STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy Resident/Resident Related Concerns, it was determined the facility failed to ensure grievances were reported, investigated and efforts to resolve concerns were done promptly for one (1) of the twenty-two (22) sampled residents (Resident #5). The findings include: Review of the facility's policy regarding Resident/Resident Related Concerns, revised 09/01/11, revealed the facility would investigate all concerns in an effort to provide for follow-up of concerns expressed by resident, family members, and/or visitors, which may affect the quality of care delivered. Any employee receiving a complaint from a resident, family member and/or visitor shall initiate a Concerns Form including the name of the person voicing the concern, the date the concern was received, the nature of the concern, and who received the concerns including name and title. The individual voicing the concern would receive a follow up communication with the resolution within five (5) days. Review of Resident #5's medical record revealed the facility admitted the resident, on 10/21/05, with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident's Range of Motion was impaired on both sides of the upper and lower extremities and the resident required total assistance with bathing. Observation and interview with Resident #5, on 01/02/14 at 11:17 AM, revealed the resident was sitting in their room, in an electric wheelchair. The resident divulged problems receiving baths and showers as scheduled which were reported, per the resident; however, these concerns had not been addressed by the facility. The resident stated he/she started keeping copies of all completed Concern forms that were filled out based on a complaint he/she had reported to the Social Service Director (SSD). A stack of completed Concern Forms was noted lying on the resident's dresser. Review of Resident #5's Concern forms revealed completed, signed and dated forms for 07/08/13, 10/17/13, and 12/02/13 explaining the resident's concern over not receiving scheduled showers. Review of the Resident Bathing Type by Day Chart, for 10/17/13 to 01/02/14, revealed the resident only had ten (10) days recorded where showers were given with none recorded from 12/04/13 to 01/02/14. Review of the facility's shower schedule revealed the resident should have received two (2) showers a week. Interview with State Registered Nursing Assistant (SRNA) #6, 01/03/14 at 3:00 PM, revealed she had not been notified of any concerns related to Resident #5 not receiving showers. Interview with SRNA #3, on 01/03/14 at 1:04 PM, revealed she normally worked second shift and did not recall ever being told Resident #5 did not receive a scheduled shower. Interview with Licensed Practical Nurse (LPN) #6, on 01/02/14 at 10:40 AM, revealed Resident #5 may occasionally refuse a shower. However, review of the Resident Bathing Type by Day Chart revealed no showers were recorded as refused. The LPN revealed she was not aware Resident #5 had filed a grievance for not receiving scheduled showers. Interview with the Unit Manager, on 01/03/14 at 4:05 PM, revealed she was not aware Resident #5 had voiced any concerns regarding showers. The Unit Manager revealed all grievances were discussed in the morning meetings, but did not recall it ever being brought to the meeting as a concern. Interview with the Director of Clinical Services (DCS), on 01/03/14 at 4:15 PM, revealed she was not aware of Resident #5's concerns regarding showers and was unable to find any evidence the nursing department was ever notified of this concern. Interview with the Social Services Director (SSD), on 01/03/14 at 1:35 PM, revealed Resident #5 made a complaint back in July 2013 about not receiving showers or Range of Motion (ROM). As a resolution, a sign-in sheet was developed to be completed every day after ROM was provided or the resident was showered. The SSD revealed the resident complained again on 08/21/13 about ROM not being completed, so it was determined the sign-in sheet was not working for ROM. The SSD revealed she was not aware of any other grievance filed regarding showers until 12/02/13. Continued interview, on 01/03/14 at 3:55 PM, revealed anyone could fill out a Concern form which was located at the nursing desk. The SSD revealed she received the forms, checked which department it should be directed to, and did a follow up to ensure there was a resolution within 72 hours. After she reviewed the resident's copy of the Concerns form completed by the SSD on 10/17/13, the SSD revealed she did not remember filling out the form and did not ensure it was directed to the nursing department for a resolution. The SSD revealed nothing was done to ensure Resident #5's grievance regarding the concern of not receiving scheduled showers was addressed.
F 0201 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or provide reasons for a transfer or discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to meet transfer and discharge requirements for two (2) of twenty-two (22) sampled residents. The facility did not afford Resident #1 and Resident #22 the opportunity to return to the facility when the hospital was ready to discharge them back. The findings include: The facility did not provide a policy regarding the right of the resident to return to the facility after a hospital stay. Review of the facility's policy regarding Interdisciplinary Discharge Planning, reviewed 09/01/11, revealed the discharge planning process involved the resident, family, Social Services, and those members of the clinical team involved in the resident's care. Review of the facility's policy regarding Transfers/ Discharges Notification and Right to Appeal, reviewed 09/01/11, revealed residents would be notified thirty (30) days in advance of an impending discharge or transfer out of the facility by Social Services. Review of the facility's policy regarding Transfer/Discharge Letter 30-Day Notice, dated January 2007, revealed notification to a resident or legal representative of a discharge or transfer due to improved health or had failed to pay for the stay at the facility. Review of the Transfer/Discharge Letter Expedited Notice, dated January 2007, revealed notification to a resident or legal representative of a discharge or transfer with a transfer date, and specified the reason due to urgent medical needs that require hospitalization , improved health, or health and the safety of individuals in the facility would be endangered. It further stated where the resident would be discharged to and the right to appeal the discharge. This notice would be handed to the resident as soon as possible or at least at the time of discharge/transfer. 1. Review of the medical record for Resident #1 revealed the facility admitted the resident on 06/22/11 with [DIAGNOSES REDACTED]. The resident was also diagnosed with [REDACTED]. Observation, on 01/07/14 at 2:21 PM, revealed the facility fire alarm was sounding. Observation at 2:25 PM revealed water pouring from the ceiling at the C Hall nurse's station near the front entrance. Observations at 2:52 PM revealed a ceiling water leak on the B Hall and at 4:09 PM a ceiling water leak at the A/D Hall nurse's station. 1. Observation of Resident #1, on 01/07/14 at 4:05 PM, revealed the resident calling out loudly at a Certified Nursing Assistant to give her back his/her cigarette lighter. The Director of Clinical Services (DCS) yelled down the hall to the Assistant Director of Clinical Services (ADCS) to call the psychiatrist, she wanted the resident out of the facility for an evaluation. At 4:42 PM, two (2) police officers arrived and walked down B Hall to the resident. The resident told the police officers that he/she just got back from receiving [MEDICAL TREATMENT] treatment and wanted to go smoke. The police officers asked the resident why he/she was going after the staff. The resident said it was a lie, he/she never tried to hit anybody, they hit him/her first. The police notified the resident that the doctor had ordered for the resident to go to the hospital and he/she had to comply. Interview with the Unit Manager, on 01/07/14 at 4:44 PM, revealed Emergency Medical Services (EMS) was notified of the order to transfer Resident #1 to the hospital for a psychiatric evaluation. The Unit Manager stated EMS called the police to arrive before they did. Continued observation of Resident #1, on 01/07/14 at 4:50 PM, revealed the

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 0201 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident propelled him/her self in the wheelchair up the hall and to the Executive Director's (ED) office. When the ED came out of his office, the resident asked to speak to him, and the resident was told it would be a moment and the ED walked away. The resident repeatedly told the police he/she did not want to leave. The Police told the resident if he/she did not go, the facility would get a Mental Inquest Warrant and then he/she would be in their custody. At 4:57 PM, EMS arrived and the resident stated if he/she could just talk to someone at the facility, but they just don't hear. The resident agreed to go with EMS and left the building without ever talking to a facility representative about the transfer or receiving any notification forms of the transfer and discharge. Interview with the current Interim Director of Clinical Services (DCS), on 01/08/14 at 1:00 PM, revealed Resident #1 was admitted to the hospital. On 01/09/14 at 5:06 PM, the DCS stated when Resident #1 left the facility with the ambulance the resident informed the officers he/she did not want to return to the facility. The DCS indicated Resident #1 had been admitted to another facility; however, the resident was currently back at the hospital. The DCS further indicated she would need to check with the Interim Executive Director (ED) if the facility followed the discharge process and the resident was not eligible for return to the facility. Continued interview with the DCS revealed Resident #1 reported to the hospital he/she did not want to return to the facility; therefore, the hospital transferred the resident to another long-term care facility. Interview with the DCS, on 01/10/14 at 2:17 PM, revealed Resident #1 would not be coming back to the facility and no change had occurred in the resident's status at the hospital. Interview with the DCS, on 01/18/14 at 1:12 PM, revealed she heard