STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HEALTH CARE CENTER	1850 MATADOR ST PERU, IN 46970

(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 #IN00130042. Complaint #IN00130042 - Substantiated. Federal/state deficiencies related to the allegation are cited at F225. Survey date: July 1, 2013 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Survey team: Julie Wagoner, RN, TC Census bed type: SNF: 05 SNF/NF: 77 Total: 82 Census payor type: Medicare: 16 Meficaid: 56 Other: 10 Total: 82 Sample: N/A This deficiency reflects state findings cited in accordance with 410 IAC 16.2 in regards to the Investigation of	F000000		

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.

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	Complaint #IN00130042. Quality Review completed on July 8, 2013, by Brenda Meredith, R.N.			

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F000225 SS=B	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 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 record review and	F000225	**F 225 The facility requests**	07/11/2013

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NAME OF PROVIDER OR SUPPLIER CARING HANDS HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN 46970	

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	interviews, the facility failed to ensure 4 residents were free from abuse in 2 of 3 investigations reviewed for verbal abuse (Resident #B), inappropriate photography (Resident C and D), and misappropriate of property for one of one unidentified residents (Resident E). Finding includes: 1. On 7/1/13 at 11:30 A.M., review of an allegation of abuse investigation, initiated by the facility on 06/24/13, indicated CNA #1 had been overheard speaking "abruptly" to Resident #B. The investigation determined CNA #1 had been verbally abusive to Resident B. Interview with the Administrator, on 07/01/13 at 12:46 P.M., indicated CNA #1 had been terminated and no longer worked at the facility due to the verbal abuse. 2. During an interview, on 07/01/13 at 10:45 A.M., the Administrator indicated he had spoken with an acquaintance of CNA #2 on the telephone and he had indicated he would send in his concerns via an email to the Administrator. The Administrator indicated he received an email on 05/31/13, which indicated that CNA #2 had taken pictures on his		**paper compliance for this citation.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: Resident B – Resident was evaluated and monitored by Social Services for psychosocial concerns and none were noted. Physician and family was notified. Resident C – Full body assessment was completed by licensed nurse and documented. Family was contacted by phone and in writing of photography incident. Resident D - Full body assessment was completed by licensed nurse and documented. Family was contacted by phone and in writing of photography incident. Resident E – Facility is unaware of misappropriation of property. CNA in question photographed with a "wig" on stated the wig was his own property. 2) How the facility identified other residents: (Res #B) All alert and oriented residents were interviewed by Social Services and no other concerns were found. (Res #'s C & D) Social Services conducted facility wide interviews of all alert and oriented residents to see if they were photographed by anyone without their permission	

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	phone and sent them to the caller. On 7/1/13 at 11:35 A.M., review of an allegation of abuse investigation, initiated by the facility on 05/31/13, indicated CNA #2 had taken inappropriate pictures of two residents, Residents C and D, and had possibly misappropriated the property of another undetermined female, Resident E. Review of copies of the 3 photos indicated one phone displayed CNA #2 and Resident C together in a picture. The Administrator indicated Resident C suffered from dementia and was unable to give his consent. A second photo was of a skin impression on what appeared to be a lower abdomen or possible upper buttocks area. The Administrator indicated after speaking with CNA #2 about the photos, he identified the photos were of a skin condition he had found on female Resident D and CNA #2 indicated he had taken the photo to show the nurse. The Administrator indicated Resident D was also unable to give consent to have her body photographed. The third photograph was of CNA #2 wearing a gray wig. It was not		and none were found. (Res E) No residents had reported any missing wigs, and all residents that wear them had them available and did not match wig in photo. 3) Measures put into place / System changes: (Res #B) Staff are in-serviced monthly on Abuse through Upstairs Solutions. (Res #'s C & D) All staff were in-serviced on company media policy. CNA in question was terminated. 4) How the corrective actions will be monitored: HR will monitor and track employee attendance to Upstairs Solutions. Management staff are monitoring all staff for any breech of media policy and offenders will be dealt with according to discipline process up to and including termination. All reported abuse allegations will be logged on an audit form. The results of these audits will be reviewed in the monthly Quality Assurance meeting for 3 months, then quarterly x1 or until compliance is 100% for 3 consecutive months. 5) Responsible Person Administrator will oversee Compliance 6) Date of Compliance: July 11, 2013	

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	determined to whom the wig belonged. The Administrator indicated CNA #2 did not identify which female resident's wig (Resident E) he was wearing in the photograph. The CNA only indicated he liked to "dress up." During an interview, on 07/01/13 at 12:30 P.M., the Administrator indicated he had terminated CNA #2 for taking photographs of residents without permission and also for not following the facility policy regarding no cell phones in the building while working. He indicated he had already reinserviced the staff regarding the policy and procedure regarding cell phones and photographing residents prior to this survey. 3.1-3(t) 3.1-27(b) 3.1-28(a)			