

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2013
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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F000000	<p>This visit was for the investigation of Complaint IN00133379 and Complaint IN00133484.</p> <p>Complaint IN00133379 Substantiated. State/Federal deficiencies cited at F164, F309, F441, and F514.</p> <p>Complaint IN00133484 Substantiated. State/Federal deficiencies cited at F164, F225, F226, and F514.</p> <p>Survey dates: August 19, 20, and 21, 2013</p> <p>Facility number: 000315 Provider number: 155720 AIM number: 100289030</p> <p>Survey team: Amy Winingger, RN</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 3 Medicaid: 36 Other: 7</p>	F000000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 9/13/13 to the state findings of the complaint survey conducted on August 19, 20 and 21, 2013.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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	<p>Total: 46</p> <p>Sample: 23</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 26, 2013, by Jodi Meyer, RN</p>						

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F000164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review the facility failed to ensure personal resident information was kept confidential in that, 2 of 2 former staff members indicated LPN #3 shared confidential personal</p>	F000164	The corrective action taken for those residents found to be affected by the deficient practice is that the LPN identified as LPN #3 has received a disciplinary action for breach of resident confidentiality in accordance with facility policy. The corrective action taken for the other residents having the potential to	09/13/2013

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	<p>information of 4 of 4 residents in a sample of 23. (Resident K, Resident C, Resident H, and Resident I)</p> <p>Findings include:</p> <p>During an interview on 08/19/13 at 5:35 a.m., LPN #3 indicated SM (Staff Member) #1 and SM #2 were her friends and she spoke with them frequently. LPN #3 was observed, at that time, standing at her assigned medication cart on the second floor nursing unit.</p> <p>During a confidential interview on 08/19/13 at 8:30 a.m., SM #1 indicated her employment had been terminated with the facility on 07/24/13. SM #1 indicated she had current concerns with the care provided to Resident K, Resident C, and Resident H since her employment at the facility had been terminated. SM #1 further indicated, at that time, the concerns were based on personal resident information provided to her by LPN #3.</p> <p>During a confidential interview on 08/19/13 at 9:00 a.m., SM #2 indicated her employment had been terminated with the facility on 07/24/13. SM #2 further indicated, at that time, she had current concerns</p>		<p>be affected by the same deficient practice is that the LPN identified as LPN #3 has received a disciplinary action for breach of resident confidentiality and was directed that all residents' personal information is to remain confidential. LPN #3 was advised that any additional or further breach of any resident confidentiality will result in additional disciplinary action which may include termination. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory inservice for all staff has been conducted by the facility. The facility policy on residents' rights was presented to the staff with a focus on residents' rights ensuring personal information was kept confidential. The staff was advised that a violation of the residents' rights to confidentiality of personal information is a serious HIPPA violation and would be dealt with in accordance with the facility disciplinary process. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure confidentiality. The tool will be completed by Social Services and/or designee weekly for four weeks, then monthly for three</p>				

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	<p>related to the care of Resident I since her employment at the facility had been terminated. SM #2 further indicated, at that time, the concerns were based on personal resident information provided to her by LPN #3.</p> <p>The Employee File of LPN #3 was reviewed on 08/21/13 at 11:15 a.m.</p> <p>An Employee Confidentially (sic) Statement dated 02/02/13 and signed by LPN #3 indicated, "...understand and agree that in the performance of my duties as an employee of this health care facility that I must hold ALL resident medical information in the strictest of confidence...This means that I will not divulge confidential information about any resident at the facility, regardless of whether I am working there or not."</p> <p>An Employee Orientation Form dated 02/12/13 and signed by LPN #3 indicated, "...I have read and understand the Residents Rights dated November 1993...".</p> <p>An undated Job Description for a Charge Nurse signed by LPN #3 indicated, "...To respect resident rights and treat resident care with confidentiality...".</p>		<p>months and then quarterly for 3 quarters. The outcome of this tool will be reviewed at the quarterly Quality assurance meeting to determine is any additional action is warranted.</p>		

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	<p>During an interview on 08/21/13 at 12:40 p.m., the DoN (Director of Nursing) indicated all staff were inserviced and educated on confidentiality upon hire and annually.</p> <p>The Resident's Rights provided by the DoN on 08/21/13 at 2:00 p.m. indicated, "...You have the right to confidentiality of your personal and clinical records..."</p> <p>This Federal tag relates to Complaint IN00133379 and IN00133484.</p> <p>3.1-3(o) 3.1-3(p)(2) 3.1-3(p)(4)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p>	F000225	The corrective action taken for	09/13/2013			

