014	
NAME OF B	DOLUBER OF GURRI IER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			520 W 9	9TH ST		
		TH CARE CENTER			R, IN 47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
TAG		*	+	TAG		DATE	
	for more than minimal harm that is not immediate jeopardy.				initial reporting of theallegation. The facility h		
	inimediate jeopa	iuy.			1	as	
					now putthat counseling in		
	F: 1: : 1 1				writing as a final written		
	Findings include	:			warning in LPN #1's		
	1 0 6/17/14	10.00 4.16 4			personnelfile. The nurse has	8	
	1. On 6/17/14 at	•			also received one onone		
		ovided an "Indiana State			education on the definition of		
	_	lealth" Incident Report			neglect, on professional and		
		Resident A. The report			ethical conductof all health		
		Report, Date: 5/26/14,			care workers in the work pla	ice	
		25/14, Incident Time:			and has been educated on		
	-	nt Name: [Resident			thefacilities standards and		
	_	ption of Incident: CNA			practices of acceptable		
		ound on the floor in			behavior/interactions		
	-	beside [Resident A's]			withresidents. The CNA		
	bed. She had BM	I on both hands. She was			identified as CNA #1was		
	not responsive to	name being called.			immediatly removed from the	ne	
		d [CNA # 1] taken to			work schedule and now has		
	hospital. When a	sked what happened			been terminated.		
	[Resident A] stat	ted that [CNA # 1] had					
	been in bed with	him"					
					The corrective action taken	· I	
	A Follow-Up rep	oort, dated 5/30/14,			the other residentshaving th		
	indicated, "At	approximately 4:00 am			potential to be affected by the	he	
	[Resident A] told	d [LPN # 1] that [CNA #			same deficient practice is th	eat	
	1] touched him i	n an inappropriate sexual			at the time of the allegation	all	
	mannerImmed	iate Action Taken:			residents wereassessed		
	Administrator no	otified immediately. Staff			physically and emotionally.		
	instructed to beg	in investigation. [CNA#			Noother residents were foun	d	
	1] suspended and	d removed from			to have any signs or sympto	ms	
	schedulePreve	ntive measures taken: All			of neglect or abuse of any		
	staff inservice sc	heduled on abuse and			nature.		
	the elder care ac	t"					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLET	ED
		155720	B. WING			06/20/20	014
NAME OF I	PROVIDER OR SUPPLIER	3	•		ADDRESS, CITY, STATE, ZIP CODE	-	
					9TH ST		
PROVID	ENCE HOME HEAL	TH CARE CENTER		JASPE	R, IN 47546		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	A syritton statom	nent by LPN # 1, dated					
		ed, "9:45 PM. On					
	1				The measures that have		
		[CNA # 1] on the floor					
	face down besid	•			beenput into place to ensure		
		ound her on the floor, she			that the deficient practice d		
		d [with] her arm draped			not recur is that the facility	nas	
		t. He was not upset, but			conducted amandatory		
		in the shift. I thought she			in-service for all staff	c	
	was consoling him from earlier. It did not seem inappropriate bx [behavior], I				members on the definition of		
		2 2.			neglect andtheir responsibil	-	
	thought she was helping. 5/26/14 0400				of immediately reporting to		
	[4:00 A.M.] I be				Administrator any signsand		
	-	to tell him the following			symptoms of neglect. In		
	_] told me @ first. He			addition thein-service inclu		
		was on top of him,			the standards and expectation		
	_	vn, kissing his face &			of all staff members tocond		
		y, sexy bunny, sexy'I			themselves in a professiona	1	
	was told to get h	is statement"			and ethical manner in all		
					interactions with the residen		
		ritten statement by LPN #			The in-service also included		
		27/14, indicated, "When I			facility handbook as it relat	es	
		oom to tell [CNA # 1] to			to appropriate behavior in		
		started on bed check she			theworkplace (standards of		
	was face down of	on the floorI asked			conduct). The Abuse/Negle		
		nat happened' he said 'she			policy was also reviewed w	ith	
	fell off the bed.'.	"			the staff during this		
					mandatoryin-service. The		
	On 6/17/14 at 11	1:30 A.M., during an			DON also went into		
	interview with L	PN # 1, she indicated she			deepconversation in regards	s to	
	was working on	5/25/14. She indicated at			being in bed with a resident	.,	
	approximately 9	:30 P.M., she was			what measures to takeif this	3	
	passing medicat	ions, and entered			was ever observed. The DO	ON	
	Resident A's roo	om to give his roommate			alsoquestioned staff during	the	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720		LDING	00	(X3) DATE SURVEY COMPLETED 06/20/2014	
	PROVIDER OR SUPPLIER	TH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	(X5) COMPLETION DATE	1
