

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

PRINTED: 10/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 10/27/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
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{F 000}	INITIAL COMMENTS  An offsite revisit was conducted, and based on the acceptable Plan of Correction, the facility was deemed to be in compliance on 10/17/15 as alleged.	{F 000}		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey, investigating Complaint KY#00023797 and Complaint KY#00023780, was initiated on 09/08/15 and concluded on 09/17/15. Complaint KY#00023780 was unsubstantiated with no deficiencies. Complaint#KY00023797, was substantiated with deficiencies cited at the highest Scope and Severity of an "D".

This Plan of Correction for the survey completed at Florence Park Center on 09/17/2015 constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

10/17/2015

F 225  
SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4)  
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225

F225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

Address what corrective action will be implemented for those residents found to have been affected by the deficient practice:

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

Resident #1 was assessed for adverse psychosocial effects by the licensed social worker on 9/15/2015. The social worker utilized the PHQ-9 to assess the resident's mood. The social worker spoke to the resident regarding her care, satisfaction with care and any concerns she had regarding staff treatment of her. The resident denied any issues and stated that she was satisfied with care and treatment. The social worker completed follow-up interviews with resident to assess for mood decline on

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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

TITLE

(X6) DATE

*ae Molozzi*

*ADM.*

*10-27-15*

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F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure all alleged incidents of abuse were reported immediately to the appropriate State Agencies in accordance with state law. In addition, the facility failed to have an effective system to ensure allegations of abuse were thoroughly investigated for one (1) of four (4) sampled residents (Resident #1).  Resident #1 reported an allegation of abuse on 09/01/15, stating she/he was afraid of State Trained Nurse Aide (STNA) #1, because the night before, STNA #1 had taken the bed controller away from the resident causing a bruise on the resident's hand, and also STNA #1 refused to give the resident any blankets. Although the Director of Nursing (DON) was notified of the allegation on 09/01/15, and again on 09/06/15, there was no documented evidence of a thorough investigation related to the allegation of abuse and no documented evidence the State Agencies were notified of the allegation.  The findings include:  Review of the facility's policy titled "Policy & Procedure for Abuse, Neglect and	F 225	9/17/15 and a follow-up assessment was completed on 9/21/15. The assessments noted no decline in mood or adverse psychosocial effects.  The resident's skin was assessed on 9/15/2015 by the Unit Manager and Director of Nursing and no issues were noted.  Address how the facility will identify other residents having the potential to be affected by the same practice:  To identify other residents who may be potentially affected, the licensed social worker completed interviews of all residents in the facility with a BIMS of 9 or greater on 9/15/15. The interview asked the residents regarding their satisfaction with care and if they had any concerns regarding staff treatment. There were no allegations or suspicions of abuse.  For residents with a BIMS of 8 or less, the Director of Nursing, Unit Managers, and MDS Nurses conducted head to toe skin assessments to identify any injuries of		

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F 225	Continued From page 2 Misappropriation" undated, revealed, Section V(6) Investigations; Florence Park Care Center will investigate all allegations and suspicions of abuse, neglect or misappropriation of property. Section VII (7) Reporting; Florence Park Care Center will report any allegation or suspicions of abuse, neglect, misappropriation of residents property to the Kentucky Cabinet for Health and Family Services, Office of the Inspector General immediately, immediately is defined as "as soon as possible but no later than twenty four (24) hours after discovery of the incident".  Review of Resident #1's medical record revealed the facility admitted the resident on 07/16/14, with diagnoses which included Dementia with Behaviors, Paralysis Agitans, Tremor, and Parkinson's Disease. Review of the Minimum Data Set (MDS) Assessment dated 08/26/15 revealed the facility assessed the resident's cognitive status on as moderately impaired. Further review, revealed the facility assessed the resident as dependent on staff of two (2) for transfers, dressing and bathing.  Interview with LPN #1, on 09/10/15 at 2:20 PM, and 09/13/15 at 8:00 PM, revealed STNA #2 reported to her on 09/01/15, Resident #1 was afraid because STNA #1 who worked the night before was there again, and the night before STNA #1 had taken the bed controller from him/her, and that was how his/her hand got bruised. LPN #1 revealed she talked with Resident #1, and was told STNA #1 took his/her call light and they had wrestled over it and the resident said she/hs just gave it to STNA #1. LPN #1 further stated Resident #1 told her STNA #1 would not give her/him any blankets.	F 225	unknown source/suspicious Injuries on 9/15/2015. No issues were noted.  Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.  On 9/14/15, the Corporate Director of Nursing re-educated the facility Director of Nursing, Administrator, and Human Resources Director on the abuse policy, including but not limited to the identification of abuse, timely reporting of a abuse allegations or suspicions, how to thoroughly investigate, and how the facility protects residents by suspending staff named in an allegation, or staff who are suspicious for abuse pending the investigation, and timely reporting of investigation results. This education was followed up with a discussion and Q&A session to ensure understanding of the facility policy.  After the Director of Nursing, Administrator, and Human Resource Director were re-educated, all staff training was initiated on 9/15/2015 by the Director of Nursing and/or Human		