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	<p>Based on observation, interview, and record review the facility failed to ensure resident to resident altercations were reported to the Indiana State Department of Health, in that, 2 occurrences of resident to resident altercations were not reported to the Indiana State Department of Health for 1 of 3 residents reviewed for behaviors in a sample of 23. (Resident D, Resident U, and Resident F)</p> <p>Findings Include:</p> <p>On 08/19/13 at 6:40 a.m., Resident D was observed sitting in a wheelchair at the nursing station.</p> <p>The clinical record of Resident D was reviewed on 08/21/13 at 8:15 a.m. The record indicated the diagnoses of Resident D included, but were not limited to, Bipolar Affective Disorder, Dementia, and Schizophrenia.</p> <p>The most recent MDS (Minimum Data Set Assessment) dated 08/07/13 indicated Resident D experienced moderate cognitive impairment and had experienced no behaviors during the assessment period.</p> <p>A Nursing note dated 07/21/13 at 1717 (5:17 p.m.) indicated, "...This</p>		<p>those residents found to be affected by the deficient practice is that the events involving resident U and resident F were reported to the Indiana State Department of Health on 8/20/13 even though there was no willful intent or injury. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility has reviewed its abuse reporting policy. The policy has been updated to include the clause that the facility must ensure that all alleged violations involving mistreatment, neglect or abuse including injury 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 measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all staff members on the changes in the facility abuse policy and procedure.The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the reporting of all alleged episodes</p>				

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	<p>res [resident] struck another res..."</p> <p>A Nursing note dated 07/21/13 at 1745 (5:45 p.m.) indicated, "...This res struck another res in passing..."</p> <p>During an interview on 08/19/13 at 6:00 a.m., LPN #1 indicated she had witnessed the altercation between Resident D and Resident U. LPN #1 further indicated, at that time, the action of Resident D couldn't be intentional because Resident D was confused.</p> <p>During an interview on 08/21/13 at 2:00 p.m. the DoN (Director of Nursing) indicated Resident F was struck by Resident D on 07/21/13 at 5:17 p.m. and Resident U was struck by Resident D on 07/21/13 at 5:45 p.m.</p> <p>The Procedure for Reporting Abuse provided by the DoN on 08/21/13 at 12:15 p.m., indicated, "...The Providence Home Health Care Center will not permit residents to be subjected to abuse by anyone including...other residents, ...". The procedure lacked any documentation of reporting resident to resident abuse with or without injury and lacked any documentation of reporting alleged violations involving mistreatment.</p>		<p>of resident mistreatment. This tool will be completed by the administrator and/or designee weekly for four weeks, then monthly for three months and then quarterly for 3 quarters. The outcomes of this tool will be reviewed at the quarterly Quality Assurance meeting to determine if any additional action is warranted.</p>		

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	<p>During an interview, at that time, the DoN indicated neither incident of resident to resident mistreatment was reported to the State.</p> <p>During an interview on 08/21/13 at 1:20 p.m. the HFA (Health Facilities Administrator) indicated the resident to resident altercations were not abusive situations, there had been no willful intent, and neither incident was reportable to the State.</p> <p>The Indiana State Department of Health Division of Long Term Care Policy dated 01/15/2013 provided by the DoN on 08/21/13 at 1:45 p.m. indicated, "...Reportable Incidents...The facility must ensure that all alleged violations involving mistreatment ...are reported immediately...to other officials in accordance with State law..."</p> <p>This Federal tag relates to Complaint number IN00133484.</p> <p>3.1-28(c)</p>				