Resident #1 tell the officers, while in front of the ED's office, that the resident said he/she was not coming back here and did not like it at the facility. She stated the facility had been considering discharging the resident at the time the resident left the facility; however, did not specify why. Additionally, the DCS stated she did not speak to anyone at the hospital about the resident returning to the facility. The DCS indicated the discharge paperwork was typically completed by the SSD; however, she was unsure if it had been completed. She further stated when a resident was discharged from the facility the decision was made by the Physician, Social Services, and the Administrator. On 01/09/14 at 9:01 AM, interview with Licensed Practical Nurse (LPN) #5 revealed she was unaware of Resident #1 being discharged from the facility since she began working at the facility two and a half (2 ?) years ago. Interview, on 01/10/14 at 1:55 PM, with the Social Services Director (SSD) revealed the facility would not accept Resident #1 for return from the hospital. Continued interview with the SSD, on 01/14/14 at 10:31 AM, revealed Resident #1 was discharged from the facility and she was not involved in the resident's discharge. The SSD stated she was informed Resident #1 had left the facility with an ambulance. The SSD indicated the Regional DCS stated that she wanted Resident #1 out of here now. The SSD further indicated the hospital called her on 01/08/14 to ask about Resident #1 returning to the facility and she then spoke to the Interim ED and the Vice President (VP) of Operations. She indicated the ED and VP of Operations told the hospital they were not sure if the facility could bring the resident back. She stated the Interim ED specified to her the facility would take the deficiency from the state survey agency as long as Resident #1 did not come back to the facility. She further indicated she had not spoken with the hospital about why the resident could not return to the facility; however, the Interim ED spoke with the hospital. On 01/14/14 at 10:08 AM, interview with MDS Coordinator #1 revealed she had not been asked to complete a resident Minimum Data Set (MDS) assessment related to discharge; however, the MDS Coordinators used the facility census for discharge and Resident #1 was listed as discharged on the census. Interview with the Adult Protective Services (APS) worker, on 01/14/14 at 10:14 AM, revealed she had spoken to Resident #1 at the hospital in addition to the hospital social worker. The APS worker stated both Resident #1 and the hospital social worker had concerns as the resident thought he/she would be returning to the facility. The APS worker indicated Resident #1 had been transferred to another facility; however, that facility determined they could not meet the resident's needs and transferred the resident back to the hospital. The APS worker further indicated the facility did not give Resident #1 notice the facility would not be taking the resident back. Interview with the Interim Executive Director (ED), on 01/18/14 at 10:59 AM, revealed Resident #1 had been discharged from the facility and did not receive a discharge notice when the resident left the facility. The ED stated he heard Resident #1 state that he/she did not want to return to the facility. He indicated several other facilities had been at the facility conducting resident evaluations in case any residents needed to be transferred due to the water line break. The ED stated he could not recall if he had spoken to anyone at the hospital, but could try to find out. The ED did not return with any additional information. Additionally, he stated he was unaware if the hospital called for Resident #1 to return to the facility. He indicated the Admissions Department was responsible to coordinate a resident returning to the facility after transfer to the hospital. The ED stated the hospital placed Resident #1 at another facility. He indicated admissions to the facility were placed on hold when the water pipes began to break. He indicated the resident was not denied re-admission to the facility. Continued interview with the ED, on 01/18/14 at 12:21 PM, revealed the facility began to re-admit residents on 01/08/14 after the water line repairs; however, was unsure of the time. Interview, on 01/19/14 at 12:13 PM with the ED revealed he did not recall if he had stated to the hospital Resident #1 could not return to the facility. He also indicated he could not remember if he had told the Director of Admissions (DA) the resident could not return to the facility. On 01/18/14 at 12:37 PM, interview with the Director of Admissions (DA) revealed she was not usually involved when a resident was transferred to the hospital. She stated she was informed by the nurses when a resident went to the hospital in order for her to update the computer system. The DA indicated a census sheet was updated every night at midnight which indicated which resident went out of the facility when, and if the resident returned or did not return. She further indicated if a resident did not have a bed hold, then the resident would be considered a re-admission upon return to the facility. The DA stated she was present in the building when Resident #1 went to the hospital; however, she was not involved in the resident's transfer. She indicated at the time Resident #1 left the facility he/she was transferred to the hospital; however, the resident had since been discharged by the facility. The DA further indicated the ED told her Resident #1 would not be returning to the facility. She stated the resident went to the hospital on [DATE] and she was told by the ED on 01/08/14 that Resident #1 had been discharged from the facility. The DA stated she had been contacted by the hospital on [DATE] for the resident to return to the facility and she had forwarded the calls to the ED. She indicated if a resident left the facility due to behavior issues, then she would defer to the ED if the facility would allow the resident to return. She further indicated she was told by the ED, Resident #1 would not be returning to the facility due to the resident's behaviors as the facility was not accepting the resident back. Additionally, the DA stated the hospital called her several times throughout the following days and she had referred the calls to the ED or the Regional VP of Operations. She stated the resident had been transferred from the hospital to another facility, which had transferred the resident back to the hospital. She further stated the hospital called on 01/10/14, after the resident had returned to the hospital from the other facility, to return Resident #1 to the facility. Interview, on 01/19/14 at 5:59 AM, with the Unit Manager (UM) of the hospital psychiatric emergency room revealed she had spoken to the facility SSD on the morning of 01/08/14 who stated she would need to check the status of the facility after the water break and would call back with more information. The hospital UM indicated Resident #1 had been transferred to another facility and had then been transferred back to the hospital one (1) to two (2) days later. She further indicated the hospital did not usually find placement for residents and the hospital did not find Resident #1 another facility. The hospital UM stated Brownsboro Hills found another facility to admit Resident #1 upon leaving the hospital. The facility did not provide any evidence that other facilities were in the building to evaluate residents for potential transfers due to the water line breaks. 2. Review of the clinical record for Resident #22 revealed the facility admitted the resident on 10/24/13. The facility's comprehensive care plan includes [DIAGNOSES REDACTED]. The care plan, dated 11/04/13, included interventions for disruptive behavior, yelling out, verbal and physical aggression, use of profanity, and resistance to care. A nurse's note, dated 01/03/14 at 10:00 PM, revealed Resident #22 was calling out, and hit the nurse with a bed remote. In addition, a nurse's note, dated 01/06/14 from 3:00 PM to 11:00 PM, revealed the resident was noted to be yelling out and cursing most of the shift. On 01/10/14 at 10:40 PM, a nurse's note revealed the resident yelling out continuously. Additionally a nurse's note, on 01/11/14, no time indicated, revealed the resident was demonstrating behaviors of a danger to self and others. A physician order, on 01/11/14, no time indicated, revealed Resident #22 was sent to the hospital for evaluation and treatment. Interview with the APS worker, on 01/14/14 at 10:14 AM, revealed Resident #22 was at the hospital because the resident bit staff. She stated the facility would not accept the resident back. On 01/18/14 at 12:30 PM, interview with the Interim ED revealed he was not as involved in the discharge of Resident #22 and would need to pull the medical record for more information. Interview, on 01/18/14 at 12:37 PM and 1:10 PM, with the DA revealed Resident #22 was discharged to the hospital. She stated the resident was screaming in the hallway, pinched and tried to bite a staff member. The DA indicated Resident #22 left the faciity on [DATE]. She indicated that she was told by the ED or the Regional VP of Operations, on 01/12/14, the facility would not be accepting Resident #22 back. Interview with the DCS, on 01/18/14 at 1:12