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F 225 Continued From page 3

Further interview with LPN #1, revealed after talking to Resident #1, she asked Registered Nurse (RN) #1 to talk with the resident. LPN #1 stated RN #1 talked with the resident and afterwards told LPN #1 the resident called STNA #1 "that big black side" and Resident #1 made the same allegation against STNA #1. LPN #1 stated, she then called the DON and notified her of Resident #1 having a bruise on the left hand, and notified her of Resident #1 stating; the aide (STNA #1) the night before had taken his/her call bell and they had fought over it and that was how he/she got the bruise. She stated she also told the DON, Resident #1 said STNA #1 would not give her/him any blankets. LPN #1 revealed the DON told her to assure the residents in STNA #1's group had their call bells and ask residents how their night was going. LPN #1 stated she thought the DON understood she was reporting abuse because she told the DON exactly what Resident #1 reported. LPN #1 stated she re-assigned SRNA #1 to a different group, but in hindsight she should have sent SRNA #1 home, started an investigation and notified the Administrator of the accusation.

Continued interview, with LPN #1 on 08/14/16 at 2:55 PM, revealed STNA #2 had reported the alleged abuse to her between 8:30 PM and 9:30 PM on 09/01/15 while she was on medication pass, and it was about 11:00 PM when she called the DON.

Interview with STNA #1, on 09/10/15 at 12:55 PM, revealed she was assigned to Resident #1's group on 08/31/15 from 7:00 PM to 09/01/15 at 7:00 AM. She revealed she had not taken a call bell away from any resident, and she always clipped the call bell to the resident's clothing or

F 225 Resources Director to re-educate all facility staff (all licensed and unlicensed personnel) on the facility's abuse policy including but not limited to the resident's right to be free from abuse including the definitions of abuse, identification of abuse, timely reporting of allegations of abuse, and to ensure understanding of the facility's abuse policy. All staff re-education was completed on 9/19/2015.

Routine staff education on the abuse protocols will be increased from annually to two times per year to ensure that staff have a continued understanding of the facility's abuse policy including the resident's right to be free from abuse and definitions of abuse.

*Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:*

All suspicions or allegations of abuse will be reported by the Administrator to the Corporate Director of Clinical Services and/or Corporate Director of Nursing for review to ensure

