

NOV/24/2015/TUE 02:25 PM

FAX No.

P. 003/071



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>Division of Health Care</u> <u>Southern Enforcement Branch</u> B. WING _____	(X3) DATE SURVEY COMPLETED C 11/02/2015
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard and partial extended survey (KY23921) was initiated on 10/20/15 and concluded on 11/02/15. The complaint was substantiated and Immediate Jeopardy was identified on 10/23/15 and was determined to exist on 08/14/15 at 42 CFR 483.13 Resident Behavior and Facility Practices (F223 "J") and 42 CFR 483.20 Resident Assessment (F280 "J"); and Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F223). The facility was notified of the Immediate Jeopardy on 10/23/15.</p> <p>The facility failed to protect Resident #4 and Resident #1 from sexual abuse by Resident #2. Resident #4 was cognitively impaired and had a guardian. Interviews with staff and review of the resident's medical record revealed the resident wandered into other residents' rooms. However, there was no documented evidence the facility revised the resident's care plan with interventions to ensure the resident was safe when wandering. Resident #4 was found in Resident #2's room on 08/14/15 performing oral sex. The facility determined Resident #4 was the "aggressor" even though the resident had no previous sexual behaviors. Review of Resident #2's "Behavioral Symptom Monitoring Flow Record" revealed on 04/06/15 the resident demonstrated "inappropriate sexual behavior." After the incident, Resident #2 was placed on fifteen (15) minute checks until 09/03/15, when the facility determined the monitoring was no longer needed because the resident was not exhibiting any further sexually inappropriate behaviors. The facility's plan to ensure the safety of other residents was to "watch [Resident #2] closely."</p>	F 000	<p>Parkview Nursing and Rehabilitation Center Acknowledges receipt of the Statement of Deficiencies and Proposes this plan of correction, to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care and safety of the residents. The plan of correction is submitted as a written allegation of compliance. Parkview Nursing and Rehabilitation Center's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE	(X6) DATE 11-24-15
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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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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 000	Continued From page 1 However, there was no evidence the facility revised Resident #2's care plan with interventions to "watch [the resident] closely." Resident #1 reported to the Director of Nursing (DON) on 09/30/15 (27 days after Resident #2's 15-minute checks were discontinued) that Resident #2 had entered his/her room, gotten into bed with him/her, and attempted to pull his/her underwear down. Resident #1 resisted Resident #2 and asked the resident to leave. Resident #2 left Resident #1's room but stated he/she would "try again." An acceptable Allegation of Compliance was received on 11/01/15, which alleged removal of the Immediate Jeopardy on 10/25/15. An extended survey was conducted on 11/02/15, and the State Survey Agency determined the Immediate Jeopardy was removed on 10/25/15 as alleged, which lowered the Scope and Severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F223) and 42 CFR 483.20 Resident Assessment (F280), while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000			
F 223 SS=J	483.13(b), 483.13(c)(1)(I) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223			

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F 223	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, review of the facility's policy, and review of the facility's investigation, it was determined the facility failed to have an effective system to ensure two (2) of nine (9) sampled residents were free from sexual abuse (Residents #1 and #4). Record review and staff interviews revealed Resident #4 was severely cognitively impaired, had a guardian, and wandered the facility aimlessly. Staff interviews revealed Resident #4 "would do pretty much anything you ask (him/her) to do." However, there was no documented evidence the facility revised the resident's care plan to address the resident's wandering with interventions to ensure the resident wandered safely. On 06/14/15, facility staff observed Resident #4 in Resident #2's room behind the curtain. Review of the facility's investigation, dated 06/14/15, revealed Resident #4 was "leaning over" Resident #2 with Resident #2's "penis out of his pants and (Resident #4) had his/her mouth around the penis." Review of the facility investigation and interview with the Director of Nursing (DON) revealed the facility determined that Resident #4, whom the facility assessed to be severely cognitively impaired and had a court-appointed guardian, was responsible and instigated the incident. However, staff interview revealed Resident #2 did not attempt to stop the abuse and did not call out to staff when Resident #4 entered Resident #2's room. Furthermore, review of Resident #2's record revealed documentation of "sexually inappropriate behaviors" on 04/06/15.	F 223	F 223 1. Resident #2 no longer resides at the facility. Resident #4 was reviewed on 10/23/15 during the Behavior Management Meeting by the Interdisciplinary Team (IDT) consisting of the Director of Clinical Services, Social Services Director, Executive Director, Minimum Data Set Coordinator and the Activity Assistant. At this time, Resident #4's care plan was reviewed but did not require any further interventions. Resident #4 was seen by the Social Service Director on 6/15/15 with no apparent psychosocial distress noted. Resident #1 was seen by the Social Services Director on 9/30/15 and 10/1/15. Resident #1 reported feeling safe at the facility.	12/02/15	

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F 223	<p>Continued From page 3</p> <p>Resident #2 was placed on 15-minute checks from 08/14/15 until 09/03/15, when the facility determined there was no longer a need for increased supervision because the resident no longer exhibited inappropriate sexual behaviors. Interview with the Director of Nursing (DON) revealed after the 15-minute checks were discontinued for Resident #2, the facility's plan to ensure safety of the residents was to "watch [Resident #2] closely." However, the facility failed to revise the resident's care plan and interviews with staff revealed they were unaware what "watch closely" entailed.</p> <p>On 09/30/15, Resident #2 went into Resident #1's room without staff knowledge, got into bed with Resident #1, and attempted to pull down the resident's underwear.</p> <p>The facility's failure to have an effective system to protect residents from sexual abuse was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 06/14/15 at 42 CFR 483.13 Resident Behavior and Facility Practices (F223) and 42 CFR 483.20 Resident Assessment (F280). The facility was notified of the Immediate Jeopardy on 10/23/15.</p> <p>An acceptable Allegation of Compliance was received on 11/01/15, which alleged removal of the Immediate Jeopardy on 10/25/15. A partial extended survey was conducted on 11/02/15. The State Survey Agency determined the Immediate Jeopardy was removed on 10/25/15, which lowered the Scope and Severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F223) and 42 CFR 483.20 Resident Assessment (F280) while the facility monitors the</p>	F 223	<p>2. All residents have the potential to be affected by the facility's deficient practice.</p> <p>a. 84 residents with at BIMS (Brief Interview for Mental Status) of 8 or greater were interviewed by a Department Manager on 10/23/15 to ensure that they had not been abused or neglected and had not witnessed any abuse or neglect of a fellow resident as well as to inquire about their safety. No further allegations were reported. 115 residents were assessed by licensed nurses via skin sweeps for suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury) on 10/23/15. No suspicious injuries were noted.</p>		

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F 223	<p>Continued From page 4 . effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Resident Abuse," revised 06/01/15, revealed each resident had the right to be free from abuse, neglect, and/or misappropriation of property. Further review revealed the monitoring of residents who may be at risk for abuse, neglect and/or misappropriation was the responsibility of all facility staff.</p> <p>1. Review of a facility investigation, dated 06/15/15, revealed on 06/14/15 Certified Nursing Assistants (CNAs) #3 and #4 "observed a resident on their knees behind a curtain" in Resident #2's room. The incident was immediately reported to Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1. RN #1 entered the room and observed Resident #4 "leaning over" Resident #2, with Resident #2's "penis out of his pants" and Resident #4's "mouth around his penis." Resident #4 was escorted out of the room while Resident #2 "placed his penis back into his pants and zipped them."</p> <p>Observations conducted on 10/20/15 at 4:55 PM revealed Resident #4 was walking up and down the hallway. The resident was observed to enter another resident's room uninvited and walked to the far side of the room before being redirected by staff out of the room. Resident #4 did not respond appropriately to questions when an interview was attempted.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 08/12/14 with</p>	F 223	<p>b. Staff across all departments (nursing, dietary, therapy, housekeeping, laundry, and office staff) were interviewed by Department Managers on 10/23/15 to ensure that none had witnessed any abuse or neglect that had not been previously reported. No further allegations were made by staff.</p> <p>c. On 10/23/15 and 10/24/15, the Facility Human Resource Coordinator and the Assistant Business Office Manager reviewed 96 of 96 employee files to ensure that the files were complete with the criminal background check, Kentucky State Board of Nursing/Nurse Aide Abuse registry check, OIG check, and telephone reference checks and Abuse/Neglect training. No discrepancies were identified.</p>		

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F 223	<p>Continued From page 5</p> <p>diagnoses that included Dementia with Behaviors, Anxiety, Restlessness and Agitation, Depression, and Wandering. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/29/15, revealed the resident's Brief Interview for Mental Status (BIMS) score was 3, which indicated the resident was severely cognitively impaired and was not interviewable.</p> <p>Review of Resident #4's admission information, dated 06/30/14, revealed the local district court had named a guardian for the resident. Review of Resident #4's care plan, dated 08/12/14, revealed the resident demonstrated impaired thought processes with poor decision-making, difficulty understanding others, and short and long-term memory loss. Review of the "Behavior Symptom Monitoring Flow Record" dated 04/24/15 through 06/13/15, revealed the resident was observed by staff to frequently go into other residents' rooms. Although the resident was frequently observed to enter other residents' rooms prior to the incident, the facility failed to revise the resident's care plan to include interventions to ensure the resident wandered safely.</p> <p>Review of Resident #2's medical record revealed the resident was initially admitted to the facility on 12/16/14 with diagnoses that included Alzheimer's disease, Depression, and Anxiety. Review of the Quarterly MDS assessment, dated 06/12/15, revealed the resident's BIMS score was 10, indicating the resident was moderately impaired but interviewable. Review of the resident's Comprehensive Plan of Care, dated 12/24/14, revealed the resident was care planned to experience insomnia. Review of the facility's "Behavioral Symptom Monitoring Flow Record"</p>	F 223	<p>d. On 10/23/15 and 10/24/15, 101 staff members across all departments were interviewed and asked if they were aware of any resident who exhibits behaviors (including sexual, verbal, mental, and physical) towards any other resident. There were no allegations of abuse/neglect that had not been previously reported.</p>		

