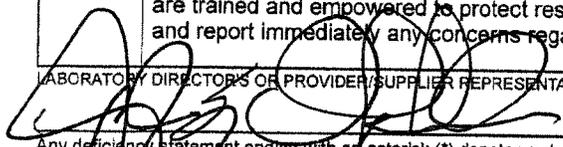


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/30/2014
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217	
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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 10/28/14 and concluded on 10/30/14 to investigate KY 22385. The Division of Health Care unsubstantiated the allegation with related deficiencies cited.	F 000	This preparation and execution of this plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT 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 observation, interview, record review, and facility policy review, it was determined the facility failed to implement the facility's Abuse Policy for one (1) of three (3) sampled residents, Resident #2. The facility did not initiate an investigation nor report to the state agency Resident #2's missing money. The findings include: Review of the facility's Abuse Prevention, Intervention and Data Collection Policy, revised August 2014, revealed the residents have the right to be free from money stolen or misused. The facility will protect the resident from abuse by anyone, including staff members, contract staff, other residents, consultants, volunteers, families, visitors or friends. Staff, residents, and families are trained and empowered to protect residents and report immediately any concerns regarding	F 226	As part of the facilities' ongoing performance improvement program, all audit results will be reported to the Performance Improvement Team with additional education as necessary. F226 The investigation was completed on 10/31/14 for resident LeMaster by Director of Social Services. However, the facility was unable to determine that the resident had money, or that money was missing. The facility has since replaced the \$19.00. All residents have the potential to be affected by the facility being deficient in the reporting/investigative process. As a result, on 10/31/14, the Administrator re-educated the Director of Social Services and Directors of Nursing in regard to following facility policy concerning the abuse investigative/reporting process. On 10/30/14 the Clinical Director of Nursing educated members of daily Team Huddle about the reporting,	

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



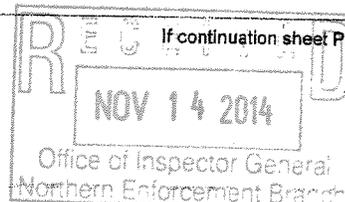
TITLE

(X6) DATE

Administrator x *11/14/2014*

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 226	<p>Continued From page 1</p> <p>how a resident was treated. All employees were required to report any observations, suspicion, information of suspected or actual abuse, neglect, and misappropriation of property to the Nursing Supervisor. Supervisors must immediately consult with the Director of Nursing, Assistant Director of Nursing or Social Services/Administration. The supervisor must complete an Unusual Occurrence form. Reports were to be taken seriously even if not reported timely. The Administrator or designee would appoint someone to conduct the internal inquiry. The investigation was to be conducted by someone knowledgeable of regulations and data collection procedures, such as the Administrator, Social Services, Nursing Administration or Human Resources. The investigation was to be completed within five (5) working days of receiving the complaint.</p> <p>Observation of Resident #2, on 10/29/14 at 4:05 PM, revealed she/he was self propelling from his/her room area towards the nurses station. She/he was dressed in weather appropriate clothing. She/he was wearing five (5) rings on his/her right hand and four (4) rings on his/her left hand. She/he was wearing two (2) bracelets on his/her left wrist. There were no visible keys attached to his/her person.</p> <p>Interview with Resident #2, on 10/29/14 at 4:10 PM, revealed she/he had money missing about one (1) month ago. The money was in a locked drawer and the key to the locked drawer was attached to the resident's clothes while he/she was asleep. When the resident looked for the key it was not found. The resident's family member brought in a replacement key and when the locked drawer was opened, \$19.00 (nineteen</p>	F 226	<p>Continued from page 1</p> <p>investigative process and abuse. The Team Huddle consisted of Unit Managers, Social Services, Dietary, MDS department, Treatment nurse, Infection Preventionist/Process Improvement Analyst, Case Manager, Assistant Director of Nursing (ADON) and Clinical Director of Nursing (DON). On 10/31/14 the Unusual occurrence policy was revised to reflect the detachment of pink and yellow copies routing to Supervisor. On 11/11/14 Abuse trivia was held for all employees. The Unusual occurrence policy was revised on 10/31/14 to reflect detachment of pink and yellow copies and routing pink and yellow copies to House supervisor. Nurses will continue to initiate the investigation process upon knowledge of allegation of abuse. Orange folders labeled "Internal Review" will be placed on the Unit Manager/ Clinical Director's door. The internal review folders will contain unusual occurrence reports. The Unit Managers, upon arrival to the unit will check the Internal Review folders for any allegations</p>	