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F 0201 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) PM, revealed the facility transferred Resident #22 to the hospital. She stated the following day the hospital called to send the resident back to the facility. The DCS indicated she could hear the resident screaming in the background and asked the hospital what had been done for the resident. The DCS further indicated when the hospital informed her they had done nothing for the resident; she told the hospital she could not have the resident come back to the facility. She stated she spoke with the hospital the morning of 01/12/14 to send Resident #22 back to the facility. The DCS stated the facility had an agreement with the hospital if the resident became uncontrollable, the hospital would accept the resident back. On 01/19/14 at 5:59 PM, interview with the UM of the hospital psychiatric emergency room revealed she spoke to a nurse at the facility the day after Resident #22 arrived to the hospital. She stated she informed the nurse the hospital was looking to discharge the resident. The UM indicated another hospital staff member contacted the facility to return the resident and was told the facility would not accept the resident back. She stated she called the facility DCS, on 01/14/14, who told the UM she would not speak with her about Resident #22 and would only speak with a particular staff member at the hospital. The UM indicated Resident #22 was in the emergency room from Friday evening to Tuesday afternoon while the hospital attempted to send the resident back to the facility. She stated the resident was admitted to a unit at the hospital on that Tuesday afternoon as the facility would not accept the resident back. Interview with LPN #4, on 01/19/14 at 10:57 AM, revealed Resident #22 would yell out and had never witnessed the resident become physically aggressive. She indicated she was not working the day the resident was transferred to the hospital; however, when she returned to work she was told in shift report Resident #22 could not return to the facility until someone from the facility went to evaluate the resident. The LPN further indicated the resident's transfer status had not been updated at this time. Interview with the Interim ED, on 01/19/14 at 11:37 AM, revealed while reviewing the twenty-four (24) hour reports for the nursing units, dated 01/10/14 and 01/11/14, Resident #22's transfer to the hospital was not documented. He stated the resident's transfer to the hospital was documented on the 24 hour report on 01/12/14. He indicated on the 24 hour report on 01/16/14, a notation reported the resident was still in the hospital. On 01/19/14 at 12:32 PM, interview with Regional VP of Operations revealed he was not involved in the discharge for Resident #22. He stated the resident was transferred to the hospital on Saturday 01/11/14 due to pinching and hitting staff. He stated he spoke with a hospital social worker who stated to him the resident was in a twenty-three (23) hour observation room. The Regional VP of Operations indicated he told the hospital social worker they could keep people for seventy-two (72) hours and the facility could not take the Resident back. He further indicated the facility had an agreement with the hospital in which the hospital would accept the resident back if the facility could not meet the resident's needs. He stated the agreement was a verbal agreement between two (2) people and there was no documentation of the agreement.
F 0203 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough notice before discharging or transferring a resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy Transfers/Discharges Notification and Right to Appeal, it was determined the facility failed to notify the resident or resident's legal representative of a transfer and discharge for two (2) of the twenty-two (22) sampled residents (Resident #1 and #22). This is a repeat deficiency from the standard survey on 08/01/13. The findings include: Review of the facility's policy Transfer/Discharges Notification and Right to Appeal, revised on 09/01/11, revealed residents would be notified thirty days prior, or as soon as practical, of an impending discharge or transfer out of the facility. The residents right to bed hold would be explained at that time. The notice would be handed to the resident as soon as possible or at least at the time of discharge/transfer. In all cases the resident has the right to appeal the decision. On 01/07/14 at 3:24 PM, observation of Resident #1 at 4:42 PM revealed two (2) police officers arrived and walked down B Hall to the resident. The police officers asked the resident why he/she was going after the staff. The resident told the police officers that he/she just got back from receiving [MEDICAL TREATMENT] treatment and wanted to go smoke. The resident said it was a lie he/she never went after the staff, he/she never tried to hit anybody, they hit him/her first. The police notified the resident that the doctor had ordered a transfer to the hospital and he/she had to comply. However, at this time the DCS, standing down the hall, did not inform the resident of the impending transfer or discharge from the facility and did not provide the resident with the notice identified in the facility's policy. Continued observation revealed the resident was in front of the Executive Director's office talking to two (2) police officers. The resident stated to the officers that he/she did not want to go to the hospital and stated he/she was ok. At 4:50 PM, the resident asked to speak to the Executive Director as he walked by, who responded to the resident it will be a moment and walked away. The staff did not provide a notice of discharge at this time either. Continued observation at 4:53 PM revealed the officers indicated to Resident #1 to go to the hospital voluntarily or the facility could have a Mental Inquest Warrant (MIW) taken out and the resident would then be in police custody. The resident continued to say he/she was ok. The officers stated to Resident #1 if he/she went with the ambulance, and if he/she was ok, then he/she could return to the facility. Observation at 5:00 PM, revealed EMS arrived and there was no facility staff in attendance to assist with the transfer or discharge. The resident stated if I could just talk to somebody, but no one will hear me. At 5:02 PM the resident left the facility without a notice of transfer or discharge. Review of Resident #1's clinical record revealed the facility admitted the resident on 06/22/11 with [DIAGNOSES REDACTED]. Resident #1 was sent to the hospital for psychiatric evaluation on 01/07/14. There was no evidence of a physician's evaluation that the resident was a danger to self or to other residents. In addition, there was no evidence the resident was provided a date or location of the transfer or the opportunity to appeal the discharge or how to contact the Ombudsman and the Agency for Mental Illness and Developmentally Disabled as the resident was a Level II PASRR. Interview with Licensed Practical Nurse (LPN) #5, on 01/19/14 at 10:06 AM, revealed the SSD was responsible for the transfer/discharge notices. The LPN stated she did not recall ever seeing a transfer notice in Resident #1's medical record. The LPN indicated she did have training on discharges and transfers, but it did not include the transfer notice or notice requirements Interview with the DCS, on 01/08/14 at 1:01 PM, revealed Resident #1 was admitted to the hospital, but the DCS was not aware of an admitting [DIAGNOSES REDACTED]. However, continuous surveyor observation of the police conversation by the ED office revealed the DCS was down B Hall and not within hearing range. Interview with the DCS, on 01/18/14 at 1:12 PM, revealed Resident #1 told the police, he/she did not like the facility and did not want to return, while waiting for EMS in front of Executive Directors office. However, surveyor observation, on 01/07/14 at 4:57 PM, revealed the DCS was talking to the surveyor, then walked down the B Hall which was not close to the Executive Directors office and not close enough to overhear a conversation. Interview with the Social Service Director (SSD), on 01/10/14 at 2:06 PM, revealed at the time of discharge it was her understanding the facility was not going to take the resident back, and it was not Resident #1's decision. The SSD revealed she had to talk with PASRR and Emergency Psychiatric Services about this because the resident was a level 2 due to the [DIAGNOSES REDACTED]. The SSD revealed she was responsible for the discharge/transfer notices and she never had the opportunity to initiate one for Resident #1 because the Regional DCS said she wanted the resident out of the building now. The SSD revealed when she returned from working on another resident's discharge she was told Resident #1 was already gone and left with a police escort. The SSD revealed she was told by the Vice President of Operations that the facility was not bringing back Resident #1 and the Executive Director said he would just take the discharge notice deficiency to get the resident out of the building. Interview with the SSD, on 01/09/14 at 2:00 PM, revealed she wrote the plan of correction for transfer/discharge notices from the survey 08/01/13. However, interview with the Vice President of Clinical Operations, on 01/14/14 at 5:20 PM, revealed the facility was unable to attest that the Plan of Correction was utilized. The Vice President of Clinical Operations revealed they were unable to find any evidence to verify that any of the reviews, audits, or meetings were completed as stated in the POC after the revisit was completed. 2. Review of Resident #22's medical record revealed the facility admitted the resident on 10/24/13 with [DIAGNOSES REDACTED]. The resident was sent to the hospital for a psychiatric evaluation on 01/11/14. Neither a bed hold notice nor a transfer form were found in the resident's chart. Interview with Adult Protective Services (APS), on 01/14/14 at 10:14 AM, revealed she saw both Resident #1 and #22 at the hospital. The APS worker revealed neither resident received a transfer/discharge notice. Interview with the current Interim ED, on 01/19/14 at 11:37 AM, revealed Resident #22's transfer was noted on the 24 hour report on 01/12/14. The ED revealed there were no other updated notes in the 24 hour report until 01/16/14 that stated the resident was still at the hospital. The ED revealed there was no discussion of Resident #22's discharge/transfer. The ED revealed transfer and discharges were a normal part of the morning meeting discussion. Interview with the Regional Vice President of Operations (RVPO), on 01/19/14 at 12:32 PM, revealed Resident #22 was sent to the hospital for a psychiatric evaluation after pinching and hitting at facility staff. The RVPO revealed he spoke with the hospital social worker and was told the resident was a 24 hour observation only. He informed the hospital they were to keep the resident for 72 hours. The

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F 0203 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) RVPO revealed he told the hospital the facility could not take back Resident #22 who was there on a contract between the facilities. The RVPO revealed it was a loose agreement, that if the facility could not meet the resident's needs, then the hospital would take the resident back. The RVPO revealed he could not provide any evidence of the facility's contract.