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F000226 SS=B	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview, and record review the facility failed to ensure a comprehensive abuse policy was developed, in that the current abuse policy did not include the reporting of resident to resident altercations and 2 of 2 allegations of resident to resident altercations were not reported to the Indiana State Department of Health. This deficiency had the potential to affect 31 of 31 residents who resided on second floor. (Resident D, Resident F, and Resident U)</p> <p>Findings Include:</p> <p>On 08/19/13 at 6:40 a.m., Resident D was observed sitting in a wheelchair at the nursing station.</p> <p>The clinical record of Resident D was reviewed on 08/21/13 at 8:15 a.m. The record indicated the diagnoses of Resident D included, but were not</p>	F000226	<p>The corrective action for those residents found to be affected by the deficient practice is that the events involving residents U and F were reported to the Indiana State Department of Health on 8/20/13 even though there was no willful intent or injury. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility reviewed and revised its abuse reporting policy. The policy has been updated to include the clause that 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 measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all staff members</p>	09/13/2013

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	<p>limited to, Bipolar Affective Disorder, Dementia, and Schizophrenia.</p> <p>A Nursing note dated 07/21/13 at 1717 (5:17 p.m.) indicated, "...This res [resident] struck another res..."</p> <p>A Nursing note dated 07/21/13 at 1745 (5:45 p.m.) indicated, "...This res struck another res in passing..."</p> <p>During an interview on 08/21/13 at 2:00 p.m. the DoN (Director of Nursing) indicated Resident F was struck by Resident D on 07/21/13 at 5:17 p.m. and Resident U was struck by Resident D on 07/21/13 at 5:45 p.m.</p> <p>The Procedure for Reporting Abuse provided by the DoN on 08/21/13 at 12:15 p.m., indicated, "...The Providence Home Health Care Center will not permit residents to be subjected to abuse by anyone including...other residents, ...". The procedure lacked any documentation of reporting resident to resident abuse with or without injury and lacked any documentation of reporting alleged violations involving mistreatment. During an interview, at that time, the DoN indicated neither incident of resident to resident mistreatment was reported to the State.</p>		<p>on the changes in the facility abuse policy and procedure .The corrective action taken to monitor to assure performance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the reporting of all alleged episodes of resident mistreatment. This tool will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes of this tool will be reviewed at the quarterly Quality Assurance meeting to determine is any additional action is warranted.</p>		

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	<p>During an interview on 08/21/13 at 12:00 p.m., the DoN indicated the abuse policy had been revised last month and did not include information regarding all allegations of mistreatment would be reported to ISDH (Indiana State Department of Health). The DoN further indicated, at that time, it would be the policy of the facility to follow the Procedure for Reporting Abuse from the ISDH.</p> <p>During an interview on 08/21/13 at 1:20 p.m. the HFA (Health Facilities Administrator) indicated the resident to resident altercations were not abusive situations, there had been no willful intent, and neither incident was reportable to the State.</p> <p>The Indiana State Department of Health Division of Long Term Care Policy dated 01/15/2013 provided by the DoN on 08/21/13 at 1:45 p.m. indicated, "...Reportable Incidents...The facility must ensure that all alleged violations involving mistreatment ...are reported immediately...to other officials in accordance with State law..."</p> <p>This Federal tag relates to Complaint number IN00133484.</p>						

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review the facility failed to ensure insulin was administered correctly for 3 of 5 residents reviewed for diabetes management, in that fast-acting insulin was administered to 1 of 3 residents (Resident C) too far in advance of a meal, without a snack, and resulted in an episode of hypoglycemia that required emergent intervention, and the insulin was administered too far in advance of a meal, without snack, for 2 of 3 residents (Resident A and Resident B) who received sliding scale insulin in the morning in the sample of 23. (Resident C, Resident A, and Resident B)</p> <p>Findings include:</p> <p>1. Resident C was observed on 08/19/13 at 5:50 a.m. to be lying in bed. During an interview, at that time, LPN #1 indicated she would have to</p>	F000309	The corrective action taken for those residents found to be affected by the deficient practice is that residents identified as residents C, A, and B are now receiving their fast acting insulin in accordance with the manufacturer guidelines and have not experienced any negative outcomes. In addition the LPN identified as LPN #1 has been terminated related to overall job performance issues. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents who receive fast acting insulin have been reviewed. The nurses have received additional direction on thee proper administration of fast acting insulin. The residents' MARs have been updated to include documentation for a substantial snack to be administered when warranted following the administration of fast acting insulin. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur	09/13/2013	