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F 225	<p>Continued From page 4</p> <p>the bed sheet. She stated, Resident #1 did not ring the call bell once he/she was in bed except when she/he needed a pain pill and Resident #1 had about five (5) blankets on her/him during that shift. Further interview, revealed Saturday (09/05/15) was the last night she worked because she was terminated.</p> <p>Interview with STNA #2, on 09/11/15 at 10:20 AM, and 09/13/15 at 5:20 PM revealed, Resident #1 told her on 09/01/15, the night before, the big black girl (STNA #1) took the call light and wouldn't give it back, and then the black girl struggled with him/her over the bed controller and the resident just let STNA #1 take it. STNA #2 further stated, Resident #1 told her STNA #1 had put him/her to bed and would not give the call bell or bed control to him/her, so the resident had no call light all night. STNA #2 stated she reported the allegation of abuse to LPN #1 on 09/01/15 about 7:30 PM to 8:00 PM and later LPN #1 told her she had reported the incident to the DON. STNA #2 further revealed, when she returned to work on Friday night (09/04/15,) STNA #1 was working on the rehab unit, and this upset her because nothing had been done about the report of abuse, and "this was handled very very wrong".</p> <p>Interview with RN #1, on 09/10/15 at 1:15 PM, revealed LPN #1 had asked her to talk with Resident #1 about the bruise on his/her left hand on 09/01/15. RN #1 stated, Resident #1 told her "that black girl tried to take my call light from me"; however, the resident did not remember when this happened. Further interview with RN #1, revealed she told LPN #1 what the resident reported, and she knew LPN #1 called the DON, but she didn't know if STNA #1 was sent home.</p>	F 225	<p>compliance with regulatory requirements. This will include but not limited to ensuring appropriate scope of investigation, residents are protected during the investigation, and compliance with state and federal reporting requirements are met.</p> <p>An audit of 100 employees, which will include at least one employee from each department and from each shift, will be completed by 10/16/2015 to ensure staff understanding of the abuse policy including but not limited to timely reporting of abuse allegations or suspicions, investigation procedures, and protection of the residents during the investigation. These audits will be completed by the Director of Nursing and/or Administrator. The results of these audits will be referred to the QA Committee to determine a schedule for ongoing monitoring.</p>		

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F 225 Continued From page 5

Interview with LPN #2, on 09/14/15 at 11:05 PM, revealed she was the nurse assigned to Resident #1's unit on 09/31/15 from 7:00 PM to 09/01/15 at 7:00 AM. She stated she was not sure, but thought Resident #1 had his/her call bell all night because the resident normally held it in his/her hand. LPN #2 revealed, she had no concerns brought to her about STNA #1 by residents or staff.

Interview with STNA #3, on 09/13/15 at 12:00 PM, revealed she was assigned to care for Resident #1 on 09/01/15 from 7:00 AM to 7:00 PM. STNA #3 stated, she did not remember seeing anything on Resident #1's hand but the resident did report the aide last night was very rough and very mean; however, did not say anything about his/her call bell being taken although the call bell was not in reach when she entered the room. She stated she reported what the resident said to LPN #3.

Interview with LPN #3, on 09/13/15 at 4:50 PM, revealed that she was the nurse on Resident #1's unit on 09/01/15 7:00 AM to 7:00 PM. She stated she did not recall seeing a bruise on Resident #1's hand, and if she had she would have followed protocol and investigated to see how the resident got the bruise. LPN #3 further stated she did not remember any STNA reporting concerns about any STNA being rough or mean, and would have reported any allegations to the DON right away.

Interview with the DON, on 09/10/15 at 2:05 PM, revealed she had received a call from LPN #1 on 09/01/15. She stated, LPN #1 reported Resident #1 had a bruise on the left hand between the 1st and 2nd digits and the resident said the bruise was from when the STNA took the call bell out of

F 225

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F 225	Continued From page 6 his/her hand and helped the resident to bed the night before. The DON stated she did not feel the report was an allegation of abuse, and thought LPN #1 was only reporting a bruise. She stated, she instructed the nurse to check the residents and assure they had their call bells. She revealed, when she arrived to work the next morning she talked with Resident #1 and asked the resident how she/he got the bruise, and the resident only stated she/he did not sleep well. The DON stated she also asked the resident if she/he had any concerns with any of the staff and the resident denied having any concerns. The DON stated she investigated the bruise and it was consistent with the call bell being removed from the resident's hand.  Further interview with the DON, revealed on Sunday 09/08/15, the day shift supervisor called her stating a STNA had reported STNA #1 had left residents doubled briefed. She further stated the day shift supervisor also reported STNA #2 was upset because she had reported a complaint and she didn't feel there was follow up related to the complaint. The DON stated, she went to the facility to talk with staff about their concerns and placed a call to STNA #2, leaving a message for her to return the call. The DON revealed, STNA #2 called back and said she felt she had reported an allegation of abuse related to Resident #1 and the allegation was not treated as abuse. She said STNA #2 was angry and did not give any further details except to say she had reported abuse which was not investigated. The DON stated, she told STNA #2 she had investigated the bruise and had removed STNA #1 from the schedule. The DON, stated she did not interview staff, but interviewed other residents related to care received and was told by residents that STNA #1	F 225			