F 0205 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Tell the resident or the resident's representative in writing how long the nursing home will hold the resident's bed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy regarding Transfers/Discharges Notification and Right to Appeal, it was determined the facility failed to provide written information regarding bed-hold policy prior to a transfer for two (2) of the twenty-two (22) sampled residents (Resident #1 and #22). The findings include: Review of the facility's policy regarding Transfers/Discharges Notification and Right to Appeal, revised 09/01/11, revealed Residents would be notified thirty days prior or as soon as practical, of an impending discharge or transfer out of the facility. The resident's right to bed hold would be explained at that time. On admission and at the time of transfer to the acute hospital, the Social Services Department would notify residents of their right to hold their bed. For non-Medicaid recipients, the Social Service Department would ask the resident or resident responsible party if they desired to hold the bed and discuss their responsibility to pay for such a bed hold. A written notice would be forwarded to the resident and/or responsible party. Medicaid recipients would be notified of the length of time Medicaid would hold the bed. 1. Review of Resident #1's clinical record revealed the facility admitted the resident, on 06/22/11, with the [DIAGNOSES REDACTED]. Observation of Resident #1, on 01/07/14 at 4:05 PM, revealed the resident was calling out loudly to a Certified Nursing Assistant to give him/her back his/her cigarette lighter. The Director of Clinical Services (DCS) yelled down hall to the Assistant Director of Clinical Services (ADCS) to call the psychiatrist; she wanted the resident out of the facility for an evaluation. At 4:42 PM, two (2) police officers arrived and walked down B Hall to the resident. The resident told the police officers that he/she just got back from receiving [MEDICAL TREATMENT] treatment and wanted to go smoke. The police officers asked the resident why he/she was going after the staff. The resident said it was a lie, he/she never tried to hit anybody, they hit him/her first. The police officers notified the resident that the doctor had ordered for the resident to go to the hospital and he/she had to comply. Interview with the Unit Manager, on 01/07/14 at 4:44 PM, revealed Emergency Medical Services (EMS) was notified of the order to transfer Resident #1 to the hospital for a psychiatric evaluation. The Unit Manager revealed EMS called the police to arrive before they did. Continued observation of Resident #1, on 01/07/14 at 4:50 PM, revealed the resident propelled him/her self in the wheelchair up the hall and to the Executive Director's (ED) office. When the ED came out of his office, the resident asked to speak to him, and the resident was told it will be a moment and the ED walked away. The resident repeatedly told the police he/she did not want to leave. The Police told the resident if he/she did not go, the facility would get a Mental Inquest Warrant and then he/she would be in their custody. At 4:57 PM, EMS arrived and the resident stated if he/she could just talk to someone at the facility, but they just don't hear. The resident agreed to go with EMS and left the building without ever talking to a facility representative about the transfer, or receiving a written copy of the bed hold policy. Interview with Social Service Director (SSD), on 01/14/14 at 10:32 AM, revealed the facility was trying to get rid of any resident that had been involved in an altercation. The SSD revealed the facility discharged Resident #1 and would not let him/her come back and sent Resident #22 to a local hospital without any transfer papers. 2. Review of Resident #22's medical record revealed the facility admitted the resident on 10/24/13 with [DIAGNOSES REDACTED]. Neither a bed hold notice nor a transfer form were located in the chart. Interview with the Director of Admission, on 01/18/14 at 12:34 PM, revealed she was responsible to provide the bed hold information. The Director of Admissions revealed if a resident had bed hold days left, then she called the hospital case worker to let them know the number of days remaining. The Director of Admissions revealed the bed hold was not offered to Resident #1 because she was told by the Executive Director the resident would not be returning to the facility due to behaviors. The Director of Admissions revealed she did receive several phone calls from the hospital, but forwarded all calls to the Executive Director or the Regional Vice President of Operations. The Director of Admissions revealed Resident #22 was not offered bed hold papers either, because he/she was discharged and sent to the hospital due to behaviors and biting staff members. Interview with the Executive Director, on 01/18/14 at 10:51 AM, revealed Resident #1 did not want to come back to the facility; however, he was unable to recall when it was said, where it was said, and who heard he/she say they did not want to come back. When asked what the requirements were regarding bed holds and transfer forms, the Executive Director revealed he would have to refer to the policy and did not know which facility staff member was involved in the transfer of Resident #22.