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	<p>wait to administer the fast-acting insulin to Resident C, because when it had been administered early on 08/10/13 Resident C had experienced a bad reaction. LPN #1 then indicated, she usually gives Resident C insulin around 6:25 a.m. because Resident C eats breakfast in her room and medications can be given one hour before or after the scheduled time.</p> <p>The clinical record of Resident C was reviewed on 08/20/13 at 10:00 a.m. The record indicated the diagnoses of Resident C included, but were not limited to, IDDM (Insulin Dependent Diabetes Mellitus).</p> <p>The most recent MDS (Minimum Data Set Assessment) dated 06/12/13 indicated Resident C experienced minimal cognitive impairment.</p> <p>The most recent Physician Order Recap dated 08/06/13 included, but was not limited to orders for "...Novolog [fast-acting insulin] 100 u [units]/ml [milliliter] vial inject 6 [six] units SQ [subcutaneous] BID [twice daily]... 0630 [6:30 a.m.] and 2100 [9:00 p.m.]...Accucheck [glucometer to measure blood glucose] QID [four times a day] 0600 [6:00 a.m.]...Novolog s/s [sliding scale]</p>		<p>is that a mandatory in-service has been conducted for all licensed nurses on the manufacturer guidelines for the administration of fast acting insulin. The nurses have also been educated in the facility practice of documenting that a substantial snack has been provided for the resident when warranted related to the administration of fast acting insulin. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the administration of fast acting insulin to ensure that the resident received a meal or substantial snack within the recommended manufacturer guidelines of 10 minutes upon the administration of fast acting insulin. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.</p>				

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	<p>inject SQ as follows: 0-120 = 0 units...".</p> <p>The August 2013 MAR (Medication Administration Record) indicated an Accucheck was performed on 08/10/13 at 0600 [6:00 a.m.] with a result of 106. The time of 0600 was observed to be overwritten with undated bold numbers of 0730 (7:30 a.m.). The MAR further indicated Resident C received 1 unit of Novolog per sliding scale on 08/10/13 at 6:30 a.m. for a total of 7 units of fast-acting insulin. The MAR lacked any documentation a substantial snack had been given.</p> <p>A Physician Telephone Order dated 08/10/13 at 0910 (9:10 a.m.) indicated, "Send to ER [Emergency Room] for eval [evaluation] and tx [treatment]"</p> <p>A Physician Telephone Order dated 08/10/13 at 1015 (10:15 a.m.) indicated, "Give RTN [routine] insulin only with meals in A.M. [morning]..."</p> <p>A untimed Nursing note dated 08/10/13 indicated, "This nurse went in res [resident] room to take meds [medicines] @ [at] 0830 [8:30 a.m.] et [and] noticed res breakfast had not been touched. Noted res slow to</p>						

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	<p>respond et diaphoretic BS [blood sugar] taken @ this time 33. Gave glucose gel @ 0840 [8:40 a.m.]. BS taken at 0850 [8:50 a.m.] to be 32. Paged MD [physician] @ 0852 [8:52 a.m.]. BS taken at 0900 [9:00 a.m.] BS was 30. Glucagon [a medication for low blood sugar] given @ 0901 [9:01 a.m.]. MD returned page @ 0911 [9:11 a.m.]. Res was unresponsive @ this time, diaphoretic...MD gave order to send to ER ..."</p> <p>A Care Plan dated 06/18/13 for Diabetes included, but was limited to, an intervention of "...provide insulin as ordered...".</p> <p>During an interview on 08/20/13 at 10:00 a.m. Resident C stated, "They take my Accucheck around 6:00 every morning and then give me my insulin right after that...I eat around 7:30 a.m."</p> <p>During an interview on 08/21/13 at 12:15 p.m., the DoN indicated she had not been told the hypoglycemic episode was the result of fast-acting insulin being administered 1-2 hours before eating. The DoN further indicated, at that time, fast-acting insulin should not be administered more than 10 (ten) minutes before a</p>				

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	<p>meal. The DoN then indicated the nursing staff had been instructed not to administer fast-acting insulin more than 10 minutes before a meal, but if it was necessary situation, the nurses should provide a substantial snack with the administration.</p> <p>During an interview on 08/21/13 at 2:00 p.m. the DoN indicated a formal policy could not be located for reporting medication errors. The DoN further indicated, at that time, the nursing staff should have reported the error to her immediately.</p> <p>2. Resident A was observed on 08/19/13 at 6:00 a.m. sitting in an upright chair in her room.</p> <p>During an interview on 08/19/13 at 12:05 p.m., Resident A stated, "...get my Accucheck around 5:00 a.m. every morning, then I get my insulin right away after that if I need it. They don't give me a snack...".</p> <p>The clinical record of Resident A was reviewed on 08/20/13 at 9:20 a.m. The record indicated the diagnoses of Resident A included, but were not limited to, Type 2 Diabetes.</p> <p>The most recent MDS dated 07/20/13 indicated Resident A experienced no</p>			