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F 225	<p>Continued From page 7</p> <p>did not listen to them and liked to do things her way. She stated she did not think STNA #1 was a good fit for the facility after the complaint of the STNA double briefing residents and also after hearing resident concerns and STNA #1 did not work again after 09/05/15.</p> <p>Further Interview with the DON, on 09/14/15 at 1:40 PM, revealed she re-litigated when LPN #1 called her on 09/01/15, she didn't think the nurse was reporting an allegation of abuse and was just reporting the resident had a bruise. However, the DON revealed when STNA #2 called her on 09/08/15, STNA #2 said she was reporting an allegation of abuse. The DON further stated she did not complete an abuse investigation because she did not think this was abuse after talking to Resident #1 and investigating the bruise and did not report the allegation to State Agencies. However, the DON stated for any allegation of abuse she was to send the perpetrator home immediately, interview all residents who were interviewable, complete head to toe skin assessments for residents who were non-interviewable, interview staff and notify state agencies, and police.</p> <p>Interview with the Administrator on 09/14/15 at 2:56 PM revealed he expected staff to notify him immediately of all allegations of abuse and either he or the DON was responsible to investigate all allegations of abuse. He stated the DON had notified him of an issue with Resident #1's hand and the call light but the resident often banged on things like the slide rail or the table when the resident wanted something. He stated he was not notified that SRNA #1 had taken the call bell out of the resident's hand or refused to give the resident blankets. He stated he and the DON</p>	F 225			

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F 225	Continued From page 8 needed to ask for clarification when an issue was reported to identify if the staff was reporting an allegation of abuse. Continued interview revealed for any allegation of abuse, the facility needed to immediately start an investigation and notify the state agencies. He stated he expected staff to follow the facility policy for abuse.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure policies and procedures were implemented related to abuse for one (1) of four (4) sampled residents (Resident #1). The facility failed to thoroughly investigate an allegation of abuse, and failed to report to the appropriate State Agencies an allegation of abuse as per the facility's policy and procedures.  Resident #1 reported an allegation of abuse on 09/01/15, stating the night before, State Trained Nurse Aide (STNA) #1 had taken the bed controller away from the resident causing a bruise on the resident's hand, and also refused to give the resident any blankets. The Director of Nursing (DON) was notified of the allegation on 09/01/15 and again on 09/06/15; however, there	F 226  F 226	Address what corrective action will be implemented for those residents found to have been affected by the deficient practice:  Resident #1 was assessed for adverse psychosocial effects by the licensed social worker on 9/15/2015. The social worker utilized the PHQ-9 to assess the resident's mood. The social worker spoke to the resident regarding her care, satisfaction with care and any concerns she had regarding staff treatment of her. The resident denied any issues and stated that she was satisfied with care and treatment. The social worker completed follow-up interviews with resident to assess for mood decline on 9/17/15 and a follow-up assessment was completed on 9/21/15. The assessments noted no decline in mood or adverse psychosocial effects.	10/17/2015

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8975 BURLINGTON PIKE FLORENCE, KY 41042	

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F 226 Continued From page 9

was no documented evidence of a thorough investigation related to the allegation of abuse and no documented evidence the State Agencies were notified of the allegation as per facility policy.

The findings include:

Review of the facility's policy titled "Policy & Procedure for Abuse, Neglect and Misappropriation" undated, revealed, Section V(5) Investigations; Florence Park Care Center will investigate allegations and suspicions of abuse, neglect or misappropriation of property. Section VI (7) Reporting; Florence Park Care Center will report all allegation or suspicions of abuse, neglect, misappropriation of residents property to the Kentucky Cabinet for Health and Family Services, Office of the Inspector General immediately. Immediately is defined as "as soon as possible but no later than twenty four (24) hours after discovery of the incident".