F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy and procedures, and investigations, it was determined the facility failed to have an effective system in place to ensure residents were free from abuse for four (4) of twenty-two (22) sampled residents (Resident #1, #2, #3 and #19). Record review revealed Resident #1 had a history of [REDACTED]. However, staff accepted the resident's behavior as the norm and there was no documented evidence the facility recognized this behavior as abuse. The facility's failure to address Resident #1's abusive behavior affected Resident #2 and Resident #3. On 07/17/13, Resident #1 was found in Resident #2's room with his/her hand under Resident #2's sheet. Resident #2 was telling Resident #1 to stop, after Resident #1 continued to play with Resident #2, the resident got mad and threw a pack of cookies at Resident #1. Resident #1 then started to throw items at Resident #2. Attempts by staff to remove Resident #1 from the room resulted in Resident #1 refusing to leave Resident #2's doorway for twenty (20) minutes while yelling and arguing with staff. On 11/08/13, a verbal exchange occurred between Resident #1 and Resident #3, that escalated in to a physical altercation. Resident #1 was verbally assaulting Resident #3. Resident #3 hit Resident #1 with the walker and fell to the ground. Resident #1 then kicked Resident #3 in the head multiple times while the resident was on the ground. Interview and record review also revealed Resident #1 verbally and physically abused staff and was the victim of abuse after an altercation with staff. On 12/31/13, State Registered Nurse Aide (SRNA) #2 and Resident #1 were overheard yelling and screaming at each other by Licensed Practical Nurse (LPN) #2, LPN #3, and LPN #4. LPN #3 stood between Resident #1 and SRNA #2 in an attempt to separate the two. When Resident #1 touched SRNA #2 on the arm, both the SRNA and the resident began hitting each other in the A/D Hall Television room. LPN #3 was unable to separate the SRNA and the resident and it took LPN #3, LPN #2 and LPN #4 to separate them. The SRNA was taken outside to the courtyard, but continued to try and get inside the building while the resident was cursing at the SRNA and hitting the staff while trying to get to the SRNA in the courtyard. In addition, Resident #19 was victim of verbal abuse by a staff member. On 12/30/13, the facility's Activities Director was observed, by staff, yelling and screaming at Resident #19. The facility's failure to have an effective system in place to ensure residents were free from abuse placed residents in a situation that has caused or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14 as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E with continued noncompliance while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: 1. Review of the facility's policy regarding Resident Abuse-Resident to Resident, reviewed 01/01/09, revealed residents must not be subjected to abuse by anyone, including facility staff or other residents. Abuse included physical, sexual, and verbal abuse. The staff were to remove the resident from danger immediately. Closely monitor and document the behavior and condition of the residents to evaluate for any injury and to prevent reoccurrence of the incident. The facility must develop measures to prevent reoccurrence and document these measures in the resident's medical record to include revision of the plan of care. Other measures to consider were obtaining orders for a psych consult. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 06/22/11 with [DIAGNOSES REDACTED]. The resident was also diagnosed with [REDACTED]. The facility completed a quarterly MDS assessment for Resident #1 on 11/25/13 and assessed the Resident to have a Brief Interview Mental

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

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F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) Status (BIMS) score of 11. The comprehensive care plan, dated 09/04/13 and revised 11/25/13, revealed the facility's care plan for Resident #1 included behaviors of verbal abuse and flirtatious behavior with male residents. Interventions included talk to the resident in a calm manner, do not argue with the resident, and re-direct the resident when the resident is being verbally abusive or using inappropriate language/profanity. Review of Resident #1's Psychiatric Services notes revealed the resident had a history of [REDACTED]. Continued review revealed a Psychiatric Services note, dated 02/08/13, stating the reason for the visit was aggression, yelling, lability, severe mood swings, and verbal outbursts. In addition, on 04/12/13 a Psychiatric Services note stated the chief complaint was anger and irritability, with an incident of aggression with a peer. On 07/13/13 a Psychiatric Services note stated the staff reported no further aggression, but remained sexually intrusive and made inappropriate comments toward male caregivers. However, record review revealed no documented evidence the facility implemented interventions to address this potential abusive behavior to protect residents. Review of a nurse's note, dated 07/17/13 at 10:25 PM, revealed Resident #1 had been in Resident #2's room with his/her hand under Resident #2's sheet touching and fondling Resident #2. The nurse's note further revealed Resident #2 told Resident #1 to stop; however, Resident #1 continued to touch Resident #2 under the sheet. Interview with the House Supervisor, on 01/09/14 at 12:59 PM, revealed she was working the evening of 07/17/13 and was told by the nurse that Resident #1 was bothering Resident #2 and was trying to get Resident #1 to leave Resident #2's room. The House Supervisor stated she instructed the nurse to document the incident. The House Supervisor revealed the next day she overheard staff talking about what really happened and she told the staff to make sure they reported what they had heard, but did not follow up to ensure it was done. The facility reported the nurse who wrote the 07/17/13 nurse's note no longer worked at the facility. Attempts to interview the nurse were made; however, the nurse did not return phone messages as of 01/22/14. During an interview with LPN #5 on 01/09/14 at 9:01 AM and 10:12 AM, LPN #5 reviewed the nurse's note for 07/17/13, and indicated Resident #1 was in Resident #2's room with his/her hand under Resident #2's sheet. She stated she vaguely remembered the incident and would not have seen the 11-7 entry on the 24 hour report as it was removed from the nurses station before she came on duty. However, it was something she should have received in report and didn't and would not have known to ask about it. She thought the note indicated Resident #2 did not want Resident #1 in his/her room. The nurse stated Resident #2 was not capable to say stop. LPN #5 stated Resident #2 was aware of what goes on around him/her and she indicated the incident on 07/17/13 was sexual abuse. She further indicated Resident #1 should not have been in Resident #2's room and should not have had his/her hand under Resident #2's sheet. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 03/03/10 with [DIAGNOSES REDACTED]. The facility completed a quarterly MDS assessment on 11/01/13 and assessed the resident with a Staff Assessment for Mental Status with a score of 1, meaning the resident was moderately independent. The facility assessed the resident to have no mood or behavioral indicators and having communication with difficulty. The comprehensive care plan, dated 08/20/13 and revised 11/04/13, revealed the resident had an alteration in communication and interventions included asking yes or no questions, and use alternate means to communicate, such as gestures. Interview with Resident #2, on 01/07/14 at 5:12 PM, revealed the resident was able to speak a few words. The resident stated yes, when asked if he/she was friends with Resident #1; however, the resident stated no friends when asked if they were boyfriend and girlfriend. The resident began to twist his/her hands when asked if he/she had been touched inappropriately. Resident #2 indicated they were just friends and at times the touch of Resident #1 went beyond friendly, which was always initiated by Resident #1. The resident further indicated Resident #1 would sometimes stop when asked and that Resident #1 had a hard time taking no for an answer. The resident indicated Resident #1 tried to push him/her into touching in a way that was more than friends. The resident further indicated a hug, or touch on the arm were okay touches. Resident #2 also indicated touch that was not okay included the thigh, knee, chest, and the resident pointed to the groin area. The resident stated Resident #1 tried to touch him/her two (2) times in the groin area. The resident looked down when he/she was asked about the incident in his/her room when Resident #1 was in the room and Resident #2 threw cookies at him/her. Resident #2 indicated the second time Resident #1 tried to touch him/her was after the incident with the cookies. The resident indicated the touching by Resident #1 made him/her feel uncomfortable and he/she just wanted to be friends. Interview with the Social Services Director (SSD), on 01/07/14 at 8:57 AM, revealed she was unaware of the incident on 07/17/13 of Resident #1's behavior toward Resident #2. She stated she should have been made aware of the incident by the staff member(s) who were present when the incident occurred. The SSD stated resident behaviors should be documented on the facility's twenty-four (24) hour report by the nurses and the 