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F 223	<p>Continued From page 6</p> <p>for Resident #2 dated 04/01/15 through 08/09/15, revealed the resident was observed to frequently "go into other rooms and take belongings." Further review revealed on 04/06/15, 06/14/15, and 06/18/15 the resident was observed demonstrating "inappropriate sexual behavior."</p> <p>Further review of the facility's investigation revealed on 08/14/15, after the incident, RN #1 returned to Resident #2's room and explained to the resident that his/her "behavior was inappropriate related to [Resident #4's] cognition and should not happen again." Resident #2 "nodded in agreement." Review of Resident #2's witness statement revealed Resident #4 kept "rubbing up against me and unzipped my pants, but I finally got (him/her) to leave." Further review of the investigation revealed Resident #2 was placed on 15-minute checks. Resident #4 was placed on one-to-one supervision with a staff member for approximately 72 hours. The investigation stated Resident #4 "did not repeat this behavior" and "this was a new behavior" for the resident. Resident #4 was placed on 15-minute checks after the initial 72 hours and remained on 15-minute checks until 08/31/15 when Resident #2 was moved to another unit of the facility.</p> <p>Further review of Resident #2's medical record revealed the resident was transferred to the hospital on 08/13/15 due to tearing pictures off the walls in his/her room and threatening staff. Review of the final report from the hospital stay revealed nursing home staff had reported Resident #2 "has been sexually inappropriate and stealing others' belongings and wandering around at night instead of sleeping."</p>	F 223	<p>3. a. 111 of 120 facility staff members across all departments were educated on the regulation for F223 and the facility's policy and procedure for Resident Abuse by the Staff Development Coordinator and/or Nurse Manager on 10/23/15 and 10/24/15. All other staff were given the education prior to their next shift, before they could return to work. This education included abuse screening, training, prevention, identification, investigation, protection, and reporting and response. This included education on the definition for abuse including what constitutes sexual abuse and to report any sexual or physical resident to resident behavior immediately to the licensed nurse. Employees completed a post test at the completion of the education. Newly hired employees will receive the educations during the new hire orientation process. The facility does not utilize agency staffing.</p>		

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F 223	<p>Continued From page 7</p> <p>Interviews with CNAs #1 and #2 on 10/20/15 at 6:27 PM, and LPN #2 on 10/20/15 at 6:39 PM revealed Resident #2 ambulated freely about the facility and had no difficulty with daily decision-making. Further interview with LPN #2 revealed Resident #4 wandered frequently throughout the unit, and was often redirected after entering other residents' rooms. The LPN stated she had observed Resident #4 on one occasion remove his/her clothing and walk out to the hallway. The LPN stated, "...[Resident #4] doesn't realize what is going on." LPN #2 stated Resident #4 was redirected when the resident exhibited these behaviors.</p> <p>Interview with RN #1 on 10/21/15 at 10:04 AM revealed upon entering Resident #2's room at the time of the incident on 06/14/15, Resident #2 "saw me and moved (his/her) head up." The RN stated she was aware of Resident #4 wandering "in and out of rooms" and had to redirect the resident from other residents' rooms. RN #1 stated she was unaware that Resident #2 or Resident #4 had previous history of any sexual behaviors.</p> <p>Interview with CNA #3 on 10/21/15 at 10:40 AM, and CNA #4 on 10/21/15 at 1:26 PM revealed Resident #4 had been found asleep in the chair of other residents' rooms. The CNAs stated Resident #4 was to be redirected when the resident was observed entering another resident's room. Further interview with CNA #3 revealed Resident #4 was "easy to redirect, just tell (him/her) to come with you and (he/she) would follow."</p> <p>Interview with LPN #1 on 10/22/15 at 3:23 PM revealed Resident #2 "always kept the curtain</p>	F 223	<p>b. The facility Executive Director and/or the Director of Clinical Services will review all allegations of resident abuse, complete the 24 hour report, investigation, and the 5 day final report.</p> <p>c. On 10/23/15, members of the Quality Assurance Committee (consisting of the Executive Director, Director of Clinical Services, Medical Director via phone, Social Services Director, Medical Records Coordinator and Nurse Unit Manager) had an Ad Hoc meeting to review the facility policy and procedure for Abuse and adopted the policy without any changes or revisions.</p>		

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F 223	<p>Continued From page 8</p> <p>pulled." The LPN stated she had observed the resident on three occasions to be either masturbating or "zipping (his/her) pants up" upon entering the resident's room. Further interview with the LPN revealed Resident #4 "would do pretty much anything you asked (him/her) to do." The LPN stated she viewed Resident #2 as the "initiator" in the incident with Resident #4 on 06/14/15. The LPN stated Resident #4 "has wandered into other male (residents) rooms and that has never happened." Further interview revealed Resident #4 frequently wandered into other residents' rooms, and was redirected when observed; however, facility staff was not able to watch the resident all the time and staff was not aware Resident #4 was in Resident #2's room at the time of the incident.</p> <p>Interview with Unit Manager (UM) #3 on 10/22/15 at 2:52 PM revealed prior to Resident #2 being transferred to the other unit, the UM was aware the resident would wander and frequently walk to the nurses' station during the night. The UM stated after the incident that occurred on 06/14/15, Resident #2 was observed to enter other residents' rooms. The UM stated Resident #4 also frequently wandered the hallways and into other residents' rooms. However, she stated Resident #4 was easily redirected when wandering.</p> <p>Interviews were attempted with Resident #4's Guardian on 10/22/15 at 10:17 AM and 3:45 PM, and on 10/26/15 at 1:33 PM, but were unsuccessful.</p> <p>Interview with the DON on 10/22/15 at 4:09 PM revealed she was aware that prior to the incident on 06/14/15, Resident #2 had been observed by</p>	F 223	<p>4. a. Department managers conducted Quality Improvement (QI) monitoring of regulation F223 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred. QI monitoring was conducted seven days/week, randomly across all shifts, using a sample size of 5 residents and 5 staff members from 10/26/15 to 11/6/15 when an Ad Hoc QA committee meeting was held and it was determined that the monitoring could decrease to 5 times a week for one month then 3 times a week for one month, then weekly for one month. Any discrepancies were or will be addressed immediately and results of the monitoring will be reported monthly to the QA committee for development of an action plan if needed.</p>		

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(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	
F 223	<p>Continued From page 9</p> <p>facility staff to pull the privacy curtain and masturbate, and had insomnia and wandered. Further Interview revealed after the incident on 08/14/15, Resident #4's 15-minute checks continued until Resident #2 was moved to another unit in the facility (08/31/15), even though she believed Resident #4 was the "aggressor." Further interview with the DON revealed facility staff continued to check on Resident #2's whereabouts every 15 minutes until 09/03/15, when the facility determined the checks could be discontinued because the resident had not exhibited any further sexually inappropriate behaviors.</p> <p>Interviews with LPNs #3 and #4 on 10/22/15 at 2:20 PM revealed staff was instructed to "watch [Resident #2] close" after the 15-minute checks were discontinued. However, staff was not given direction on how often to check on the resident.</p> <p>2. Review of a facility investigation dated 09/30/15 (27 days after Resident #2's 15-minute checks were discontinued) revealed at 7:50 AM on 09/30/15, Resident #1 reported to the DON that Resident #2 had entered his/her room early that morning, gotten into bed, and attempted to remove his/her underwear. Resident #1 resisted Resident #2, stating he/she "didn't like that." It was reported that Resident #2 responded by asking Resident #1 if he/she "liked (him/her) as a friend." Resident #2 left the room, but stated before leaving that he/she would "try that again." According to the facility's investigation, Resident #2 later returned to Resident #1's room, asked how the resident was, and then proceeded down the hallway.</p> <p>Review of Resident #1's medical record revealed</p>	F 223	<p>b. The Director of Clinical Services/Nurse Manager conducted QI monitoring utilizing resident skin sweeps to ensure no suspicious injuries and/or injuries of unknown origin exist. QI monitoring was conducted 7 times weekly, randomly across all shifts, using a sample size of 5 random residents from 10/26/15 to 11/6/15. An Ad Hoc QA committee meeting was held on 11/6/15 and it was determined that the monitoring could decrease to 5 times weekly for one month, then 3 times weekly for one month, and then weekly for one month. Any discrepancies were/will be addressed immediately. Results of the monitoring will be reported monthly to the QA committee for development of an action plan as needed.</p>		

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
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F 223	<p>Continued From page 10</p> <p>the facility admitted the resident on 08/19/15 with diagnoses that included Mild to Moderate Intellectual Disability, Depression, and Anxiety. Review of the facility's admission Minimum Data Set (MDS) Assessment, dated 08/26/15, revealed the facility assessed the resident's BIMS score to be 11, indicating the resident was moderately cognitively impaired and interviewable.</p> <p>Review of Resident #2's Quarterly MDS Assessment, dated 09/08/15, revealed the resident's BIMS score was 14, indicating the resident was cognitively intact and interviewable. Review of the resident's Comprehensive Plan of Care, dated 06/15/15, revealed the resident displayed socially inappropriate sexual behavior. Review of the Behavioral Health Unit History and Physical, dated 08/13/15, revealed nursing home staff had reported the resident had been "sexually inappropriate, stealing others' belongings, and wandering around at night instead of sleeping." Further review of the resident's care plan revealed no interventions were put into place to monitor the resident after 09/03/15, when the 15-minute checks were discontinued, even though the resident had a history of sexually inappropriate behavior and insomnia.</p> <p>Interview with Resident #1 on 10/20/15 at 4:35 PM revealed when asked about the incident, the resident stated Resident #2 "attacked me." Resident #1 stated Resident #2 "got in my bed" and "tried to do nasty things." Resident #1 stated Resident #2 "scared me." The resident stated he/she was afraid at the time of the incident; however, he/she was not scared now because the facility informed him/her that they were "watching [Resident #2] close."</p>	F 223	<p>c. The Assistant Director of Clinical Services/RN supervisor/Unit Manager/Staff Development Coordinator will monitor 5 days a week for new resident to resident behaviors via staff observation and resident medical record documentation and report in the daily department head meeting (this meeting includes the IDT) for discussion to ensure appropriate care plans with appropriate interventions are implemented.</p>		