	# 1 laying in bed her arm over him A had been upse "some of the new with residents to indicated it did not a indicated the did eyes were open of was in her face. It CNA # 1 soon car call light went of answered Reside indicated she did bed check, so she found her on the A's bed, BM was forearms of the C asked Resident A told her, "She roindicated she the CNA # 1 to the It checked on Resident A.	Int A's light. She I not see CNA # 1 doing we went to check her, and floor beside Resident sobserved on hands and CNA. She indicated she what happened, and he fled out of bed." LPN # 1 In took care of sending hospital, and when she dent A, approximately 45			in-service, if anyone had evereducated orencouraged climbing into bed with a resident as an appropriate intervention. The DON discussed appropriate/inappriate interventions with staff when caring for residents. In addition the DON mandated that this in-service provided to all employees at volunteers working within the facility.	rop f n e be nd ne	
	indicated that wh 4:00 A.M., she w	was sleeping. She nen the resident awoke at vent in to talk with him			The corrective action taken monitor to assurecompliance is that a QualityAssurance t	ce	
	indicated that is her the CNA sex	t had happened. She when the resident told ually abused him, and Iministrator then.			has been developed and implemented to ensure that residents are provided the necessary goods and service which are necessary to avoid		
	On 6/17/14 at 3:4	45 P.M., during an			physicalharm, mental angui	sh	

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	OF CORRECTION OF CORRECTION 155720	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/20/2014		
	PROVIDER OR SUPPLIER ENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	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 abuseNeglect 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 residentsPrevention:Staffwill 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 abuseInvestigation: All reported incidents of alleged violations involving mistreatment, neglect or abuseare reported to the Administrator immediately"		or mental illness. The tool walso assess that the resident receives these services in aprofessional manner in conjunction with the facility practices in accordance with the standards set forth in the facility handbook. This too will be completed by the Administratorand/or designed 3 times weekly for the first month, then weekly for the 2ndmonth. After 2nd month goes to monthly on an ongo base. The outcome of this the will be reviewed at the Quality Assurance meeting to determine if any additional action iswarranted.	ee l ee ing ool		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/20 /	ETED
	ROVIDER OR SUPPLIER		520 W 9		•	
PROVIDI		TH CARE CENTER	 JASPER	R, IN 47546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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
	5/25/14 was rem the facility began inappropriatenes and to immediate to the Administration noncompliance rescope and severi actual harm with minimal harm the jeopardy, because been inserviced.	eopardy that began on oved on 6/20/14 when a inservicing staff on the s of lying with residents, ely report such incidents ator immediately, but the emained at the lower ty level of isolated, no potential for more than at is not immediate e all employees had not relates to Complaint				
F000226 SS=J	ETC POLICIES The facility must d	IENT ABUSE/NEGLECT, evelop and implement d procedures that prohibit				

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i i		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155720	B. WIN			06/20/2014	
NAME OF B	ADOLUDED OD GLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>		520 W 9	9TH ST		
		TH CARE CENTER			R, IN 47546		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
TAG	mistreatment, neg		+	TAU	BEITEER(CT)	DATE	
		appropriation of resident					
		ew and record review,	F00	0226	F – 226	06/30/2014	
	the facility failed	to implement their					
	_	staff member who was			The corrective action takenf	or	
		a resident was not			those residents found to hav	e	
		noved from the bed, and			been affected by the deficien	nt	
	failed to notify the	he Administrator			practice isthat the		
		he incident, resulting in			residentidentified as residen	t A	
		chosocial distress and			has been evaluated by his		
		ual abuse, for 1 of 7			physician and a		
	_	ed for abuse/neglect, in a			psychologistand has been		
	sample of 7. (Re				found to have suffered no		
	`	,			physical harmor psychosoci	al	
	The Immediate J	eopardy began on			distress as it relates to the		
		staff member was			event identified in thesurvey	7.	