24 hour report would be discussed in the morning meeting the following day. However, she did not remember this incident being discussed. On 01/07/14 at 10:24 AM, interview with Interim Director of Clinical Services (DCS) revealed she began employment on 11/05/13 as the Assistant DCS (ADCS) and became the facility's Interim DCS on 11/12/13 or 11/13/13. She stated she was unaware of the incident between Resident #1 and Resident #2; however, based on the nurse's note on 07/17/13 it appeared Resident #1 invaded another resident's privacy and was possible sexual abuse. She stated although Resident #2 had episodes of confusion, he/she was aware of what goes on around him/her. The DCS further indicated Resident #2 had difficulty with speech; however, the resident can make his/her needs known through gestures and throwing things like cookies at Resident #1 was Resident #2's way of communicating. Further interview with the SSD, on 01/07/14 at 8:57 AM revealed she had observed Resident #1 and Resident #2 kissing each other in the hallway on 01/06/14, but never interviewed to determined if it was consensual and she assumed they were girlfriend and boyfriend. Interview with SRNA #1, on 01/09/14 at 10:20 AM, revealed Resident #1 and Resident #2 kiss often, and she had personally seen them kiss on two (2) to three (3) occasions. She stated Resident #1 always initiated the contact. She stated Resident #2 was moody and the resident did not want the attention of Resident #1, even if they were seen kissing. The aide stated she had seen Resident #2 look like he/she did not want to be bothered by Resident #1. She indicated she had never asked Resident #2 if it was okay for Resident #1 to kiss him/her. The SRNA indicated Resident #1 had sexually abused Resident #2. On 01/09/14 at 9:01 AM and 10:12 AM, interview with LPN #5 revealed it was sexually inappropriate behavior for Resident #1 to try and kiss Resident #2. She stated Resident #2 could not push Resident #1 away as Resident #2 only had use of one (1) arm; however, the resident could say no. The nurse stated she had told Resident #1 on two or three occasions to back off and leave the room. She indicated when Resident #1 left the room, Resident #2 would say thank you. LPN #5 further indicated she did not think Resident #2 liked it when Resident #1 would become affectionate, as Resident #2 would make a face at Resident #1. The nurse stated around 12/31/13, or within a couple of days, Resident #1 was seen by a staff member to enter Resident #2's room and was kissing him/her. LPN #5 further stated if she had known about the incident on 07/17/13, she would have reported Resident #1 touching/kissing Resident #2 to the SSD. Continued interview with the DCS, on 01/08/14 at 11:06 AM, revealed she was not aware of any reported behaviors of Resident #1 toward Resident #2, and was unaware of the two (2) residents kissing in the hallway recently. She stated staff could misinterpret inappropriate behavior as staff come from different backgrounds and views. She indicated Resident #1's behaviors were not documented on the 24 hour report, which was used for the morning meetings. If the behaviors were not documented, she stated she would not know the behaviors had occurred and therefore Resident #1's behaviors could not be addressed. The DCS further indicated if two (2) residents had contact with each other, the facility would need to look at whether both persons were able to give consent. The DCS further stated someone from the facility should speak to Resident #2 to find out what the resident feels is or is not okay to touch. Continued interview with the SSD and the DCS on 01/09/14 at 1:54 PM, revealed they spoke to Resident #2 who reported he/she and Resident #1 had kissed earlier on that day outside the SSD's office. The DCS stated Resident #2 reported a friendly relationship with Resident #1; however, when asked if Resident #1 had ever been in his/her room unwelcomed, the DCS stated Resident #2 reported the incident in July. The SSD stated Resident #2 said he/she did not want sexual contact with Resident #1. However, by the time of this interview with Resident #2, Resident #1 had already been transferred from the facility. Interview, on 01/07/14 at 12:35 PM, with the Interim Executive Director (ED) revealed he began employment at the facility as the Interim ED on 12/06/13 and was unaware of the incident on 07/17/13 between Resident #1 and Resident #2. Upon review of the nurse's note, dated 07/17/13, the ED stated Resident #1 was inappropriate with Resident #2 and the SSD, DCS and the ED should have been notified and an investigation completed. Interview, on 01/16/14 at 3:07 PM, revealed the ED could not give an example of abuse, and stated he would need to review the law. After obtaining a copy of the regulations, the ED indicated, on 01/16/14 at 4:05 PM, that a resident had the right to be free from sexual abuse. He further stated he would need to refer to the law for more information and did not know what the law stated in relation to abuse. On 01/09/14 at 12:40 PM, interview with the Psychiatrist for Resident #1 revealed he had not been notified of the incident noted in the 07/17/13 nurse's note. He stated he should have been called so that he could have tried to intervene. 2. Continued review of Resident #1's clinical record revealed a psychiatrist's note, dated 11/08/13, which stated the resident had a recent verbal altercation with a male peer witnessed by staff, and misinterpreted as a

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

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F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) physical altercation. Review of Resident #1's nurse's noted, dated 11/06/13 at 4:20 PM, revealed Resident #1 complained of pain to the left shoulder and side with a physician order [REDACTED]. Interview, on 01/07/14 at 8:57 AM, with the SSD revealed the altercation between Resident #1 and Resident #3 was a verbal exchange that had been misinterpreted as a physical altercation. She stated Resident #3 was walking in the courtyard and his/her pants were sagging. The SSD indicated Resident #1 was following behind Resident #3 and told Resident #3 to pull up his/her pants, that no one wanted to see his/her ass. The SSD further indicated when Resident #3 turned to sit down on a bench, the resident lost his/her balance and accidentally fell forward toward Resident #1 with his/her walker hitting Resident #1's wheelchair. She stated neither resident touched the other. She also stated she had talked with both Resident #1 and Resident #3, as well as SRNA #3. Interview, on 01/09/14 at 3:08 PM, with SRNA #3 revealed she had been outside in the courtyard on 11/05/13 and witnessed the incident between Resident #1 and Resident #3. She stated she heard Resident #1 tell Resident #3 to pull up his/her pants. The aide stated she redirected Resident #1 who continued to aggravate Resident #3. She indicated Resident #3 had become aggravated and raised his/her walker and hit Resident #1 with the walker two (2) to three (3) times, possibly on the arm. She further indicated Resident #3 then lost his/her balance and fell , and Resident #1 attempted to move his/her wheelchair away from Resident #3. The SRNA stated Resident #3 fell with his/her head falling into Resident #1's lower legs. Additionally, she stated Resident #1 then kicked Resident #3 in the head about three (3) times. The aide stated she reported the incident to the House Supervisor. The aide indicated Resident #1 often picked at Resident #3 and felt Resident #3 had enough that evening. Interview with the House Supervisor, on 01/09/14 at 12:59 PM, revealed the incident happened on 11/05/13 involving Resident #1 and #3 and was brought to her attention by SRNA #3. The residents were arguing in the courtyard and Resident #3 fell , they completed an incident report and turned in written statements. The report and the statements were given to the ED by SRNA #3. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 12/03/12 with [DIAGNOSES REDACTED]. The facility completed a Significant Change MDS, on 10/14/13, and utilized the Staff Assessment for Mental Status and determined the resident was moderately impaired. The comprehensive care plan, dated 10/04/13, revealed the care plan for behaviors included interventions to not argue with the resident and to ensure the safety of the resident and others. A skin assessment of Resident #3, dated 11/05/13, revealed a mark on the left side of the resident's mouth. Interview with Resident #3, on 01/06/14 and on 01/08/14 at 5:17 PM, revealed he/she was in a fight with someone a couple of months ago. The resident stated they both swung at each other and yelled at each other; however, there had not been any other problems since. Resident #3 indicated he/she and Resident #1 were arguing in the courtyard and Resident #1 hit him/her. The resident further indicated he/she did not remember if he/she fell . Resident #3 stated Resident #1 had not ever touched him/her before. Resident #1 was not available to interview regarding the incident with Resident #3. The resident was transferred out of the facility before an interview could be obtained. On 01/07/14 at 10:24 AM, interview with the Interim DCS revealed the SSD had reported to her that she (the SSD) overheard staff talking about an incident involving Resident #1 and Resident #3 and began an investigation. The DCS stated at the time of the incident, she was the ADCS at the facility and was unaware if the investigation by the SSD was completed. She stated physical abuse was physical contact between two (2) people