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F 223	<p>Continued From page 11</p> <p>Interview with Resident #2 on 10/20/15 at 1:16 PM revealed the resident denied the incident occurred with Resident #1 on 09/30/15. The resident stated, "I wouldn't do that, I come from a very respectable family."</p> <p>Interview with UM #1 on 10/22/15 at 2:35 PM revealed although she was not aware of Resident #2 entering another resident's room (prior to the incident on 09/30/15), she was aware the resident got up "very early" and often walked to the nurses' station for ice. The UM stated after the resident's 15-minute checks were discontinued on 09/03/15, staff was "watching to make sure [Resident #2] didn't go into rooms."</p> <p>Interview with LPN #7 on 10/21/15 at 3:48 PM revealed she had to "keep my eye" on Resident #2 because he/she "likes to wander up and down the hall." The LPN stated she worked the night of 09/29/15; however, she did not observe Resident #2 enter Resident #1's room. The LPN stated Resident #2 typically slept until 3:30 AM or 4:00 AM, and then the resident "might wander some." Further interview revealed Resident #2 was often observed to pace up and down the hallway early in the morning. Although the LPN had not observed the resident enter other residents' rooms, she had observed the resident "stand at the doorway" of other rooms.</p> <p>Interview with CNA #10 on 10/23/15 at 8:27 AM revealed prior to the incident on 09/30/15, she had been instructed to "watch [Resident #2] close and make sure [Resident #2] didn't go into anyone else's room." The CNA stated Resident #2 was "hard to watch" and that he/she was "very quiet." Further interview revealed Resident #2 routinely got up early and would walk up and</p>	F 223		

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F 223	<p>Continued From page 12</p> <p>down the hallway. The CNA stated she had not observed Resident #2 enter any other residents' rooms.</p> <p>Interview with the DON on 10/22/15 at 4:09 PM revealed after the 15-minute checks were discontinued for Resident #2 on 09/03/15, the facility's plan to ensure the safety of residents was to "watch [Resident #2] closely." Further interview with the DON revealed she believed "watching" Resident #2 was effective because "more alert and oriented residents" lived on the unit where Resident #2 resided. However, there was no facility policy that defined "watch closely," there was no staff training/in-service on what "watch closely" entailed for Resident #2, and no documentation that Resident #2 was being "watched closely." In addition, review of Resident #2's Comprehensive Care Plan revealed the facility had no interventions in place to monitor Resident #2.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 11/01/15. The facility implemented the following actions to remove Immediate Jeopardy:</p> <p>1) Resident #2 was placed 1:1 with staff on 10/23/15 and will remain on 1:1 until deemed safe per review by the Interdisciplinary Team (IDT) (members include the Executive Director (ED), Director of Clinical Services (DCS), Social Services Director (SSD), and Activity Director) and Primary Care Physician. On 10/23/15, Resident #2's care plan was updated, per the IDT Behavior Management Meeting, to reflect 1:1 supervision.</p> <p>Resident #4 was reviewed on 10/23/15 during the</p>	F 223			

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F 223	<p>Continued From page 13</p> <p>Behavior Management Meeting with the IDT (including the Director of Clinical Services, Social Services Director, Executive Director, Minimum Data Set Coordinator, and the Activity Assistant). At this time, Resident #4's care plan was reviewed by the IDT, but did not require any further interventions. The Social Services Director saw Resident #4 on 08/15/15 with no apparent psychosocial distress noted.</p> <p>The Social Services Director saw Resident #1 on 09/30/15 and 10/01/15. Resident #1 reported feeling safe at the facility.</p> <p>2) Eighty-four (84) residents with a BIMS (Brief Interview for Mental Status) score of 8 or greater were interviewed by a Department Manager (Activity Director, Admission Coordinator, Case Manager) on 10/23/15 to ensure that they had not been abused or neglected and had not witnessed any abuse or neglect of a fellow resident as well as to inquire about their safety. Questions asked included, "Is there currently a staff member or resident in the facility who you feel threatened by?" and "Do you feel safe in the facility?" No further allegations were reported at that time.</p> <p>3) One hundred fifteen (115) of 115 residents were assessed by a licensed nurse via skin sweeps for suspicious injuries on 10/23/15. No suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury) were noted at those times.</p> <p>4) Staff across all departments (Nursing, Dietary, Housekeeping/Laundry, and Office Staff) was interviewed by the Staff Development Coordinator, Nurse Manager, Admissions</p>	F 223			

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
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F 223	<p>Continued From page 14</p> <p>Director, or Medical Records Coordinator on 10/23/15 to ensure that none had witnessed any abuse or neglect that had not been previously reported. Staff acknowledged that they were aware of the different types of abuse/neglect and to whom to report it to. Staff reported no further allegations.</p> <p>5) One hundred one (101) staff members across all departments (Nursing, Dietary, Housekeeping/Laundry, and Office Staff) were interviewed by the Staff Development Coordinator/Nurse Manager/Medical Records Coordinator on 10/23/15 and 10/24/15. The staff was asked if they were aware of any resident who exhibited behaviors (including sexual, verbal, mental, and physical) toward any other resident. There were no allegations of abuse/neglect that had not been previously reported. Resident #2 was not identified as having been involved in an allegation that was not previously reported.</p> <p>6) Sixty-eight (68) staff members across all departments (Nursing, Dietary, Housekeeping/Laundry, and Office Staff) were interviewed by the Staff Development Coordinator/Nurse Manager/Medical Records Coordinator on 10/23/15. The staff was asked if they were aware of any resident who exhibits behaviors (including sexual, verbal, mental, and physical) toward any other resident. From these interviews, two residents with physical and sexual resident to resident targeted behaviors were placed on 1:1 supervision for safety (the safety of self and others), per the IDT Behavior Management Meeting held on 10/23/15. Seven residents with physical behaviors and two residents with sexual behaviors had their care plans reviewed and/or updated to include, but not</p>	F 223			

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 223	<p>Continued From page 15</p> <p>limited to, some of the following interventions: redirection, provide privacy, verbal cueing, speak with a calming voice, assess for pain, distraction and remove stimulus.</p> <p>7) Ninety-six (96) of 96 employee personnel files were reviewed by the Facility Human Resources/Payroll Coordinator and Facility Business Office Coordinator on 10/23/15 and 10/24/15 to ensure that the files were complete with the Criminal Background Check, Kentucky State Board of Nursing, Nurse Aide Abuse Registry check, Office of the Inspector General Exclusion Check, Telephone Reference Checks, and abuse/neglect training. No discrepancies were identified.</p> <p>B) One hundred eleven (111) of 120 facility staff members across all departments (Department Managers, Nursing, Dietary, Housekeeping/Laundry, and Therapy) were educated on the regulation for F223 and the facility's Policy and Procedure for Resident Abuse by the Staff Development Coordinator or the Nurse Manager on 10/23/15 and 10/24/15. Staff members were educated on abuse screening, training, prevention, identification, investigation, protection, reporting, and response. They were educated on the definition for abuse including what constitutes sexual abuse and to report any sexual or physical resident-to-resident behavior immediately to the licensed nurse. Employees completed a posttest at the completion of the education. Staff members who have not been in-serviced will not be allowed to work until they have been in-serviced and completed the Abuse posttest. The Facility Executive Director and/or Director of Clinical Services reviewed all allegations of resident abuse and completed the</p>	F 223			

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F 223	Continued From page 16 24-hour report, the investigation, and the five-day report. The other nine staff members were educated before returning to work. 9) The Director of Clinical Services and Nurse Managers educated 111 of 120 facility staff members in all departments (Department Managers, Nursing, Dietary, Housekeeping/Laundry, and Therapy) on the facility's Care Plan policy on 10/23/15 and 10/24/15. The facility does not use agency staff. Nine (9) facility staff members, who had not received the training, did not work beyond 10/24/15 without having the education prior to the start of their next shift. The facility's staff has been educated to follow the resident's plan of care and that revisions to the resident's care plan were required to ensure their needs were addressed. The staff completed a posttest to demonstrate understanding of the education. Newly hired employees will receive the education during the new hire orientation process. The other nine staff members were educated before returning to work. 10) The Director of Clinical Services, the Medical Director via phone, the Executive Director, Social Services Director, Medical Records Coordinator, and Unit Manager conducted an Ad-Hoc Quality Assurance/Performance Improvement Committee Meeting on 10/23/15 to review the facility's policy and procedure for care plans including revising the resident's plan of care with specific interventions, and abuse prevention. The policies and procedures were adopted without any changes or revisions. As per the facility's Abuse Policy and Procedure: "All incidents of resident abuse are to be reported immediately to the Clinical Nurse in Charge, the Director of Clinical	F 223			

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F 223	Continued From page 17 Services, and the Executive Director." Once reported to one of those three officials an investigation will begin immediately. The ED/Abuse Coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations. 11) A Department Manager will conduct Quality Improvement (QI) monitoring of regulation F223 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred. QI monitoring will be conducted five times a week, randomly across all shifts, using a sample size of five interviewable residents and five staff members. Any issues identified will be addressed immediately. 12) The Director of Clinical Service and Nurse Manager will conduct Quality Improvement Monitoring utilizing resident skin assessments to ensure no suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury)/injuries of unknown origin exist. QI monitoring will be done five times a week, randomly across all shifts, using a sample size of five residents. Any issues identified will be addressed immediately. 13) Quality Improvement monitoring of the facility's process for Care Plans and Behavior Management monitoring has been done utilizing the following: A. Beginning on 10/23/15 the staff was educated by the Staff Development Coordinator/Nurse Manager to report resident-to-resident physical and/or sexual behaviors immediately to the licensed nurse. The licensed nurse will ensure	F 223		