	observed in bed	with a resident, the staff			The resident has and		
		removed and/or the			willcontinue to be assessed	ov	
	Administrator wa	as not notified			nursing in accordance with l	1	
	immediately. Th	ne Administrator and			plan of care. The LPN		
	_	ing were notified of the			identified as LPN #1 initiall	y	
		ardy at 4:40 P.M. on			receiveda very stern verbal		
	•	mediate jeopardy was			counseling on her failure to		
		0/14, but noncompliance			address the		
		ower scope and severity			CNA'sinappropriate and		
		ctual harm with potential			unprofessional behavior at the	he	
		nimal harm that is not			initial reporting of		
	immediate jeopa				theallegation. The facility h	as	
		<i>J</i> -			now putthat counseling in		
	Findings include	:			writing as a final written		
					warning in LPN #1's		
	1. On 6/17/14 at	10:00 A.M. the			personnelfile. The nurse has	,	
		ovided an "Indiana State			also received one onone		
	riammismator pr	origod an indiana batto			also received one onone		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING			COMPLETED
		155720	B. WIN			06/20/2014
			В. (/П (ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R		520 W 9		
PROVIDE	ENCE HOME HEAL	TH CARE CENTER	JASPER, IN 47546			
					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE COMPLETION DATE
TAG		<u> </u>		TAG	education on the definition of	
	•	lealth" Incident Report				
		Resident A. The report			neglect, on professional and	
		l Report, Date: 5/26/14,			ethical conductof all health	
		/25/14, Incident Time:			care workers in the work pla	ice
	-	ent Name: [Resident			and has been educated on	
	_	iption of Incident: CNA			thefacilities standards and	
	[CNA # 1] was f	found on the floor in			practices of acceptable	
	[room number] b	beside [Resident A's]			behavior/interactions	
	bed. She had BM	I on both hands. She was			withresidents. The nurse ha	S
	not responsive to	name being called.			also receivedone on one	
	EMT's called and [CNA # 1] taken to				education of the up-dated	
	hospital. When asked what happened				Abuse and Neglect policy.	
	•	ted that [CNA # 1] had			The CNA identified as CNA	
	been in bed with				#1 was immediatelyremoved	d
					from the work schedule and	
	A Follow-Un ret	oort, dated 5/30/14,			has been terminated.	
		approximately 4:00 am			nas seen terminatea.	
	· ·	d [LPN # 1] that [CNA #				
		n an inappropriate sexual				
	-	iate Action Taken:				
		otified immediately. Staff				
	_	in investigation. [CNA #				
	1] suspended and					
		ntive measures taken: All				
		cheduled on abuse and				
	the elder care ac	t"				
	A written statem	ent by LPN # 1, dated				
	5/26/14, indicate	ed, "9:45 PM. On				
	5/25/14, I found	[CNA # 1] on the floor			The corrective action taken	for
	face down beside	•			the other residentshaving th	
		und her on the floor, she			potential to be affected by the	
		d [with] her arm draped			same deficient practice is th	
		t. He was not upset, but			at the time of the allegation	
ı	over the restuction	. 110 was not upset, out			at the time of the anegation	u11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLETED			
		155720	B. WIN	G		06/20/	2014
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				520 W 9			
PROVIDE	ENCE HOME HEAL	TH CARE CENTER		JASPER	R, IN 47546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		in the shift. I thought she			residents wereassessed		
	was consoling hi	im from earlier. It did not			physically and emotionally.		
	seem inappropris	ate bx [behavior], I			Noother residents were foun	d	
	thought she was	helping. 5/26/14 0400			to have any signs or sympton	ms	
	[4:00 A.M.] I be	lieve I called			of neglect or abuse ofany		
	[Administrator]	to tell him the following			nature. The Abuse/Neglect		
	that [Resident A] told me @ first. He			policy hasbeen reviewed and	i l	
	_	was on top of him,			will be strictly enforced in		
		n, kissing his face &			accordance with the		
		y, sexy bunny, sexy'I			facilitydisciplinary process.		
	was told to get h						
	An additional wi	ritten statement by LPN #					
		7/14, indicated, "When I					
		om to tell [CNA # 1] to					
	~ ~	started on bed check she					
		on the floorI asked					
		nat happened' he said 'she					
	fell off the bed.'.	"					
		ent by CNA # 2, dated					
	· ·	ed, "I walked in the door					
	and saw [CNA #	2 2 0					
	floorLater on I	found [CNA # 1's] shoes					
	in [room number	r of Resident A]. I asked					
	and [Resident A]	replied [CNA # 1]					
		efore climbing in bed."					