and verbal abuse could be anything said that was demeaning to another person. Interview with the Interim ED, on 01/07/14 at 12:35 PM, revealed he had been in this role and with the facility since 12/06/13. The ED stated the incident on 11/05/13 was a verbal altercation misinterpreted as a physical altercation between Resident #1 and Resident #3. He stated the incident would warrant further looking into. The ED stated physical abuse was physically harming another person and emotion/mental abuse was words or actions that create a significant emotional impact on another person. Interview with the Advanced Registered Nurse Practitioner (ARNP), on 01/14/14 at 12:01 PM, revealed she was aware of the incident between Resident #1 and Resident #3. She stated the facility had notified her of the incident in which Resident #3 had fallen and Resident #1 had hit him/her. She indicated the facility later called her to report that Resident #3 had fallen and was not hit. The ARNP stated the SSD had stated to her that the incident had been blown out of proportion and was not a physical altercation. On 01/15/14 at 4:51 PM, interview with the Vice President (VP) of Clinical Operations revealed while reviewing the facility QA binder, a note, under the November tab, contained documentation that Resident #1 hit, and was hit by another resident, and that Resident #3 hit, and was hit by another resident on 11/05/13. However, no other information regarding the incident was available. Observation of Resident #1, on 01/03/14 at 10:29 AM, revealed the resident was in his/her room, sitting in a wheelchair. Continued observation on 01/06/14 at 1:54 PM revealed the resident seated in a wheelchair and able to self-propel backwards down the hallway using only the right foot. Observation, on 01/07/14 at 3:24 PM, of Resident #1 revealed the resident was yelling wanting to go outside to smoke. At 4:04 PM, Resident #1 was yelling emergency while self-propelling down the hallway. Continued observation at 4:06 PM revealed Resident #1 was near the nurse's station for the A/D Halls. The resident was yelling at a staff member, cursing, and positioned his/her wheelchair to corner the staff member between the nurse's station and resident rooms without a way to remove herself from the resident. 3. Review of the facility's policy regarding Resident Abuse, revised 01/01/12, revealed staff would treat residents so they were free from abuse, neglect, and mistreatment. No employee would, at any time, commit an act of physical, psychological, or emotional abuse or mistreatment against any resident. The policy indicated physical abuse as striking the resident with a part of the body, or an object, kicking, non-therapeutic shoving, pushing the resident's body, or physical contact intentionally or through carelessness that resulted in or was likely to result in physical injury, pain, or psychological harm to the resident. Additionally, physical abuse included acts of physical retaliation, even in response to a physical attack. Verbal Abuse was identified as statements made to a resident which resulted in ridicule or humiliation of a resident, cursing, disparaging and derogatory terms. Psychological/Emotional abuse included humiliation and harassment. The policy stated all actions in which employees engage with residents must have a healthful, proper, and humane care and treatment of [REDACTED]. Review of the completed facility investigation, dated 01/06/14, revealed SRNA #2 verbally and physically abused Resident #1 on 12/31/13. The facility investigation substantiated abuse by the aide against Resident #1. Interview with Resident #1, on 01/03/14 at 10:29 AM and 01/06/14 at 1:54 PM, revealed the resident wanted to go outside to smoke and SRNA #2 stated it was not the time to smoke. The resident stated he/she playfully told the aide to shut up. He/she indicated the aide said not to tell her to shut up. Resident #1 further indicated he/she asked the aide what she, the aide, would do and touched the aide's arm. The resident stated SRNA #2 then tried to pull his/her hair, and hit the resident on the right side of the face, with a motion of an open claw; however, he/she could not remember how many times. Resident #1 stated two (2) nurses, one of whom was LPN #3, had to pull the aide off of him/her. The resident denied having any injuries from the altercation. He/she indicated he/she had not had any problems with the aide previously and the aide's behavior was unexpected. He/she indicated SRNA #2's behavior was abusive. On 01/03/14 at 1:56 PM, interview with LPN #1 revealed she heard screaming down the hall and when she arrived she saw Resident #1 and SRNA #2 separated from the other with the aide outside in the courtyard. She stated both the resident and aide were yelling at each other; however, as the aide was outside, LPN #1 stated she could not hear what the aide was saying. Interview, on 01/03/14 at 2:19 PM, with LPN #2 revealed he heard yelling coming from the TV room at the A and D Hallways and found Resident #1 and SRNA #2 in a physical altercation. The LPN stated Resident #1 was in a wheelchair and the aide was standing over and bent down to the resident. He stated he witnessed both the resident and the aide grabbed each other. He stated he assisted to pull the aide off of the resident and had to hold the aide back. The LPN stated both the resident and aide continued to yell at each other. He indicated he took the aide outside to calm her down, while the aide continued to try to get to the resident. The LPN stated LPN #4 stayed with the aide outside. He further indicated Resident #1 had taken a fork off the dinner tray cart in the hallway; however, was able to get the fork from the resident. LPN #2 stated he felt the altercation between SRNA #2 and Resident #1 was abusive as the aide made physical contact with the resident. He indicated it was unacceptable for the aide to hit the resident back. Interview with LPN #3, on 01/03/14 at 2:37 PM, revealed he was the nurse assigned to the A Hall and heard screaming and yelling. He stated he called for another nurse to assist. The LPN stated when he reached the TV room at the A and D Hall he found Resident #1 in the wheelchair and SRNA #2 was standing over the resident, both verbally insulting each other and making motions of fighting. The nurse stated the resident and aide were not fighting when he arrived; however, they were face to face. He indicated when he stepped between them both the resident and aide made threatening statements to each other; I am going to get you; I am going to find you; and both were cursing at the other. He indicated he stood between the resident and the aide and they both immediately tried to hit each other, however he could not recall who hit the other person first. The nurse further indicated both the aide and the resident were hitting and grabbing the other. He further indicated he could not separate them and required the assistance of two (2) other nurses. The LPN stated it took a total of three (3) nurses between five (5) to ten (10) minutes to separate the aide from the resident and move the aide to the outside of the

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 6) building. He stated SRNA #2 said I am going to get you to Resident #1 while he and other nurses were attempting to remove the aide from Resident #1. LPN #3 indicated after the aide was taken outside, he went back to check on the resident while the other two (2) nurses stayed with the aide outside. He stated he took Resident #1 to his/her room to try to calm the resident down. The LPN indicated when he left the resident's room the aide was still outside with one (1) nurse, the resident self-propelled him/herself out of the room and began to insult the aide. He further indicated the aide then began again to attempt to get at the resident. LPN #3 stated it took about fifteen (15) to twenty (20) minutes for SRNA #2 to calm down and control herself. The nurse stated the aide wrote a statement about what happened and left the building. The LPN stated he felt the aide's behavior was abusive, regardless of what the resident may have done. He stated the aide should not have engaged in abusive language, and especially should not have become physical with the resident. Interview with LPN #4, on 01/06/14 at 10:37 AM, revealed she heard screaming, yelling, and cussing down the hallway. The nurse stated she, LPN #2, and LPN #3 all responded, and when she arrived SRNA #2 and Resident #1 were in a fist fight with LPN #3 standing between them. She indicated both the aide and the resident were trying to get at each other, around LPN #3, and were throwing fists at each other. The nurse further indicated it took her and LPN #2 several minutes to get the aide separated from Resident #1 and took the aide outside. She further indicated LPN #2 and LPN #3 went to the resident while she, LPN #4 stayed outside with SRNA #2. The nurse stated even after removing the aide to the outside, SRNA #2 continued to yell and cuss at the resident, saying she did not care if the resident was in a wheelchair. Additionally, LPN #4 stated while outside, the aide attempted two (2) to three (3) times to go back into the building, saying she was going to F. you up. The nurse stated after the aide calmed down, she wrote a statement and left the building. The LPN indicated she completed Resident #1's physical assessment after the incident occurred. She stated the resident had slight bruising to the right cheek and the resident denied any other injuries. LPN #4 stated she felt SRNA #2's behavior was abusive toward Resident #1. On 01/07/14 at 12:41 