Review of Resident #1's clinical record revealed the facility admitted the resident on 07/18/14, with diagnoses including Dementia with Behaviors, Paralysis Agitans, Tremor, and Parkinson's Disease. Review of the Minimum Data Set (MDS) Assessment dated 08/26/15 revealed the facility assessed the resident as having moderate cognitive impairment. Continued review, revealed the facility assessed the resident as dependent on staff of two (2) for transfers, dressing and bathing.

Per interview with Licensed Practical Nurse (LPN) #1, on 09/10/15 at 2:20 PM, and 09/13/15 at 5:00 PM, STNA #2 reported to her on 09/01/15, Resident #1 was afraid because STNA #1 who

F 226

The resident's skin was assessed on 9/15/2015 by the Unit Manager and Director of Nursing and no issues were noted.

*Address how the facility will identify other residents having the potential to be affected by the same practice:*

To identify other residents who may be potentially affected, the licensed social worker completed interviews of all residents in the facility with a BIMS of 9 or greater on 9/15/15. The interview asked the residents regarding their satisfaction with care and if they had any concerns regarding staff treatment. There were no allegations or suspicions of abuse.

For residents with a BIMS of 8 or less, the Director of Nursing, Unit Managers, and MDS Nurses conducted head to toe skin assessments to identify any injuries of unknown source/suspicious injuries on 9/15/2015. No issues were noted.

*Address what measures will be put into place or systematic changes made*

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NAME OF PROVIDER OR SUPPLIER

FLORENCE PARK CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE  
6975 BURLINGTON PIKE  
FLORENCE, KY 41042

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F 226	<p>Continued From page 10</p> <p>worked the night before was there again. LPN #1 revealed Resident #1 reported to STNA #2, that STNA #1 had taken the bed controller from him/her, and that was how his/her hand got bruised and also STNA #1 wouldn't give him/her any blankets. LPN #1 revealed she talked with Resident #1, and was told STNA #1 took his/her call light and they had wrestled over it and the resident said she/he just gave it to STNA #1.</p> <p>Continued Interview with LPN #1, revealed after talking to Resident #1, she asked Registered Nurse (RN) #1 to talk with the resident. LPN #1 stated RN #1 talked with Resident #1 and afterwards told LPN #1 the resident called STNA #1 "that big black aide" and Resident #1 made the same allegation against STNA #1. LPN #1 revealed, she then called the DON and notified her of Resident #1 having a bruise on the left hand, and notified her of Resident #1 stating; the aide (STNA #1) the night before had taken his/her call bell and they had fought over it and that was how he/she got the bruise. She stated she also told the DON, Resident #1 said STNA #1 would not give her/him any blankets. LPN #1 revealed the DON told her to assure the residents in STNA #1's group had their call bells and also ask residents how their night was going. LPN #1 revealed she thought the DON understood she was reporting abuse. She stated, in hindsight she should have sent STNA #1 home, started an investigation and notified the Administrator of the accusation.</p> <p>Continued interview, with LPN #1 on 09/14/15 at 2:55 PM, revealed STNA #2 had reported the alleged abuse to her between 8:30 PM and 9:30 PM on 09/01/15, while she was on medication pass, and it was about 11:00 PM when she</p>	F 226	<p>to ensure that the deficient practice will not recur:</p> <p>On 9/14/15, the Corporate Director of Nursing re-educated the facility Director of Nursing, Administrator, and Human Resources Director on the abuse policy, including but not limited to the identification of abuse, timely reporting of abuse allegations or suspicions, how to thoroughly investigate, and how the facility protects residents by suspending staff named in an allegation, or staff who are suspicious for abuse pending the investigation, and timely reporting of investigation results. This education was followed up with a discussion and Q&amp;A session to ensure understanding of the facility policy.</p> <p>After the Director of Nursing, Administrator, and Human Resource Director were re-educated, all staff training was initiated on 9/15/2015 by the Director of Nursing and/or Human Resources Director to re-educate all facility staff (all licensed and unlicensed personnel) on the facility's abuse policy including but not limited</p>	

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8976 BURLINGTON PIKE FLORENCE, KY 41042
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F 228 Continued From page 11 notified the DON by phone.