		-					
	On 6/17/14 at 11	:30 A.M., during an					
		PN # 1, she indicated she					
		5/25/14. She indicated at					
		:30 P.M., she was					
	passing medicati						
		m to give his roommate					
	Acsident A 5 100	in to give his roullinate					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	A. BUII	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/20 /	ETED
		133720	B. WIN			00/20/	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DDOMDI	ENCE HOME HEAL	TH CARE CENTER		520 W 9	91H S1 R, IN 47546		
				<u> </u>	X, IIV 47540	,	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		indicated she saw CNA		1710	·		DATE
		with Resident A with					
		n. She indicated Resident					
		t earlier in the shift, and					
	-	v aides had been lying					
		console them." She					
		ot look inappropriate, so					
		ything. She indicated the					
		appear upset. She					
		not know if CNA # 1's					
	eyes were open or not, because her hair was in her face. LPN # 1 indicated that						
		ame out to the desk, a					
	call light went of	•			The measures that have		
	answered Reside				beenput into place to ensure		
		not see CNA # 1 doing			that the deficient practice do		
		e went to check her, and			not recur is that the facility		
	-	floor beside Resident			conducted amandatory	iias	
		cated she asked Resident			in-service for all staff		
		d, and he told her, "She			members on the definition of	£	
	* *	"LPN # 1 indicated she			neglect andtheir responsibil		
		Sending CNA # 1 to the			of immediately reporting to	-	
		en she checked on			Administrator any signsand	uic	
	_	oximately 45 minutes			symptoms of neglect. In		
		eping. She indicated that			addition thein-service include	led	
	· ·	t awoke at 4:00 A.M.,			the standards and expectation		
		lk with him and ask him			of all staff members tocond		
		ed. She indicated that is			themselves in a professional		
		t told her the CNA			and ethical manner in all	L	
		him, and she called the			interactions with the resident	ta	
	Administrator th	-			The in-service also included		
	Aummsnawi III	CII.			facility handbook as it relate		
	On 6/17/14 at 2:	45 P.M., during an			to appropriate behavior in	J.3	
		e Administrator and					
	interview with th	e Auministrator and			theworkplace (standards of		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		155720	B. WIN			06/20/2014	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			520 W 9	9TH ST		
	ENCE HOME HEAL	TH CARE CENTER		JASPEI	R, IN 47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
	· · · · · · · · · · · · · · · · · · ·	nistrator indicated it was			conduct). The Abuse/Negleo		
	_	ctice for a staff member			policy was also reviewed wi	th	
		a resident, and he did			the staff during this		
	not know why LPN # 1 did not make CNA # 1 get out of the bed.				mandatoryin-service. The		
					DON also went into		
					deepconversation in regards		
		12:05 P.M., the Director			being in bed with a resident,		
	0 1	ded the current facility			what measures to takeif this		
	policy on "Resid	ent Mistreatment,			was ever observed. The DO	N	
	Neglect, Abuse &	& Misappropriation of			alsoquestioned staff during t	he	
	Property," dated	February 2014. The			in-service, if anyone had eve	er	
	policy included:	"Residents will be free			educated orencouraged		
	from mistreatme	nt, neglect, abuse,			climbing into bed with a		
	misappropriation	of resident funds and			resident as an		
		mental, sexual, and			appropriateintervention. Th	e	
		Neglect occurs when			DON		
		s to monitor and/or			discussedappropriate/inappr	op	
	<u>-</u>	ivery of resident care			riate interventions with staff	-	
	and services to a	_			when caring forresidents. Ir	1	
	provided as need				addition the DON		
	_	ntion:Staffwill be			mandatedthat this in-service	he	
		apervised by their			provided to all employees a		
		visors to ensure that the			volunteers working withinth		
		appropriate care and			facility. All staff members	`	
		their needs and to			wereadvised that failure to		
		ntial of neglect and/or			follow the facility policies a	nd	
		tion: All reported			procedures on Abuseand	III.	
		ged violations involving			Neglect will result in serious	,	
	1						
		glect or abuseare			disciplinary action, up to and	ı l	
	reported to the A	aministrator			including discharge in		
	immediately"				accordance with the facility		
					disciplinary process.		