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F 223	<p>Continued From page 18</p> <p>an intervention is in place and notify the ED or DCS immediately. Once reported an investigation will begin immediately. The ED/Abuse Coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations. The licensed nurse will document resident-to-resident physical and/or sexual behaviors in the resident's medical record and on the 24 Hour Report.</p> <p>B. Documentation of the event will be discussed/reviewed in the Daily Department Head meeting by the IDT team (may include the Executive Director, Director of Clinical Services, Social Services Director, Activity Director, MDS Nurse, Nurse Manager, Assistant Director of Clinical Services, and the Therapy Director). The Executive Director(ED), Director of Clinical Services (DCS), RN Supervisor, or Unit Manager will validate this seven times weekly.</p> <p>C. Residents with new resident-to-resident physical and sexual behaviors will have their Care Plans and Kardexes reviewed/updated with an appropriate intervention in the Daily Department Head Meeting by the IDT team. This is validated by the ED/DCS RN Supervisor seven times weekly.</p> <p>D. Residents at risk for harm to self or others will be reported to the ED or DCS immediately and will be reported to appropriate officials in accordance with Federal and State Regulations.</p> <p>14) The MDS Coordinator/Nurse Manager will conduct Quality Improvement (QI) monitoring via staff observation and resident medical record documentation to ensure interventions are appropriate and the resident's plan of care is</p>	F 223			

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F 223	<p>Continued From page 19 being followed. Random daily QI monitoring will be conducted across all shifts using a sample size of five residents.</p> <p>**The SSA validated on 11/02/15 the Immediate Jeopardy was removed as follows:</p> <p>1) Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed Resident #2's behaviors were reviewed, 1:1 supervision was provided, and interventions were to continue per the resident's care plan. Review of Resident #2's care plan, with a revision date of 10/23/15, revealed the resident's care plan had been revised to include 1:1 supervision. Review of Resident #2's Resident Safety Checks, dated 10/23/15 through 10/27/15, revealed staff documented one on one supervision was provided. Interviews on 11/02/15 at 12:55 PM with Unit Manager (UM) #1, at 1:21 PM with Licensed Practical Nurse (LPN) #5, and at 1:40 PM with Certified Nurse Assistant (CNA) #7 confirmed Resident #2 had been placed on 1:1 supervision with staff since 10/23/15, until the resident was discharged on 10/27/15. Interviews on 11/02/15 at 1:30 PM with the Activities Director, at 1:32 PM with the Social Services Director (SSD), at 1:37 PM with the Administrator, and at 1:43 PM with the Director of Nursing (DON) confirmed Resident #2's care plan was updated, per the IDT during the Behavior Management Meeting held on 10/23/15, to reflect 1:1 supervision.</p> <p>Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed Resident #4's behaviors and care plan were reviewed. Interviews on 11/02/15 at 1:27 PM with the Minimum Data Set (MDS) Coordinator, at 1:30</p>	F 223			

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(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
F 223	<p>Continued From page 20</p> <p>PM with the Activities Director, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed Resident #4's care plan was reviewed, per the IDT during the Behavior Management Meeting held on 10/23/15, but did not require any further interventions. Review of Resident #4's medical record on 11/02/15 at 11:50 AM confirmed the resident was seen by the SSD on 06/15/15 with no apparent psychosocial distress noted.</p> <p>Review of Resident #1's medical record on 11/02/15 at 4:15 PM confirmed the resident was seen by the SSD on 09/30/15 and 10/01/15; no concerns were identified.</p> <p>2) Review of the Resident Interview sheets, dated 10/23/15, revealed a Department Manager interviewed 84 residents on 10/23/15 to ensure they had not been abused or neglected. Interviews on 11/02/15 at 1:05 PM with the Admission Director, at 1:23 PM with the Case Manager, and at 1:30 PM with the Activities Director confirmed a Department Manager interviewed 84 residents on 10/23/15 to ensure they had not been abused or neglected, and no further allegations were reported at that time. Interviews during the facility tour on 11/02/15 at 11:48 AM with Resident #7 and unsampled Residents F, J, K, N, O, and P confirmed facility staff had interviewed the residents on 10/23/15 regarding abuse and neglect and the residents had no concerns.</p> <p>3) Review of the facility's Skin Integrity sheets, dated 10/23/15, revealed skin assessments were completed on 115 of 115 residents for suspicious injuries, and none were noted at that time. Interviews on 11/02/15 at 1:12 PM with LPN #1,</p>	F 223		

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F 223	Continued From page 21 at 1:21 PM with LPN #5, and at 1:34 PM with LPN #8 confirmed skin sweeps were completed on 115 of 115 residents on 10/23/15 and no suspicious injuries were identified. 4) Review of staff rosters, dated 10/23/15, revealed facility staff across all departments was interviewed to ensure no one had witnessed any abuse or neglect that had not been previously reported. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the Medical Records Coordinator, at 1:05 PM with the Admissions Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed facility staff across all departments were interviewed to ensure that no one had witnessed any abuse or neglect that had not been previously reported. They stated staff also acknowledged that they were aware of the different types of abuse/neglect and to whom to report. Interviews with Therapy Assistant #1 on 11/02/15 at 12:45 PM and Maintenance Staff Members #1 and #2 at 1:19 PM confirmed they had been interviewed on 10/23/15 regarding abuse/neglect, and had been educated regarding the different types of abuse/neglect and to whom to report allegations. 5) Review of staff rosters, dated 10/23/15 and 10/24/15, revealed 101 facility staff members across all departments were interviewed regarding any residents that exhibited behaviors toward any other resident. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the Medical Records Coordinator, at 1:05 PM with the Admissions Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed facility staff across all departments was interviewed	F 223			

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F 223	Continued From page 22 regarding resident to resident behaviors, and no allegations of abuse/neglect were identified that had not been previously reported. Interviews with Therapy Assistant #1 on 11/02/15 at 12:45 PM and Maintenance Staff Members #1 and #2 at 1:19 PM confirmed they had been interviewed regarding resident-to-resident behaviors on 10/23/15. 6) Review of staff rosters, dated 10/23/15, revealed 68 facility staff members across all departments were interviewed regarding any residents that exhibit behaviors toward any other resident. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the Medical Records Coordinator, at 1:05 PM with the Admissions Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed facility staff across all departments were interviewed regarding resident to resident behaviors. Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed behaviors for Residents #1, #2, and #4, and unsampled Residents A, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, and HH were discussed/reviewed by the IDT team, and the care plan/interventions were reviewed and revised accordingly. Interviews on 11/02/15 at 12:45 PM with Therapy Assistant #1 and at 1:19 PM with Maintenance Staff Members #1 and #2 confirmed they had been interviewed regarding resident-to-resident behaviors on 10/23/15. Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed seven residents with physical behaviors and two residents with sexual behaviors had their care plans reviewed and/or updated. Review of the residents' care plans confirmed the care plans had been reviewed/updated. Review of Resident	F 223			

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F 223	<p>Continued From page 23</p> <p>#2 and Resident Q's care plans confirmed both had been revised to include 1:1 supervision. Interviews on 11/02/15 at 1:30 PM with the Activities Director, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed the residents' behaviors and care plans were reviewed per the IDT during the Behavior Management Meeting held on 10/23/15.</p> <p>7) Review of the Employee Personnel File Checklist, dated 10/23/15, revealed 96 of 96 employee personnel files were reviewed to ensure that files were complete with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry Check, Office of Inspector General Exclusion Check, Telephone Reference Checks, and Abuse/Neglect training. Interview with the Assistant Business Office Coordinator on 11/02/15 at 1:29 PM confirmed all employee personnel files were reviewed on 10/23/15.</p> <p>8) Review of the facility's in-service staff rosters, dated 10/23/15 and 10/24/15, revealed 111 of 120 facility staff members were in-serviced on F223 and the facility's Policy and Procedure for Resident Abuse and given a posttest. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed they educated staff members on F223 and the facility's Policy and Procedure for Resident Abuse on 10/23/15 and 10/24/15. Staff members not in-serviced during that period were in-serviced prior to being allowed to work. All staff members were in-serviced by 10/25/15. Further interview confirmed posttests were given to and passed by staff after completion of the</p>	F 223			

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F 223	<p>Continued From page 24</p> <p>In-services. Interviews on 11/02/15 at 1:12 PM with LPN #1, at 1:21 PM with LPN #5, at 1:34 PM with LPN #8, and at 1:40 PM with CNAs #7, #8, and #9 confirmed they were in-serviced during 10/23/15 and 10/24/15 regarding resident abuse and F223, and were given a posttest after completing the education. Interview on 11/02/15 at 1:37 PM with the Administrator and at 1:43 PM with the DON confirmed they reviewed all allegations of resident abuse and ensured investigations were completed.</p> <p>9) Review of facility in-service staff rosters, dated 10/23/15 and 10/24/15, revealed 111 of 120 facility staff members were in-serviced and given a posttest on the facility's Care Plan policy. Review of the posttests confirmed all staff completed and passed the test. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:43 PM with the DON confirmed facility staff was in-serviced and posttests were given. Interviews on 11/02/15 at 1:12 PM with LPN #1, at 1:21 PM with LPN #5, at 1:34 PM with LPN #8, and at 1:40 PM with CNAs #7, #8, and #9 confirmed they were in-serviced during 10/23/15 and 10/24/15 regarding the facility's Care Plan policy, and they were given a posttest after completing the education. Interview with the Staff Development Coordinator on 11/02/15 at 1:36 PM confirmed he was responsible to ensure newly hired employees would receive the education during the new hire orientation process.</p> <p>10) Review of the Ad-Hoc Quality Assurance/Performance Improvement (QA/PI) Committee Meeting Minutes, dated 10/23/15, revealed the facility Policy and Procedure for care plans and abuse were reviewed and adopted</p>	F 223			