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	<p>cognitive impairment.</p> <p>The most recent Physician Order Recap dated 07/23/13 included, but was not limited to orders for "...Accucheck QID @ 0600...with Novolog 100 u/ml use sliding scale ..."</p> <p>The August 2013 MAR indicated Resident A received sliding scale insulin at 6:30 a.m. on the following dates: 08/01/13, 08/03/13, 08/04/13, 08/05/13, 08/07/13, 08/08/13, 08/10/13, 08/11/13, 08/12/13, 08/14/13, and 08/15/13. The MAR lacked any documentation a snack had been provided.</p> <p>A Care Plan for Diabetes dated 04/28/13 included, but was not limited to, an intervention of "...administer meds per order..."</p> <p>3. Resident B was observed on 08/19/13 at 5:55 a.m. lying in bed. LPN #1 was observed, at that time, to perform a blood sugar check without wearing gloves.</p> <p>The clinical record of Resident B was reviewed on 08/20/13 at 9:00 a.m. The record indicated the diagnoses of Resident B included, but were not limited to, DM (Diabetes Mellitus).</p>						

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	<p>The most recent MDS dated 06/20/13 indicated Resident B experienced severe cognitive impairment.</p> <p>The most recent Physician Order Recap dated 07/23/13 included, but was not limited to, orders for, "...Accucheck QID @ 0600...with Novolog sliding scale ..."</p> <p>The August 2013 MAR indicated Resident B received sliding scale insulin at 6:30 a.m. on the following dates: 08/01/13, 08/02/13, 08/03/13, 08/06/13, 08/07/13, 08/10/13, 08/12/13, and 08/16/13. The MAR lacked any documentation a snack had been provided.</p> <p>A Care Plan dated 06/04/13 for Diabetes included, but was not limited to, an intervention of "...administer meds per order..."</p> <p>During an interview with on 08/19/13 at 9:00 a.m., the ADON (Assistant Director of Nursing) indicated the blood sugar checks were typically scheduled for 6:00 a.m. and the insulins were typically scheduled for 6:30 and stated, "...they have one hour before and one after to do Accucheck and administer insulin."</p> <p>A Listing of Mealtimes provided by</p>			

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	<p>the DoN on 08/19/13 at 11:15 a.m. indicated Breakfast was served at 7:30 a.m.</p> <p>During an interview on 08/21/13 at 10:45, RPH (Pharmacist) #1 indicated a blood sugar will start to drop within 15 minutes of fast-acting insulin administration and the peak action of fast-acting insulin would occur within 1 (one) to 3 (three) hours. RPH #1 further indicated, at that time, fast-acting insulin should be given with a snack if greater than 15 minutes before a meal.</p> <p>A Drug Facts and Comparison Information Sheet for Antidiabetic Agents provided by RPH #1 on 08/21/13 at 10:45 a.m. indicated, "...Novolog [fast-acting insulin]...Administration and Dosage...Administration...Because insulin aspart [fast-acting insulin] has a more rapid onset and a shorter duration of activity...it should be injected immediately (within 5-10 minutes) before a meal."</p> <p>An undated Insulin Administration Policy provided by the DoN (Director of Nursing) on 08/20/13 at 3:00 p.m., indicated, "...Insulin Administration Procedure...If insulin must be given with a meal and time does not allow,</p>			

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	<p>then patient may be given snack with insulin administration to prevent low blood sugars/hypoglycemia...".</p> <p>During an interview on 08/20/13 at 10:45 a.m. MD #1 indicated he was the attending physician of Resident C, Resident A, and Resident B. MD #1 further indicated, at that time, he had been told by a facility nurse that Resident C experienced a hypoglycemic episode because she had received fast-acting insulin 1 (one) -2 (two) hours before eating and had not been offered a snack. MD #1 then indicated he would not recommend giving insulin more than 10 minutes before a meal.</p> <p>This federal tag relates to complaint number IN00133379.</p> <p>3.1-37(a)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and</p>	F000441	The corrective action taken for those residents found to have	09/13/2013			