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F 226	<p>Continued From page 2</p> <p>dollars) that was in a small black change purse was missing. The staff were notified and a report filed. The resident did not know what happened to the money. The resident reported he/she never had any missing jewelry.</p> <p>Review of the facility's quarterly Minimal Data Set (MDS), dated 09/23/14, revealed the facility completed a Brief Interview of Mental Status (BIMS). Resident #2 scored fourteen (14) out of fifteen (15), which indicated the resident was cognitively intact.</p> <p>Interview, on 10/29/14 at 4:20 PM, with the Co-Director of Nursing (Co-DON) in the presence of the Administrator, revealed she had an Unusual Occurrence report, dated 10/24/14, for Resident #2's missing \$19.00. However, she did not have report of the facility's investigation. She stated the Unusual Occurrence report was filed in the Social Services' desk drawer.</p> <p>Interview with the Administrator, on 10/29/14 at 4:25 PM, revealed he was not aware of Resident #2's missing money or the filed report.</p> <p>Telephonic interview with Licensed Practical Nurse (LPN) #2, on 10/30/14 at 10:40 AM, revealed it was during shift change when Resident #2 reported he/she could not find his/her key. Staff looked for the key in the bag on the back of Resident #2's wheelchair. The resident's family member was called and the family member brought in a replacement key. Once the key arrived and the drawer opened, the money was identified as missing from the locked drawer. LPN #2 stated, she did not recall seeing anything unusual about the locked drawer. When the family member came in with the replacement</p>	F 226	<p>Continued from page 2</p> <p>of abuse and address allegations of abuse immediately per facility protocol. House supervisors will check the Internal Review folder daily while rounding, looking for any allegations of abuse. If allegations of abuse are found these will be reported immediately per facility policy. The House supervisor will log type of abuse, whether the unusual occurrence was detached according to policy, and if notification of appropriate parties occurred in a timely manner.</p> <p>The House supervisors will leave a copy of the Internal Review log with the Clinical Director of Nursing and Administrative Director of Nursing. The Clinical Director of Nursing and Administrative Director of Nursing will address and failure to initiate facility protocol in regard to incident reporting/ investigation.</p> <p>Compliance Officer will monitor for compliance with the Internal Review folder weekly for 4 weeks, monthly for 3 months, and quarterly for the remainder of the year. The findings of these audits will be brought to PIA meetings quarterly.</p>	11-12-14

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F 226	<p>Continued From page 3</p> <p>key, she did not speak with that family member. LPN #2 initially stated, the missing money was reported to the Unit Manager. She stated the Unit Manager reviewed the unusual occurrences. LPN #2 stated any reports of unusual occurrences were left at the nurses' station so that other nurses would be informed of what was going on. She stated, she completed the unusual occurrence form for the missing \$19.00, and did not recall reporting it to anyone else. LPN #2 stated she had been trained on abuse and that the resident's missing money was misappropriation of resident funds. She stated the missing \$19.00 should have been reported immediately to the Unit Manager and if in the absence of the Unit Manager then it should have been reported to the Supervisor. LPN #2 stated, the process was dropped by not reporting the missing money when it was identified missing.</p> <p>Interview with the Director of Social Services (DSS), on 10/30/14 at 11:00 AM, stated she was hired on 08/11/14, and completed abuse training. She was aware of the types of abuse, including misappropriation of money and personal items taken or used without the resident/family's permission. Staff members were not allowed to accept money or gifts from families or residents. Also, to allow for resident safety the investigation was to began immediately. She stated she would investigate once a resident's missing items have been reported. The DSS stated, anytime a resident's items were missing, the Administrator was notified to determine the next step to be taken. The DSS stated, she received Resident #2's unusual occurrence, probably the following morning. The investigation should have started at the time the missing money was reported; then Social Services would have continued the</p>	F 226		

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F 226	<p>Continued From page 4</p> <p>investigation. The DSS stated, upon receiving the unusual occurrence for Resident #2, she did not do any further investigation and did not report to any outside agency. She stated there was a break in the reporting and investigation process. The DSS stated that she had a file, but no tracking tool to know the status of the unusual occurrences. She related that she usually took the reports to the morning meeting and discussed with the Director of Nursing (DON) and the Unit Managers. She stated this report was not taken to the Administrator. The unusual occurrence should have been taken to the Administrator for review and direction.</p> <p>Interview with Family Member #1, on 10/30/14 at 11:25 AM, stated Resident #2 had the key pinned to his/her person. The key was removed while he/she slept. The drawer was opened and the money (\$19.00) was removed from the locked drawer. The money was in a black change purse in the locked drawer. Family Member #1 stated the lock had been changed twice, once in June 2014 and again in September 2014. A few days after the money was missing, the empty black change purse showed up in Resident's #2's room. Family Member #1 stated during a visit the Monday before the money came up missing, Resident #2 had counted the money in his/her presence. Family member #1 stated a diaper pin was now being used as those are more difficult to get off of someone while they are asleep. Family Member #1 stated the missing items in June was not reported to the facility.</p> <p>Interview with the Administrator, on 10/30/14 at 12:10 PM, stated the staff were trained on immediately reporting of any allegations of abuse, including misappropriations of money. The DSS</p>	F 226			

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F 226	Continued From page 5 was new to the position, but received abuse training. He stated staff were educated on reporting allegations in the facility. He stated, he should have been made aware of the missing money immediately and an investigation initiated. The Administrator related that this occurrence should have been reported to the state agency; however, was not since he was not aware of the missing money.	F 226			