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F 223	Continued From page 25 without any changes or revisions. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the Medical Records Coordinator, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed the facility's Policy and Procedure for care plans and abuse were reviewed and adopted without changes during Ad-Hoc QA/PI Committee Meeting held on 10/23/15. 11) Interviews on 11/02/15 at 1:05 PM with the Admission Director, at 1:23 PM with the Case Manager, and at 1:30 PM with the Activities Director confirmed QI monitoring of regulation F223 would be conducted by interviewing residents and staff to determine if any instances of abuse/neglect have occurred. Further interview revealed the QI monitoring would be conducted five times a week, randomly across all shifts, using a sample size of five interviewable residents and five staff members. Review of the QI monitoring tools revealed residents and staff were being interviewed to determine if any instances of abuse/neglect had occurred. The facility had identified no concerns. 12) Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, 1:24 PM with UM #2, and at 1:43 PM with the DON confirmed QI monitoring would be conducted by utilizing resident skin assessments to ensure no suspicious injuries/injuries of unknown origin exist. Further interview revealed the QI monitoring would be conducted five times a week, randomly across all shifts, using a sample size of five interviewable residents and five staff members. Review of the QI monitoring for skin assessments revealed they were being	F 223		

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F 223	<p>Continued From page 26</p> <p>conducted as required by the AOC, and no concerns were identified.</p> <p>13) Review of the facility's in-service staff rosters, dated 10/23/15, revealed staff was educated to report resident-to-resident physical and/or sexual behaviors immediately to the Licensed Nurse.</p> <p>A. Interviews on 11/02/15 at 12:45 PM with Therapy Assistant #1, at 1:12 PM with LPN #1, at 1:19 PM with Maintenance Staff Members #1 and #2, at 1:21 PM with LPN #5, at 1:34 PM with LPN #6, and at 1:40 PM with CNAs #7, #8, and #9 confirmed they were aware to report any resident-to-resident behaviors immediately to the Licensed Nurse. Interviews on 11/02/15 at 1:12 PM with LPN #1, at 1:21 PM with LPN #5, and at 1:34 PM with LPN #6 confirmed that after being made aware of resident-to-resident behavior, they were responsible to ensure an intervention was in place, immediately notify the Administrator or DON, and immediately begin an investigation. Further interview revealed the LPNs were aware they were responsible to document any resident-to-resident behaviors in the resident's medical record and on the 24 Hour Report. Interview with the Administrator on 11/02/15 at 1:37 PM confirmed she was responsible to ensure allegations were reported to the appropriate officials in accordance with Federal and State Regulations.</p> <p>B. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:09 PM with the Assistant Director of Nursing (ADON), at 1:12 PM with the Therapy Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:27 PM with the MDS Coordinator, at 1:30 PM with the Activities Director (AD), at 1:32 PM with the SSD, at 1:37 PM with the</p>	F 223			

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F 223	<p>Continued From page 27</p> <p>Administrator, and at 1:43 PM with the DON confirmed documentation of resident-to-resident behaviors would be discussed/reviewed in the Daily Department Head meeting by the IDT team. Further interview confirmed the information would be validated seven times weekly. Review of the Daily Department Head meeting minutes revealed resident-to-resident behaviors were being discussed as directed by the AOC and no new behaviors had been identified.</p> <p>C. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:09 PM with the ADON, at 1:12 PM with the Therapy Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:27 PM with the MDS Coordinator, at 1:30 PM with the Activities Director, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed residents with new resident-to-resident behavior would have their care plans and Kardexes reviewed/updated with appropriate interventions during the Daily Department Head meeting by the IDT team. Further interview confirmed the information would be validated seven times weekly.</p> <p>D. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:09 PM with the ADON, at 1:12 PM with the Therapy Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:27 PM with the MDS Coordinator, at 1:30 PM with the Activities Director, and at 1:32 PM with the SSD confirmed they were aware any residents at risk for harm to self or others would be reported to the DON or Administrator immediately. Interviews on 11/02/15 at 1:37 PM with the Administrator and at 1:43 PM with the DON confirmed any residents at risk for harm to self or others would be reported to the appropriate officials in accordance with</p>	F 223			

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F 223	Continued From page 28 Federal and State Regulations. 14) Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:27 PM with the MDS Coordinator confirmed QI monitoring would be conducted via staff observation and resident medical record review to ensure interventions were appropriate and the resident's care plan was being followed. Staff stated the monitoring would occur daily across all shifts by using a sample size of five random residents. Review of the QI monitoring revealed no concerns with the audits and revealed the audits were being completed as directed by the AOC. No concerns were identified.	F 223		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F 280 1. On 10/23/15, a Behavior Management Meeting was held by the IDT and the care plans of residents #2 and #4 were reviewed. Resident #2's care plan was revised to include 1:1 staff supervision. Resident #4's care plan needed no revision.	12/02/15

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F 280	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility policy, and review of the facility's investigations, it was determined the facility failed to revise the resident's plan of care for two (2) of nine (9) sampled residents (Residents #4 and #2). Interviews and review of Resident #4's Behavior Monitoring Logs revealed Resident #4 was frequently observed to enter other residents' rooms and wander the facility aimlessly; however, the facility failed to revise the resident's care plan to include interventions to ensure the resident wandered safely. On 06/14/15, Resident #4 (a cognitively impaired resident) was observed performing oral sex for Resident #2 (whom the facility assessed to be interviewable). The facility placed Resident #2 on 15-minute checks (facility staff checks the resident's whereabouts every 15 minutes) until 09/03/15, when the facility determined the 15-minute checks were no longer necessary for Resident #2. Staff stated they were required to "closely monitor" Resident #2. However, staff did not know what "closely monitoring" the resident entailed. Review of Resident #2's care plan revealed the facility failed to revise the resident's care plan to include interventions to "closely monitor" the resident to ensure the resident was not sexually inappropriate with another resident. On 09/30/15, Resident #2 entered Resident #1's room without staff knowledge, got into bed with Resident #1, and attempted to remove the	F 280	2. All residents have the potential to be affected by the facility's failure to revise the resident care plan. On 10/23/15, 115 of 115 residents had a skin assessment performed by a licensed nurse to ensure no suspicious injuries were present. None were noted. On 10/23/15 68 staff members across all departments were asked by department managers if they were aware of any resident who exhibits behaviors (including sexual, verbal, mental and physical) towards any other resident. From these interviews two residents with physical and sexual resident to resident targeted behaviors were placed on 1:1 staff supervision for safety of self and others per the IDT Behavior Management Meeting held on 10/23/15. Seven residents with physical	

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F 280	<p>Continued From page 30 resident's underwear.</p> <p>The facility's failure to have an effective system to ensure resident care plans were revised with interventions to keep residents safe was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 08/14/15 at 42 CFR 483.13 Resident Behavior and Facility Practices (F223) and 42 CFR 483.20 Resident Assessment (F280). The facility was notified of the Immediate Jeopardy on 10/30/15.</p> <p>An acceptable Allegation of Compliance was received on 11/01/15, which alleged removal of the Immediate Jeopardy on 10/25/15. A partial extended survey was conducted on 11/02/15. The State Survey Agency determined the Immediate Jeopardy was removed on 10/25/15, which lowered the Scope and Severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F223) and 42 CFR 483.20 Resident Assessment (F280) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Plans of Care," effective 11/30/14 and revised 09/01/15, revealed the comprehensive plan of care was reviewed, updated, and revised by the Interdisciplinary team to "... ensure needs were addressed and that the plan was oriented toward attaining or maintaining the highest practicable physical, mental, and psychosocial well-being."</p> <p>1. Review of Resident #4's medical record revealed the facility admitted the resident on 08/12/14, with diagnoses that included Dementia</p>	F 280	<p>behaviors and two residents with sexual behaviors had care plans reviewed and/or revised to include but not limited to some of the following interventions: redirection, provide privacy, verbal cueing, speak with a calming voice, assess for pain, distraction and remove stimulus. On 10/24/15, 115 residents charts were compared with their care plans by Administrative Nurses to ensure needs were addressed. Revisions were made as needed.</p> <p>3. a. On 10/23/15 and 10/24/15, the Director of Clinical Services/RN Nurse Managers reeducated 111 of 120 facility staff members across all departments on the facility's policy and procedure on Care Plans.</p>	

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F 280	<p>Continued From page 31</p> <p>with Behaviors, Anxiety, Restlessness and Agitation, Depression, and Wandering. Review of the resident's admission paperwork revealed on 06/30/15, the court appointed a temporary guardian for the resident. Review of the Annual Minimum Data Set (MDS) Assessment, dated 04/29/15, revealed the resident's Brief Interview for Mental Status (BIMS) score was 3, indicating the resident was severely cognitively impaired and not interviewable. Further review of the MDS revealed the facility assessed the resident to exhibit other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) to occur one to three days during the seven-day look back period for the assessment.</p> <p>Review of the Behavior Symptom Monitoring Flow Record for May and June 2015 revealed the resident was frequently observed to "go in others' rooms." According to the Behavior Flow Record, staff redirected the resident when this behavior occurred.</p> <p>Interview with Certified Nurse Assistant (CNA) #6 on 10/20/15 at 5:00 PM and Licensed Practical Nurse (LPN) #1 on 10/22/15 at 3:23 PM, revealed Resident #4 frequently wandered into other residents' rooms and was redirected when observed; however, facility staff was not able to watch the resident all the time. Further Interview with the LPN revealed she was responsible for Resident #4's care on 06/14/15 and was not aware the resident had wandered into Resident #2's room until she was notified of the incident.</p>	F 280	<p>All other staff were given the reeducation prior to their next shift, before returning to work. The education included following the resident's plan of care and making revisions as needed to ensure needs are addressed. The staff completed a posttest to demonstrate understanding of the education. Residents with physical and/or sexual resident to resident behaviors have a care plan in place with interventions. Newly hired employees will receive the education during the new hire orientation process. The facility does not utilize agency staffing.</p>	