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	<p>record review, the facility failed to ensure proper glove use and proper handwashing were performed for 2 of 2 residents (Resident W and Resident B) observed for blood glucose testing and for 2 of 3 residents (Resident V and Resident B) observed for medication administration in the sample of 23. (LPN #1, LPN #2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 08/19/13 at 5:50 a.m., LPN #1 was observed to perform a blood glucose test for Resident W. LPN #1 was observed, at that time, to not wear gloves. LPN #1 was then observed to not perform handwashing or hand hygiene. LPN #1 was then observed on 08/19/13 at 5:55 a.m. to perform a blood glucose test for Resident B. LPN #1 was observed, at that time, to not wear gloves. On 08/20/13 at 8:25 a.m., LPN #2 was observed to administer medication to Resident V. LPN #2 was then observed to touch the right arm of Resident V. LPN #2 was observed, at that time, to not perform handwashing or hand hygiene. LPN #2 was then observed to administer medication to Resident B. 		<p>been affected by the deficient practice is that acceptable standards of infection control practices in the proper use of gloves and handwashing are being followed while conducting accuchecks for the resident identified as resident W. The corrective action taken for those residents found to have been affected by the deficient practice is that acceptable standards of infection control practices in proper use of gloves and handwashing are being followed while conducting accuchecks for the resident identified as resident B. The corrective action taken for those residents found to be affected by the deficient practice is that acceptable standards of infection control practices in proper handwashing during medication administration are now being provided for residents identified as residents V and B. The corrective action taken for those residents to be affected by the deficient practice is that the LPN identified as LPN #1 has been terminated due to several issues related to unacceptable job performance. The LPPN identified as LPN #2 has received a disciplinary action related to poor infection control practices. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents that are insulin dependent diabetics and all</p>				

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	<p>The Handwashing Policy and Procedure provided by the DoN on 08/21/13 at 12:15 p.m., indicated "Purpose: ...2. Proper handwashing technique preserves the health and safety of residents and staff by preventing the spread of infection. Policy: Handwashing will be done before and after direct resident care...Specific Indications or [sic] Handwashing: ...5. After contact with resident blood...13. Between contact of different residents..."</p> <p>During an interview on 08/21/13 at 12:20 p.m. the DoN indicated a policy and procedure specific to glove use could not be located. The DoN further indicated, at that time, gloves should have been worn while a blood sugar check was performed and handwashing or hand hygiene should have been performed between resident contacts.</p> <p>This Federal tag relates to Complaint IN00133379.</p> <p>3.1-18(l)</p>		<p>residents that receive medications have the potential to be affected by the deficient practice. The LPN identified as LPN #1 has been terminated due to several issues related to unacceptable job performance. The LPN identified as LPN #2 has received a disciplinary action related to poor infection control practices. The measures or systematic changes put into place to ensure the deficient practice does not recur is that a mandatory in-service has been conducted for all licensed nurses on the facility's infection control practices as it relates to the proper use of gloves while conducting accuchecks and proper handwashing practices during medication administration. The corrective action taken to monitor to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the proper infection control practices during accuchecks and medication administration. The tool will monitor for appropriate use of gloves during accuchecks and proper handwashing practices during medication administration. This tool will be completed by the Director of Nursing and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the</p>		

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			quarterly Quality Assurance meeting to determine if any additional action is warranted.		

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F000514 SS=E	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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.</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure the Medication Administration Record and/or Activities of Daily Living Record were accurately and completely documented, in that a time revision to the MAR was inaccurately documented for 1 of 5 residents reviewed for insulin and the Shower record was inaccurate for for 5 of 6 residents reviewed for showers in the sample of 23. (Resident C, Resident R, Resident T, Resident N, Resident F, and Resident G)</p> <p>Findings include:</p> <p>1. The clinical record of Resident C was reviewed on 08/20/13 at 10:00</p>	F000514	The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident C has had their medication record reviewed and the medication times are correct and have not been inappropriately altered. The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as residents r, T, N, F, and G are receiving their showers regularly and the ADL record reflects the administration of those showers. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. All medication records have been reviewed to ensure that any changes in	09/13/2013	