Interview with STNA #1, on 09/10/15 at 12:58 PM, revealed she was assigned to Resident #1's group on 08/31/16 from 7:00 PM to 09/01/15 at 7:00 AM. Per interview, she had not taken a call bell away from any resident, and she always clipped the call bell to the resident's clothing or the bed sheet. She revealed, Resident #1 did not ring the call bell once he/she was in bed except when she/he needed a pain pill and Resident #1 had about five (5) blankets on her/him during that shift. Continued interview, revealed Saturday (09/05/15) was the last night she worked because she was terminated.

Interview with STNA #2, on 09/11/15 at 10:20 AM, and 09/13/15 at 5:20 PM revealed, Resident #1 told her on 09/01/16, the night before, the big black girl (STNA #1) took the call light and wouldn't give it back, and then the black girl struggled with the resident over the bed controller and the resident just let STNA #1 take it. STNA #2 stated, Resident #1 told her STNA #1 had put him/her to bed and would not give the call bell or bed control to him/her, so the resident had no call light all night. STNA #2 further stated she reported the allegation of abuse to LPN #1 on 09/01/16 about 7:30 PM to 8:00 PM and later LPN #1 told her she had reported the incident to the DON. Per interview with STNA #2, when she returned to work on Friday night (09/04/15,) STNA #1 was working on the rehab unit, and this upset her because nothing had been done about the report of abuse, and "this was handled very very wrong".

Interview with RN #1, on 09/10/15 at 1:16 PM, revealed LPN #1 had asked her to speak with

F 228 to the resident's right to be free from abuse including the definitions of abuse, identification of abuse, timely reporting of allegations of abuse, and to ensure understanding of the facility's abuse policy. All staff re-education was completed on 9/19/2015.

Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:

All suspicions or allegations of abuse will be reported by the Administrator to the Corporate Director of Clinical Services and/or Corporate Director of Nursing for review to ensure compliance with regulatory requirements. This will include but not limited to ensuring appropriate scope of investigation, residents are protected during the investigation, and compliance with state and federal reporting requirements are met.

An audit of 100 employees, which will include at least one employee from each department and from each shift, will be completed by 10/15/2015 to ensure staff understanding of the

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F 226 Continued From page 12  
Resident #1 about the bruise on his/her left hand on 09/01/16. RN #1 stated, Resident #1 told her "that black girl tried to take my call light from me", however, the resident did not remember when this occurred. Per interview with RN #1, she told LPN #1 what the resident reported, and LPN #1 called the DON, but she didn't know if STNA #1 was sent home.

Interview with LPN #2, on 09/14/16 at 11:05 PM, revealed she was assigned to Resident #1's unit on 08/31/15 from 7:00 PM to 09/01/16 at 7:00 AM. Per interview, she was not sure, but thought Resident #1 had his/her call bell all night because the resident normally held it in his/her hand. LPN #2 stated, she had no concerns brought to her about STNA #1 by residents or staff.

Interview with STNA #3, on 09/13/16 at 12:00 PM, revealed she was assigned to Resident #1 on 09/01/16 from 7:00 AM to 7:00 PM. STNA #3 revealed, she did not remember seeing anything on Resident #1's hand but the resident did report the aide last night was very rough and very mean. Per interview, Resident #1 did not say anything about his/her call bell being taken although the call bell was not in reach when she entered the room. She stated she reported what Resident #1 said to LPN #3.