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F 280	<p>Continued From page 32</p> <p>Interview with LPN #2 on 10/20/15 at 6:39 PM revealed Resident #4 "likes to hold your hand and stand very close to people, but (he/she) doesn't realize what is going on."</p> <p>Interview with Unit Manager (UM) #3 on 10/22/15 at 2:52 PM stated Resident #4 frequently wandered the hallways and into other residents' room. The UM stated Resident #4 was easily redirected when wandering.</p> <p>Review of Resident #4's care plan, dated 08/12/14, revealed the resident demonstrated impaired thought processes with poor decision-making, difficulty understanding others, and short and long-term memory loss. Further review of the care plan revealed although the facility assessed the resident to exhibit other behaviors not directed toward others, and facility staff had observed the resident to "go into others' rooms," the facility failed to revise the resident's care plan to include interventions to ensure Resident #4's safety.</p> <p>Review of a facility investigation dated 06/15/15, revealed on 06/14/15 Certified Nursing Assistants (CNAs) #3 and #4, "observed a resident on their knees behind a curtain" in Resident #2's room. The incident was immediately reported to Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1. RN #1 entered the room and observed Resident #4 "leaning over" Resident #2, with Resident #2's "penis out of [the resident's] pants" and Resident #4's "mouth around [the resident's] penis." Resident #4 was escorted out of the room while Resident #2 "placed (the resident's) penis back into [the resident's] pants and zipped them." Further review of the facility's investigation revealed after the incident occurred</p>	F 280	<p>b. The QA committee conducted an Ad Hoc meeting on 10/23/15 to review the facility's policy and procedure for care plans that includes following the resident's plan of care and revising the plan of care with specific interventions as needed. The policy and procedure was adopted without changes and/or revisions by the committee.</p> <p>c. On 10/23/15, staff were educated by the Staff Development Coordinator/Nurse Manager to report resident to resident physical and/or sexual behaviors immediately to the Licensed Nurse who will ensure an intervention is in place and notify the Executive Director or Director of Clinical Services immediately to begin an investigation. The</p>		

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F 280	<p>Continued From page 33</p> <p>Resident #2 was placed on 15-minute checks.</p> <p>2. Review of Resident #2's medical record revealed the resident was initially admitted to the facility on 12/16/14 with diagnoses that included Alzheimer's Disease, Depression, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/12/15, revealed the resident's BIMS score was 10, indicating the resident was interviewable.</p> <p>Review of the resident's Comprehensive Plan of Care, dated 06/15/15, revealed the facility revised Resident #2's care plan to include socially inappropriate sexual behavior. The facility determined the goal was for the resident to not display any inappropriate or sexual behaviors.</p> <p>Review of the Behavioral Health Unit History and Physical, dated 08/13/15, revealed nursing home staff had reported Resident #2 had been "sexually inappropriate, stealing other residents' belongings, and wandering around at night instead of sleeping." Review of the facility's "Behavioral Symptom Monitoring Flow Record" for Resident #2 dated 04/01/15 through 08/09/15 revealed the resident frequently went "... into other rooms and take belongings." Further review of the Behavioral Monitoring log revealed on 04/06/15, 08/14/15, and 08/18/15 the resident was observed demonstrating "inappropriate sexual behavior."</p> <p>Interview with the Director of Nursing (DON) on 10/22/15 at 4:09 PM revealed Resident #2 was transferred to another unit in the facility per resident and family request on 08/31/15. The DON stated Resident #2's 15-minute checks were discontinued on 09/03/15 because the</p>	F 280	<p>Licensed Nurses were educated to document resident to resident physical and/or sexual behavior in the resident's medical record and on the 24 hour report.</p> <p>d. Documentation of the event in 3c will be discussed in the Daily Department Head meeting by the IDT. Residents with new resident to resident physical and/or sexual behaviors will have their care plans and Nurse Aide Kardexes reviewed and updated with appropriate interventions at this time.</p> <p>4. a. The MDSC/Nurse Manager will conduct QI monitoring via staff observation and resident medical record documentation to ensure interventions are appropriate and resident's plan of care is being</p>		

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F 280	<p>Continued From page 34</p> <p>resident had not exhibited any further sexually inappropriate behaviors. Further interview with the DON revealed the facility's plan to ensure the safety of other residents was to "watch [Resident #2] closely." However, further review of Resident #2's care plan revealed the facility failed to include interventions related to "watch closely" and the facility failed to instruct staff on the appropriate amount of supervision required for the resident.</p> <p>Interviews with LPNs #3 and #4 on 10/22/15 at 2:20 PM revealed staff was instructed to "watch [Resident #2] close" after the 15-minute checks were discontinued. However, they were not given direction on how often to check on the resident.</p> <p>Interview with CNA #10 on 10/23/15 at 8:27 AM revealed prior to the incident on 09/30/15, she had been instructed to "watch [Resident #2] close and make sure [Resident #2] didn't go into anyone else's room." Further interview revealed the CNA had not been given parameters on how often to check on the resident.</p> <p>Review of a facility investigation, dated 09/30/15, revealed at 7:50 AM on 09/30/15, Resident #1 reported to the DON that Resident #2 had entered the resident's room, gotten into the resident's bed, and attempted to remove his/her (Resident #1's) underwear. Resident #1 resisted Resident #2, stating he/she "didn't like that." Resident #1 stated Resident #2 responded by asking Resident #1 if he/she "liked (him/her) as a friend." Resident #2 left the room, but stated before leaving that he/she would "try that again." According to the facility's investigation, Resident #2 later returned to Resident #1's room, asked the resident how he/she was, and then</p>	F 280	<p>followed. Random daily QI monitoring will be conducted across all shifts using a sample size of 5 random residents 7 times a week from 10/26/15 to 11/6/15. On 11/6/15 an Ad Hoc meeting was held by the QA committee and it was decided to decrease the monitoring to 5 times a week for one month, then 3 times a week for one month, then weekly for one month. Any discrepancies were and will be addressed immediately. Results of the monitoring will be reported monthly at the QA committee meeting for development of an action plan as needed.</p>	

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F.280	<p>Continued From page 35 proceeded down the hallway.</p> <p>Interview with Unit Manager (UM) #1 on 10/22/15 at 2:35 PM revealed she was responsible to ensure Resident #2's care plan was reviewed and revised by Nursing. The UM stated monitoring interventions for the resident should have been included on the care plan.</p> <p>Interview with the MDS Coordinator on 11/02/15 at 1:27 PM revealed resident care plans should be revised to include monitoring interventions, if indicated. The MDS Coordinator stated Resident #2's care plan should have been revised to include what "watch closely" entailed.</p> <p>Interviews with the Administrator on 11/02/15 at 1:37 PM and the DON on 11/02/15 at 1:43 PM revealed nursing staff was responsible to review residents' care plans daily. Further interview revealed Resident #2's care plan should have been revised to include monitoring interventions and "watch closely" should have been defined. Further interview revealed interventions to ensure resident safety should be included on the care plan.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 11/01/15. The facility implemented the following actions to remove Immediate Jeopardy:</p> <p>1) Resident #2 was placed 1:1 with staff on 10/23/15 and will remain on 1:1 until deemed safe per review by the Interdisciplinary Team (IDT) (members include the Executive Director (ED), Director of Clinical Services (DCS), Social Services Director (SSD), and Activity Director) and Primary Care Physician. On 10/23/15,</p>	F.280	<p>b. Documented (see 3c above) resident to resident physical and/or sexual behaviors will be discussed daily in the department head meeting, care plans of residents involved will be reviewed and/or revised as will the residents' nurse aide Kardexes. This will be validated by the Executive Director, Director of Clinical Services, and/or RN supervisor/Nurse Unit Manager daily in the department head meeting.</p>		

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F 280	<p>Continued From page 36</p> <p>Resident #2's care plan was updated, per the IDT Behavior Management Meeting, to reflect 1:1 supervision.</p> <p>Resident #4 was reviewed on 10/23/15 during the Behavior Management Meeting with the IDT (Including the Director of Clinical Services, Social Services Director, Executive Director, Minimum Data Set Coordinator, and the Activity Assistant). At this time, Resident #4's care plan was reviewed by the IDT, but did not require any further interventions. The Social Services Director saw Resident #4 on 08/15/15 with no apparent psychosocial distress noted.</p> <p>The Social Services Director saw Resident #1 on 09/30/15 and 10/01/15. Resident #1 reported feeling safe at the facility.</p> <p>2) Eighty-four (84) residents with a BIMS (Brief Interview for Mental Status) score of 8 or greater were interviewed by a Department Manager (Activity Director, Admission Coordinator, Case Manager) on 10/23/15 to ensure that they had not been abused or neglected and had not witnessed any abuse or neglect of a fellow resident as well as to inquire about their safety. Questions asked included, "Is there currently a staff member or resident in the facility who you feel threatened by?" and "Do you feel safe in the facility?" No further allegations were reported at that time.</p> <p>3) One hundred fifteen (115) of 115 residents were assessed by a licensed nurse via skin sweeps for suspicious injuries on 10/23/15. No suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury) were noted at those times.</p>	F 280			