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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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a.m. The record indicated the diagnoses of Resident C included, but were not limited to, IDDM (Insulin Dependent Diabetes Mellitus).</p> <p>The most recent Physician Order Recap dated 08/06/13 included, but was not limited to orders for "...Accucheck [glucometer to measure blood glucose] QID [four times a day] 0600 [6:00 a.m.]...".</p> <p>The August 2013 MAR (Medication Administration Record) indicated an Accucheck was performed on 08/10/13 at 0600 [6:00 a.m.] with a result of 106. The time of 0600 was observed to be overwritten with bold numbers of 0730 (7:30 a.m.). The notation lacked any indication of when the time had been revised.</p> <p>2. The Resident Care Flow Record for Resident R was reviewed on 08/21/13 at 1:00 p.m. The record indicated Resident R had not received a shower or bed bath from 07/13/13 through 07/26/13. (13 days) During an interview on 08/19/13 at 6:45 a.m., Resident R indicated he received his showers regularly and was observed, at that time to be clean, well-groomed, and without body odor.</p>		<p>medication administration times have been made in acceptable and accurate standards of documentation practices. In addition the facility has reviewed and revised the process whereby showers are recorded in an effort to improve the accurate documentation of the receiving of showers. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has implemented the use of shower sheets to improve the accurate documentation of tracking when the residents receive their showers. In addition a mandatory in-service was conducted for all nursing staff on the facility practice of documenting showers accurately on the ADL flow sheet and the nurses' responsibility for monitoring the flow sheets for accuracy. The corrective action taken to monitor to assure compliance to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the accuracy of the MARs and ADL flow sheets to ensure accuracy of the documentation. this tool will be completed by Medical Records and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be</p>		

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	<p>3. The Resident Care Flow Record for Resident T was reviewed on 08/21/13 at 1:03 p.m. The record indicated Resident T had not received a shower or bed bath from 07/15/13 through 07/28/13. (14 days) During an interview on 08/20/13 at 3:00 p.m., Resident T indicated he always gets his showers and had no complaints and was observed, at that time, to be clean, well-groomed, and without body odor.</p> <p>4. The Resident Care Flow Record for Resident N was reviewed on 08/21/13 at 1:05 p.m. The record indicated Resident N had not received a shower or bed bath from 08/09/13 through 08/15/13. (6 days). The clinical record of Resident N was reviewed on 08/19/13 at 1:45 p.m. The most recent MDS (Minimum Data Set Assessment) dated 07/30/13 indicated Resident N experience severe cognitive impairment. Resident N was observed on 08/19/13 at 5:55 a.m. to be clean, well-groomed and without body odor.</p> <p>5. The Resident Care Flow Record for Resident F was reviewed on 08/21/13 at 1:07 p.m. The record indicated Resident F had not received a shower or bed bath from 07/07/13</p>		<p>reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.</p>		

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	<p>through 07/24/13 (17 days) and from 08/02/13 through 08/18/13. (16 days). The clinical record of Resident F was reviewed on 08/21/13 at 11:20 a.m. During an interview on 08/19/13 at 10:05 a.m., CNA #1 indicated Resident F was frequently confused. Resident F was observed, at that time, to be clean, well-groomed, and without body odor.</p> <p>6. The Resident Care Flow Record for Resident G was reviewed on 08/21/13 at 1:09 p.m. The record indicated Resident G had not received a shower or bed bath from 07/19/13 through 07/28/13. (9 days) The clinical record of Resident G was reviewed on 08/20/13 at 11:30 a.m. The most recent MDS dated 08/09/13 indicated Resident G experienced moderate cognitive impairment. Resident G was observed on 08/19/13 6:43 a.m. to be clean, well groomed, and without body odor.</p> <p>During an interview on 08/20/13 at 1:30 p.m., CNA #2 indicated shower documentation was often inaccurate because one CNA initials the whole ADL (Activities of Daily Living) book and doesn't always know what the other CNA's have done during the shift.</p>			

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	<p>During an interview on 08/20/13 at 3:00 p.m., the DoN indicated the CNA's should not be documenting for each other because they can't know everything the other CNA's have done during the day.</p> <p>This Federal tag relates to Complaint IN00133379 and IN00133484.</p> <p>3.1-50(a)(2)</p>			