	_	eopardy that began on					
	5/25/14 was rem	oved on 6/20/14 when					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/20/2014		
	PROVIDER OR SUPPLIER ENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	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 monitor to assurecompliant is that a QualityAssurance has been developed and implemented to ensure that residents are provided the necessary goods and service which are necessary to avoor physicalharm, mental anguor mental illness. The tool also assess that the resident receives these services in aprofessional manner in conjunction with the facility practices in accordance with the standards set forth in the facility handbook. This too will be completed by the Administrator and/or designee 3 times weekly for the first month, then weekly the 2nd month, After 2nd month, goes to monthly on anongoing base. The outco of this tool will be reviewed the QualityAssurance meet to determine if any addition action is warranted.	tool tee tid ish will t y n e ol or yfor me d at ing		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155720		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/20/2014	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER		STREET 520 W	ADDRESS, CITY, STATE, ZIP CODE 9TH ST R, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000514 SS=D	SSIBLE The facility must reach resident in a professional standare complete; accreadily accessible organized. The clinical recordinformation to ider of the resident's a care and services any preadmission the State; and probased on intervithe facility failed documentation of staff member was record, for 1 of 3 documentation, (Resident A) Findings included 1. On 6/17/14 at Administrator professional standard professional staff and staff according to the s	ew and record review, It to ensure If alleged abuse against a Its complete in the clinical Its residents reviewed for It in a sample of 7.	F000514	F – 514 The corrective action takenf those residents found to have been affected by the deficient practice is that the clinical record of the resident identified as resident A has been amended to include the information related to the allegation of abuse.	t t

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
155720		B. WING 06/			06/20/2014	06/20/2014	
l					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					9TH ST		
PROVIDENCE HOME HEALTH CARE CENTER					R, IN 47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ie	PLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		ATE
		Resident A. The report			The corrective action taken	·	
		l Report, Date: 5/26/14,			the other residentshaving th		
		/25/14, Incident Time:			potential to be affected by t		
	9:45 PM, Reside	ent Name: [Resident			same deficient practice is th	nat	
	A]Brief Descr	iption of Incident: CNA			changes in resident condition	n	
	[CNA # 1] was f	found on the floor in			or status, includingallegation	ns	
	[room number] l	peside [Resident A's]			of abuse/neglect, will be		
	bed. She had BN	I on both hands. She was			documented in the involved		
	not responsive to	o name being called.			resident's clinical records as		
	EMT's called an	d [CNA # 1] taken to			per facility policy.		
		asked what happened					
		ted that [CNA # 1] had			The measures that have bee	n	
	been in bed with				put into place to ensurethat	the	
	occi in oca wiai inii				deficient practice does not		
	A Follow-Up re	port, dated 5/30/14,			recur is that a mandatory		
		approximately 4:00 am			in-service has been conduct	ed	
	-	d [LPN # 1] that [CNA #			for alllicensed nurses on the		
		n an inappropriate sexual			accepted professional		
	_	iate Action Taken:			standards and practices and		
		otified immediately. Staff			facilitypolicies that related i	n	
		gin investigation. [CNA #			residents clinical records of		
	1] suspended and	- -			changes and conditionand		
		ntive measures taken: All			status, including allegations	of	
		cheduled on abuse and			abuse and neglect. The facil		
	the elder care ac				hasdeveloped and	ity	
	line eiger care ac				•		
	A symittom atota	cont by I DNI # 1 datad			implemented a protocol that the clinical record of any		
	A written statement by LPN # 1, dated				1		
	5/26/14, indicated, "9:45 PM. On				residentinvolved in an		
	5/25/14, I found [CNA # 1] on the floor				allegation of abuse will be		
	face down beside [Resident A's]				reviewed by the DON and/o		
	bedBefore I found her on the floor, she				herdesignee the same day or		
	was laying in bed [with] her arm draped				next business day to ensure		
	over the resident	t. He was not upset, but			that the allegation		
	had been earlier in the shift. I thought she				ofabuse/neglect has been		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIII	A. BUILDING 00		COMPLETED		
155720		B. WIN			06/20/2014		
			D. 171		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				520 W 9			
PROVIDENCE HOME HEALTH CARE CENTER			JASPER, IN 47546				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	_	im from earlier. It did not			documented in accordance		
	seem inappropri	ate bx [behavior], I			with acceptable		
	thought she was	helping. 5/26/14 0400			professionalstandards and		
	[4:00 A.M.] I be	elieve I called			practices. If the DON or		
	[Administrator]	to tell him the following			designee finds that it has		
	that [Resident A	a] told me @ first. He			beendocumented satisfactor	ily,	
	stated the CNA	was on top of him,			the DON will follow up with	h	
	holding him dov	vn, kissing his face &			the nurse/nursesinvolved an	d	
	calling him 'bab	y, sexy bunny, sexy'I			will re-train them on the		
	was told to get h				facility policy at that time.		