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F 280	Continued From page 37 4) Staff across all departments (Nursing, Dietary, Housekeeping/Laundry, and Office Staff) was interviewed by the Staff Development Coordinator, Nurse Manager, Admissions Director, or Medical Records Coordinator on 10/23/15 to ensure that none had witnessed any abuse or neglect that had not been previously reported. Staff acknowledged that they were aware of the different types of abuse/neglect and to whom to report it to. Staff reported no further allegations. 5) One hundred one (101) staff members across all departments (Nursing, Dietary, Housekeeping/Laundry, and Office Staff) were interviewed by the Staff Development Coordinator/Nurse Manager/Medical Records Coordinator on 10/23/15 and 10/24/15. The staff was asked if they were aware of any resident who exhibited behaviors (including sexual, verbal, mental, and physical) toward any other resident. There were no allegations of abuse/neglect that had not been previously reported. Resident #2 was not identified as having been involved in an allegation that was not previously reported. 6) Sixty-eight (68) staff members across all departments (Nursing, Dietary, Housekeeping/Laundry, and Office Staff) were interviewed by the Staff Development Coordinator/Nurse Manager/Medical Records Coordinator on 10/23/15. The staff was asked if they were aware of any resident who exhibits behaviors (including sexual, verbal, mental, and physical) toward any other resident. From these interviews, two residents with physical and sexual resident to resident targeted behaviors were placed on 1:1 supervision for safety (the safety of	F 280			

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F 280	<p>Continued From page 38</p> <p>self and others), per the IDT Behavior Management Meeting held on 10/23/15. Seven residents with physical behaviors and two residents with sexual behaviors had their care plans reviewed and/or updated to include, but not limited to, some of the following interventions: redirection, provide privacy, verbal cueing, speak with a calming voice, assess for pain, distraction and remove stimulus.</p> <p>7) Ninety-six (96) of 96 employee personnel files were reviewed by the Facility Human Resources/Payroll Coordinator and Facility Business Office Coordinator on 10/23/15 and 10/24/15 to ensure that the files were complete with the Criminal Background Check, Kentucky State Board of Nursing, Nurse Aide Abuse Registry check, Office of the Inspector General Exclusion Check, Telephone Reference Checks, and abuse/neglect training. No discrepancies were identified.</p> <p>8) One hundred eleven (111) of 120 facility staff members across all departments (Department Managers, Nursing, Dietary, Housekeeping/Laundry, and Therapy) were educated on the regulation for F223 and the facility's Policy and Procedure for Resident Abuse by the Staff Development Coordinator or the Nurse Manager on 10/23/15 and 10/24/15. Staff members were educated on abuse screening, training, prevention, identification, investigation, protection, reporting, and response. They were educated on the definition for abuse including what constitutes sexual abuse and to report any sexual or physical resident-to-resident behavior immediately to the licensed nurse. Employees completed a posttest at the completion of the education. Staff members who have not been</p>	F 280			

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F 280	<p>Continued From page 39</p> <p>in-serviced will not be allowed to work until they have been in-serviced and completed the Abuse posttest. The Facility Executive Director and/or Director of Clinical Services reviewed all allegations of resident abuse and completed the 24-hour report, the investigation, and the five-day report. The other nine staff members were educated before returning to work.</p> <p>9) The Director of Clinical Services and Nurse Managers educated 111 of 120 facility staff members in all departments (Department Managers, Nursing, Dietary, Housekeeping/Laundry, and Therapy) on the facility's Care Plan policy on 10/23/15 and 10/24/15. The facility does not use agency staff. Nine (9) facility staff members, who had not received the training, did not work beyond 10/24/15 without having the education prior to the start of their next shift. The facility's staff has been educated to follow the resident's plan of care and that revisions to the resident's care plan were required to ensure their needs were addressed. The staff completed a posttest to demonstrate understanding of the education. Newly hired employees will receive the education during the new hire orientation process. The other nine staff members were educated before returning to work.</p> <p>10) The Director of Clinical Services, the Medical Director via phone, the Executive Director, Social Services Director, Medical Records Coordinator, and Unit Manager conducted an Ad-Hoc Quality Assurance/Performance Improvement Committee Meeting on 10/23/15 to review the facility's policy and procedure for care plans including revising the resident's plan of care with specific interventions, and abuse prevention. The policies</p>	F 280			

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F 280	<p>Continued From page 40</p> <p>and procedures were adopted without any changes or revisions. As per the facility's Abuse Policy and Procedure: "All incidents of resident abuse are to be reported immediately to the Clinical Nurse in Charge, the Director of Clinical Services, and the Executive Director." Once reported to one of those three officials an investigation will begin immediately. The ED/Abuse Coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations.</p> <p>11) A Department Manager will conduct Quality Improvement (QI) monitoring of regulation F223 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred. QI monitoring will be conducted five times a week, randomly across all shifts, using a sample size of five interviewable residents and five staff members. Any issues identified will be addressed immediately.</p> <p>12) The Director of Clinical Service and Nurse Manager will conduct Quality Improvement Monitoring utilizing resident skin assessments to ensure no suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury/injuries of unknown origin exist. QI monitoring will be done five times a week, randomly across all shifts, using a sample size of five residents. Any issues identified will be addressed immediately.</p> <p>13) Quality Improvement monitoring of the facility's process for Care Plans and Behavior Management monitoring has been done utilizing the following:</p>	F 280			

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F 280	<p>Continued From page 41</p> <p>A. Beginning on 10/23/15 the staff was educated by the Staff Development Coordinator/Nurse Manager to report resident-to-resident physical and/or sexual behaviors immediately to the licensed nurse. The licensed nurse will ensure an intervention is in place and notify the ED or DCS immediately. Once reported an investigation will begin immediately. The ED/Abuse Coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations. The licensed nurse will document resident-to-resident physical and/or sexual behaviors in the resident's medical record and on the 24 Hour Report.</p> <p>B. Documentation of the event will be discussed/reviewed in the Daily Department Head meeting by the IDT team (may include the Executive Director, Director of Clinical Services, Social Services Director, Activity Director, MDS Nurse, Nurse Manager, Assistant Director of Clinical Services, and the Therapy Director). The Executive Director(ED), Director of Clinical Services (DCS), RN Supervisor, or Unit Manager will validate this seven times weekly.</p> <p>C. Residents with new resident-to-resident physical and sexual behaviors will have their Care Plans and Kardexes reviewed/updated with an appropriate intervention in the Daily Department Head Meeting by the IDT team. This is validated by the ED/DCS RN Supervisor seven times weekly.</p> <p>D. Residents at risk for harm to self or others will be reported to the ED or DCS immediately and will be reported to appropriate officials in accordance with Federal and State Regulations.</p>	F 280			

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F 280	<p>Continued From page 42</p> <p>14) The MDS Coordinator/Nurse Manager will conduct Quality Improvement (QI) monitoring via staff observation and resident medical record documentation to ensure interventions are appropriate and the resident's plan of care is being followed. Random daily QI monitoring will be conducted across all shifts using a sample size of five residents.</p> <p>**The SSA validated on 11/02/15 the Immediate Jeopardy was removed as follows:</p> <p>1) Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed Resident #2's behaviors were reviewed, 1:1 supervision was provided, and interventions were to continue per the resident's care plan. Review of Resident #2's care plan, with a revision date of 10/23/15, revealed the resident's care plan had been revised to include 1:1 supervision. Review of Resident #2's Resident Safety Checks, dated 10/23/15 through 10/27/15, revealed staff documented one on one supervision was provided. Interviews on 11/02/15 at 12:55 PM with Unit Manager (UM) #1, at 1:21 PM with Licensed Practical Nurse (LPN) #5, and at 1:40 PM with Certified Nurse Assistant (CNA) #7 confirmed Resident #2 had been placed on 1:1 supervision with staff since 10/23/15, until the resident was discharged on 10/27/15. Interviews on 11/02/15 at 1:30 PM with the Activities Director, at 1:32 PM with the Social Services Director (SSD), at 1:37 PM with the Administrator, and at 1:43 PM with the Director of Nursing (DON) confirmed Resident #2's care plan was updated, per the IDT during the Behavior Management Meeting held on 10/23/15, to reflect 1:1 supervision.</p>	F 280			

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F 280	<p>Continued From page 43</p> <p>Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed Resident #4's behaviors and care plan were reviewed. Interviews on 11/02/15 at 1:27 PM with the Minimum Data Set (MDS) Coordinator, at 1:30 PM with the Activities Director, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed Resident #4's care plan was reviewed, per the IDT during the Behavior Management Meeting held on 10/23/15, but did not require any further interventions. Review of Resident #4's medical record on 11/02/15 at 11:50 AM confirmed the resident was seen by the SSD on 08/15/15 with no apparent psychosocial distress noted.</p> <p>Review of Resident #1's medical record on 11/02/15 at 4:15 PM confirmed the resident was seen by the SSD on 09/30/15 and 10/01/15; no concerns were identified.</p> <p>2) Review of the Resident Interview sheets, dated 10/23/15, revealed a Department Manager interviewed 84 residents on 10/23/15 to ensure they had not been abused or neglected. Interviews on 11/02/15 at 1:05 PM with the Admission Director, at 1:23 PM with the Case Manager, and at 1:30 PM with the Activities Director confirmed a Department Manager interviewed 84 residents on 10/23/15 to ensure they had not been abused or neglected, and no further allegations were reported at that time. Interviews during the facility tour on 11/02/15 at 11:48 AM with Resident #7 and unempled Residents F, J, K, N, O, and P confirmed facility staff had interviewed the residents on 10/23/15 regarding abuse and neglect and the residents had no concerns.</p>	F 280			