Interview with LPN #3, on 09/13/16 at 4:50 PM, revealed that she was the nurse on Resident #1's unit on 09/01/16 7:00 AM to 7:00 PM. She stated she did not recall seeing a bruise on Resident #1's hand, and if she had she would have followed protocol and investigated to find out how the resident got the bruise. LPN #3 further revealed she did not remember any STNA reporting concerns about any STNA being rough

F 226 abuse policy including but not limited to timely reporting of abuse allegations or suspicions, investigation procedures, and protection of the residents during the investigation. These audits will be completed by the Director of Nursing and/or Administrator. The results of these audits will be referred to the QA Committee to determine a schedule for ongoing monitoring.

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F 226	<p>Continued From page 13</p> <p>or mean, and would have reported any allegations to the DON right away.</p> <p>Interview with the DON, on 09/10/15 at 2:05 PM, revealed she had received a call from LPN #1 on 09/01/15 who reported Resident #1 had a bruise on the left hand between the 1st and 2nd digits. She stated LPN #1 explained the resident said the bruise was from when the STNA took the call bell out of his/her hand and helped the resident to bed the night before. The DON revealed she did not feel the report was an allegation of abuse, and thought LPN #1 was only reporting a bruise. She further stated, she instructed the nurse to check the residents and assure they had their call bells. The DON stated, when she arrived to work the next morning she talked with Resident #1 and asked the resident how she/he got the bruise, and the resident only stated she/he did not sleep well. The DON revealed she also asked the resident if she/he had any concerns with any of the staff and the resident denied having any concerns. Per interview, the DON investigated the bruise and it was consistent with the call bell being removed from the resident's hand.</p> <p>Continued Interview with the DON, revealed on Sunday 09/06/15, the day shift supervisor called her stating a STNA had reported STNA #1 had left residents doubled brased. She stated the day shift supervisor also reported STNA #2 was upset because she had reported a complaint and she didn't feel there was follow up related to the complaint. The DON revealed, she went to the facility to talk with staff about their concerns and placed a call to STNA #2, leaving a message for her to return the call. Per interview, STNA #2 called back and said she felt she had reported an allegation of abuse related to Resident #1 and the</p>	F 226			

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F 228	<p>Continued From page 14</p> <p>allegation was not treated as abuse. The DON revealed, STNA #2 was angry and did not give any further details except to say she had reported abuse which was not investigated. Continued interview with the DON, revealed she told STNA #2 she had investigated the bruise and had removed STNA #1 from the schedule. The DON revealed she did not interview staff, but interviewed other residents related to care received and was told by residents that STNA #1 did not listen to them and liked to do things her way. The DON stated she did not think STNA #1 was a good fit for the facility after the complaint of the STNA double briefing residents and also after hearing resident concerns, and STNA #1 did not work again after 09/05/16.</p> <p>Further interview with the DON, on 09/14/16 at 1:40 PM, revealed she re-iterated when LPN #1 called her on 09/01/16, she didn't realize the nurse was reporting an allegation of abuse and thought the nurse was just reporting the resident had a bruise. However, the DON revealed when STNA #2 called her on 09/06/16, STNA #2 stated she was reporting an allegation of abuse. Per interview, she did not complete an abuse investigation because she did not think this was abuse after talking to Resident #1 and investigating the bruise, and she did not report the allegation to State Agencies. However, the DON revealed for any allegation of abuse she would send the perpetrator home immediately, interview all residents who were interviewable, complete head to toe skin assessments for residents who were non-interviewable, interview staff and notify state agencies, and police.</p> <p>Interview with the Administrator on 09/14/16 at 2:55 PM revealed his expectation was for staff to</p>	F 228			

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F 226	Continued From page 15 notify him immediately of all allegations of abuse and himself or the DON was responsible to investigate all allegations of abuse. He revealed the DON had notified him of an issue with Resident #1's hand and the call light but the resident often banged on things like the side rail or the table when the resident wanted something. He further stated he was not notified that SRNA #1 had taken the call bell out of the resident's hand or refused to give the resident blankets. Per interview, he and the DON needed to ask for clarification when an issue was reported to identify if the staff was reporting an allegation of abuse. Further interview revealed for any allegation of abuse, the facility needed to immediately start an investigation and notify the state agencies. He revealed his expectation was for staff to implement the facility policy related to abuse, when there was an allegation of abuse.	F 226		