					Progressivedisciplinary action	on	
	An additional written statement by LPN #				will be taken for continued		
		27/14, indicated, "When I			noncompliance.		
	· ·	oom to tell [CNA # 1] to					
		started on bed check she					
	-	on the floorI asked			The corrective action taken	to	
		hat happened' he said 'she			monitor to assurecompliance		
	fell off the bed.'				is that the DON will bringth		
	len on the bea.				results of the documentation		
	A	and has CNIA #2 dated				1	
		nent by CNA # 2, dated			reviews to QA committee	1	
	· ·	ed, "I walked in the door			meeting for furtherreview an	na	
	_	# 1] laying on the			recommendations for		
		I found [CNA # 1's] shoes			improvement. These review	S	
	-	r of Resident A]. I asked			will continue on anongoing		
	_				basis.		
	removed them b	before climbing in bed."					
	On 6/17/14 at 1	1:30 A.M., during an					
	interview with LPN # 1, she indicated she						
	_						
	1 .	·					
		_					
	On 6/17/14 at 11 interview with I was working on approximately 9 passing medicat Resident A's roo	, .			basis.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155720		A. BUI	LDING	00	COMPL		
155720		B. WIN	G		06/20/	2014	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
DDOWDENOS HOME HEALTH OADS OSNITED				520 W 9			
PROVIDENCE HOME HEALTH CARE CENTER				JASPER	R, IN 47546		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
		with Resident A with					
		n. She indicated Resident					
	_	t earlier in the shift, and					
		v aides had been lying					
		console them." She					
		ot look inappropriate, so					
	_	ything. She indicated the					
		appear upset. She					
		⁴ 1 did not speak. She					
		I not know if CNA # 1's					
		or not, because her hair					
		LPN # 1 indicated that					
	CNA # 1 soon came out to the desk, a						
	call light went of						
	answered Reside	ent A's light. She					
	indicated she did	I not see CNA # 1 doing					
	bed check, so she	e went to check on her,					
	and found her or	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 the	n took care of sending					
	CNA # 1 to the h	nospital, and when she					
	checked on Resi	dent A, approximately 45					
	minutes later, he	was sleeping. She					
	indicated that wh	nen the resident awoke at					
	4:00 A.M., she v	vent in to talk with him					
	and ask him wha	t had happened. She					
		when the resident told					
	her the CNA sex	ually abused him, and					
		Iministrator at that time.					
	On 6/17/14 at 1:4	45 P.M., during an					
		ne Social Services					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155720		A. BUII	DING	00		COMPLETED 06/20/2014	
155720			B. WIN			06/20/	2014
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
DDOV/DENOE HOME HEALTH CARE OF MED				520 W 9			
PROVIDENCE HOME HEALTH CARE CENTER					R, IN 47546		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓΕ	COMPLETION DATE
1710		she indicated she had		1710	<u> </u>		DATE
	` ''	nily regarding the					
	incident.	mry regarding the					
	meident.						
	The clinical reco	ord of Resident A was					
		7/14 at 1:30 P.M.					
		ded, but were not limited					
	~	ental retardation, anxiety					
	1	affective disorder.					
	state, and semizo	arrective disorder.					
	A Minimum Dat	a Set (MDS) assessment,					
	dated 5/21/14, indicated the resident						
		of 15 for cognition,					
		emory impairment. The					
		t indicated the resident					
		assistance of one person					
	_	and transfer, and					
		nce of two+ staff for					
		esident was assessed as					
		tinent of bladder, and					
	always continent	•					
	arways continent	or sower.					
	Documentation 1	regarding the resident's					
		5/14 was not found in the					
	clinical record.						
	On 6/19/14 at 11	:15 A.M., during an					
		ne Director of Nursing					
		ninistrator, the DON					
	` ′	"her fault" that the					
		vas not in the clinical					
		cated, "Whenever					
		ens, I tell the staff to put					
		aper, and not document					
		1 ,					

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AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED 06/20/2014		
	NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE		
	it." 2. On 6/19/14 a provided the curegarding docured february 2014. "Documentation required each si experiences a proposition statusNurses' condition change pertinent nursing and intervention.	at 12:05 P.M., the DON arrent facility policy mentation practices, dated The policy included, in in the nurses' notes is hift on any resident who roblem, demonstrates a my change of notes will identify the ge and will describe any ng assessment indicators						

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