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F 280	Continued From page 44 3) Review of the facility's Skin Integrity sheets, dated 10/23/15, revealed skin assessments were completed on 115 of 115 residents for suspicious injuries, and none were noted at that time. Interviews on 11/02/15 at 1:12 PM with LPN #1, at 1:21 PM with LPN #5, and at 1:34 PM with LPN #6 confirmed skin sweeps were completed on 115 of 115 residents on 10/23/15 and no suspicious injuries were identified. 4) Review of staff rosters, dated 10/23/15, revealed facility staff across all departments was interviewed to ensure no one had witnessed any abuse or neglect that had not been previously reported. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the Medical Records Coordinator, at 1:05 PM with the Admissions Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed facility staff across all departments were interviewed to ensure that no one had witnessed any abuse or neglect that had not been previously reported. They stated staff also acknowledged that they were aware of the different types of abuse/neglect and to whom to report. Interviews with Therapy Assistant #1 on 11/02/15 at 12:45 PM and Maintenance Staff Members #1 and #2 at 1:19 PM confirmed they had been interviewed on 10/23/15 regarding abuse/neglect, and had been educated regarding the different types of abuse/neglect and to whom to report allegations. 5) Review of staff rosters, dated 10/23/15 and 10/24/15, revealed 101 facility staff members across all departments were interviewed regarding any residents that exhibited behaviors toward any other resident. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the	F 280			

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F 280	Continued From page 45 Medical Records Coordinator, at 1:05 PM with the Admissions Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed facility staff across all departments was interviewed regarding resident to resident behaviors, and no allegations of abuse/neglect were identified that had not been previously reported. Interviews with Therapy Assistant #1 on 11/02/15 at 12:45 PM and Maintenance Staff Members #1 and #2 at 1:19 PM confirmed they had been interviewed regarding resident-to-resident behaviors on 10/23/15. 6) Review of staff rosters, dated 10/23/15, revealed 68 facility staff members across all departments were interviewed regarding any residents that exhibit behaviors toward any other resident. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the Medical Records Coordinator, at 1:05 PM with the Admissions Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed facility staff across all departments were interviewed regarding resident to resident behaviors. Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed behaviors for Residents #1, #2, and #4, and unsampled Residents A, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG, and HH were discussed/reviewed by the IDT team, and the care plan/interventions were reviewed and revised accordingly. Interviews on 11/02/15 at 12:45 PM with Therapy Assistant #1 and at 1:19 PM with Maintenance Staff Members #1 and #2 confirmed they had been interviewed regarding resident-to-resident behaviors on 10/23/15. Review of the Behavior/Psychoactive Meeting Minutes, dated 10/23/15, revealed seven	F 280			

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F 280	Continued From page 46 residents with physical behaviors and two residents with sexual behaviors had their care plans reviewed and/or updated. Review of the residents' care plans confirmed the care plans had been reviewed/updated. Review of Resident #2 and Resident Q's care plans confirmed both had been revised to include 1:1 supervision. Interviews on 11/02/15 at 1:30 PM with the Activities Director, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed the residents' behaviors and care plans were reviewed per the IDT during the Behavior Management Meeting held on 10/23/15. 7) Review of the Employee Personnel File Checklist, dated 10/23/15, revealed 96 of 98 employee personnel files were reviewed to ensure that files were complete with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry Check, Office of Inspector General Exclusion Check, Telephone Reference Checks, and Abuse/Neglect training. Interview with the Assistant Business Office Coordinator on 11/02/15 at 1:29 PM confirmed all employee personnel files were reviewed on 10/23/15. 8) Review of the facility's in-service staff rosters, dated 10/23/15 and 10/24/15, revealed 111 of 120 facility staff members were in-serviced on F223 and the facility's Policy and Procedure for Resident Abuse and given a posttest. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:36 PM with the Staff Development Coordinator confirmed they educated staff members on F223 and the facility's Policy and Procedure for Resident Abuse on 10/23/15 and 10/24/15. Staff	F 280			

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F 280	<p>Continued From page 47</p> <p>members not in-serviced during that period were in-serviced prior to being allowed to work. All staff members were in-serviced by 10/25/15. Further interview confirmed posttests were given to and passed by staff after completion of the in-services. Interviews on 11/02/15 at 1:12 PM with LPN #1, at 1:21 PM with LPN #5, at 1:34 PM with LPN #6, and at 1:40 PM with CNAs #7, #8, and #9 confirmed they were in-serviced during 10/23/15 and 10/24/15 regarding resident abuse and F223, and were given a posttest after completing the education. Interview on 11/02/15 at 1:37 PM with the Administrator and at 1:43 PM with the DON confirmed they reviewed all allegations of resident abuse and ensured investigations were completed.</p> <p>9) Review of facility in-service staff rosters, dated 10/23/15 and 10/24/15, revealed 111 of 120 facility staff members were in-serviced and given a posttest on the facility's Care Plan policy. Review of the posttests confirmed all staff completed and passed the test. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:43 PM with the DON confirmed facility staff was in-serviced and posttests were given. Interviews on 11/02/15 at 1:12 PM with LPN #1, at 1:21 PM with LPN #5, at 1:34 PM with LPN #6, and at 1:40 PM with CNAs #7, #8, and #9 confirmed they were in-serviced during 10/23/15 and 10/24/15 regarding the facility's Care Plan policy, and they were given a posttest after completing the education. Interview with the Staff Development Coordinator on 11/02/15 at 1:36 PM confirmed he was responsible to ensure newly hired employees would receive the education during the new hire orientation process.</p>	F 280		

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F 280	<p>Continued From page 48</p> <p>10) Review of the Ad-Hoc Quality Assurance/Performance Improvement (QA/PI) Committee Meeting Minutes, dated 10/23/15, revealed the facility Policy and Procedure for care plans and abuse were reviewed and adopted without any changes or revisions. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:03 PM with the Medical Records Coordinator, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed the facility's Policy and Procedure for care plans and abuse were reviewed and adopted without changes during Ad-Hoc QA/PI Committee Meeting held on 10/23/15.</p> <p>11) Interviews on 11/02/15 at 1:05 PM with the Admission Director, at 1:23 PM with the Case Manager, and at 1:30 PM with the Activities Director confirmed QI monitoring of regulation F223 would be conducted by interviewing residents and staff to determine if any instances of abuse/neglect have occurred. Further interview revealed the QI monitoring would be conducted five times a week, randomly across all shifts, using a sample size of five interviewable residents and five staff members. Review of the QI monitoring tools revealed residents and staff were being interviewed to determine if any instances of abuse/neglect had occurred. The facility had identified no concerns.</p> <p>12) Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, 1:24 PM with UM #2, and at 1:43 PM with the DON confirmed QI monitoring would be conducted by utilizing resident skin assessments to ensure no suspicious injuries/injuries of unknown origin exist. Further interview revealed the QI</p>	F 280			

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F 280	<p>Continued From page 49</p> <p>monitoring would be conducted five times a week, randomly across all shifts, using a sample size of five interviewable residents and five staff members. Review of the QI monitoring for skin assessments revealed they were being conducted as required by the AOC, and no concerns were identified.</p> <p>13) Review of the facility's in-service staff rosters, dated 10/23/15, revealed staff was educated to report resident-to-resident physical and/or sexual behaviors immediately to the Licensed Nurse.</p> <p>A. Interviews on 11/02/15 at 12:45 PM with Therapy Assistant #1, at 1:12 PM with LPN #1, at 1:19 PM with Maintenance Staff Members #1 and #2, at 1:21 PM with LPN #5, at 1:34 PM with LPN #6, and at 1:40 PM with CNAs #7, #8, and #9 confirmed they were aware to report any resident-to-resident behaviors immediately to the Licensed Nurse. Interviews on 11/02/15 at 1:12 PM with LPN #1, at 1:21 PM with LPN #5, and at 1:34 PM with LPN #8 confirmed that after being made aware of resident-to-resident behavior, they were responsible to ensure an intervention was in place, immediately notify the Administrator or DON, and immediately begin an investigation. Further interview revealed the LPNs were aware they were responsible to document any resident-to-resident behaviors in the resident's medical record and on the 24 Hour Report. Interview with the Administrator on 11/02/15 at 1:37 PM confirmed she was responsible to ensure allegations were reported to the appropriate officials in accordance with Federal and State Regulations.</p> <p>B. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:09 PM with the Assistant Director of</p>	F 280			

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F 280	<p>Continued From page 50</p> <p>Nursing (ADON), at 1:12 PM with the Therapy Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:27 PM with the MDS Coordinator, at 1:30 PM with the Activities Director (AD), at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed documentation of resident-to-resident behaviors would be discussed/reviewed in the Daily Department Head meeting by the IDT team. Further interview confirmed the information would be validated seven times weekly. Review of the Daily Department Head meeting minutes revealed resident-to-resident behaviors were being discussed as directed by the AOC and no new behaviors had been identified.</p> <p>C. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:09 PM with the ADON, at 1:12 PM with the Therapy Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:27 PM with the MDS Coordinator, at 1:30 PM with the Activities Director, at 1:32 PM with the SSD, at 1:37 PM with the Administrator, and at 1:43 PM with the DON confirmed residents with new resident-to-resident behavior would have their care plans and Kardexes reviewed/updated with appropriate interventions during the Daily Department Head meeting by the IDT team. Further interview confirmed the information would be validated seven times weekly.</p> <p>D. Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:09 PM with the ADON, at 1:12 PM with the Therapy Director, at 1:14 PM with UM #3, at 1:24 PM with UM #2, at 1:27 PM with the MDS Coordinator, at 1:30 PM with the Activities Director, and at 1:32 PM with the SSD confirmed they were aware any residents at risk for harm to self or others would be reported to the DON or</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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	
F 280	Continued From page 51 Administrator immediately. Interviews on 11/02/15 at 1:37 PM with the Administrator and at 1:43 PM with the DON confirmed any residents at risk for harm to self or others would be reported to the appropriate officials in accordance with Federal and State Regulations. 14) Interviews on 11/02/15 at 12:55 PM with UM #1, at 1:14 PM with UM #3, at 1:24 PM with UM #2, and at 1:27 PM with the MDS Coordinator confirmed QI monitoring would be conducted via staff observation and resident medical record review to ensure interventions were appropriate and the resident's care plan was being followed. Staff stated the monitoring would occur daily across all shifts by using a sample size of five random residents. Review of the QI monitoring revealed no concerns with the audits and revealed the audits were being completed as directed by the AOC. No concerns were identified.	F 280			