PM, interview with SRNA #2 revealed she worked with Resident #1 every day. The aide stated she was telling another resident that it was not time to go outside for the smoke break. The aide indicated Resident #1 then cussed at her and told her to shut up. She further indicated she told the resident she was not speaking to him/her and that was when Resident #1 began to yell and scream. She stated the resident was in the wheelchair and touched her and she told the resident not to touch her. The aide stated LPN #3 had then arrived and stepped between them. The aide indicated LPN #3 had grabbed for her, not the resident and felt the nurse was afraid she would do something to Resident #1. She indicated at that point Resident #1 grabbed her and had hold of her, and she began to cuss at the resident. She further indicated it took three (3) nurses to move her away from Resident #1, as she was holding the handrail at the time, and out the door. The aide stated as mad as she was, if LPN #3 had not moved her away from the resident, she would have hit the resident. She indicated she would have hurt the resident; however, she did not have a chance to hit Resident #1. Additionally, SRNA #2 further indicated after being pulled outside by the nurses, she had attempted to get back into the building. She indicated the resident had taken a fork and both of them continued to scream and yell at each other. The aide stated when she had calmed down she re-entered the building to write a statement and then left. She further indicated she had told the resident at some time during the incident she was going to kick (the resident's) ass. She stated she could have handled the situation better. The aide stated she should have informed Resident #1's nurse and it all could have been avoided. Additionally, SRNA #2 stated her behavior could be interpreted as abusive toward Resident #1. She denied touching the resident; however, she stated she did cuss and threaten the resident. On 01/06/14 at 9:04 AM, interview with the SSD revealed she was called in on 12/31/13 and spoke to Resident #1 about the incident. She stated the resident reported to her that he/she wanted to go outside to smoke and the aide told him/her it was not time. The SSD stated the resident told her he/she rubbed the aide's arm, and the aide began to curse and flail her arms at the resident. She indicated Resident #1 reported three (3) nurses came to assist the resident, including LPN #2, LPN #3, and LPN #4. She further indicated the three (3) nurses took the aide outside to the courtyard and the resident was taken to his/her room. The SSD stated she and Resident #1 spoke to a police officer about the incident and the resident declined to press charges of battery against the aide. She indicated the facility substantiated abuse by the aide to the resident. Additionally, the SSD
F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility policy and procedures, review of the facility's personnel files, it was determined the facility failed to have an effective system to ensure incidents of potential abuse were investigated and reported immediately to the appropriate State Survey Agency (SSA) for fourteen (14) of twenty-two (22) sampled residents (Resident #1, #2, #3, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18 and #19). The facility failed to investigate and report allegations of verbal, physical and sexual abuse by resident to resident and staff to resident. The facility also failed to prevent further potential abuse by failing to conduct investigations. On [DATE], Resident #1 was found in Resident #2's room with his/her hand under Resident #2's sheet. Resident #2 was telling Resident #1 to stop, after Resident #1 continued to play with Resident #2, the resident got mad and threw a pack of cookies at Resident #1. Resident #1 then started to throw items at Resident #2. Attempts by staff to remove Resident #1 from the room resulted in Resident #1 refusing to leave Resident #2's doorway for twenty (20) minutes while yelling and arguing with staff. The incident was not reported to the Abuse Coordinator or the State Survey Agency (SSA), and no investigation was completed. On [DATE], revealed a verbal exchange occurred between Resident #1 and Resident #3, that escalated in to a physical altercation. Resident #1 was verbally assaulting Resident #3. Resident #3 hit Resident #1 with the walker and fell to the ground. Resident #1 then kicked Resident #3 in the head multiple times. On [DATE], Resident #1 complained of arm pain and an X-ray revealed a dislocated shoulder. This incident was never reported to the SSA or investigated as potential abuse. On [DATE], the facility's Activities Director was observed, by the adult Psychiatric Advanced Registered Nurse Practitioner (ARNP), yelling and screaming at Resident #19. The ARNP reported an allegation of verbal abuse to the Social Service Director; however, the facility failed to report the allegation to the SSA or complete an abuse investigation. (Refer to F223) Record review and interview revealed incidents of physical and/or verbal altercations between residents with no documented evidence the incidents were investigated to identify potential abuse and no documented evidence actions were taken to protect residents from further potential abuse. This failure affected ten (10) residents. On [DATE] Resident #10 received and unwelcomed kiss from Resident #9. On [DATE], Resident #13 made verbally threatening remarks to Resident #14. On [DATE], Resident #11 threw a bowl of soup that landed on Resident #12. On [DATE] Resident #15 and Resident #16 were in a physical altercation. On [DATE], there was a physical altercation between Resident #17 and Resident #18. In addition, the facility failed to have an effective system for abuse screening and prevention for eight (8) of eighteen (18) sampled personnel files. The facility failed to verify staff licenses, complete nurse aide abuse registry (NAR) checks, complete reference checks, and/or criminal background checks were conducted or contained negative information regarding theft. The facility's failure to have an effective system for abuse investigation, reporting, prevention and protection of residents at risk placed residents in a situation that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AOC) was received on [DATE] and the State Survey Agency validated the Immediate Jeopardy was removed on [DATE] as alleged, prior to exit on [DATE]. The scope and severity was lowered to an E with continued noncompliance while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Resident Abuse, revised [DATE], revealed each resident would be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriate of property. Any employee who witnessed or had knowledge of an act of abuse to a resident was obligated to report such information to the Clinical Nurse in charge, Director of Clinical Services (DCS) and the Executive Director. All reported events would be investigated by the DCS. This information would be forwarded to the Executive Director, who would serve as the facility's Abuse Coordinator, and an abuse investigation would be conducted. In the absence of the Executive Director, the DCS will serve as the Abuse Coordinator. All incidents of abuse were to be reported immediately and the prescribed forms were to be completed and delivered to the Abuse Coordinator. The Abuse Coordinator was responsible for reporting to the appropriate officials in

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) accordance with Federal and State Regulation. The Abuse Coordinator or designee would investigate all reports of suspected abuse. Immediately upon report of an incident the suspect would be segregated from the resident. An incident report would be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. The Abuse Coordinator and/or DCS would take statements from the victims, the suspects and all possible witnesses including all other employees in the vicinity of the alleged abuse. Once the investigation was completed the report would be reviewed by the DCS, the Abuse Coordinator, and one other Administrative staff member. Review of the facility's policy Resident Abuse-Resident to Resident, revised [DATE], revealed residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. If applicable, the staff was to move the resident causing the danger to another room or unit, pending investigation of the incident. Closely monitor and document the behavior and condition of the residents involved to evaluate for any injury and to prevent recurrence of the incident. A documented investigation by the Executive Director, DCS, or designee must be initiated within twenty-four (24) hours of knowledge of the alleged incident. The investigation included talking to all involved (directly or indirectly), any family involved, all residents involved, and any visitors or volunteers involved. The Executive Director, DCS, or their designee must notify Adult Protective Services, the local Ombudsman, and law enforcement (if criminal act) of any alleged abuse. The facility must develop measures to prevent reoccurrence and document these measures in the resident's medical record to include revision of the plan of care. Review of the list of the facility's Key Personnel provided to the State Survey Agency on [DATE] revealed the SSD was also the facility's Abuse Coordinator. However, a revised list provided on [DATE] at 8:50 AM, revealed the facility's Abuse Coordinator was the Interim Executive Director (ED). 1. Interview and record review revealed Resident #1 had a history of [REDACTED]. However, there was no documented evidence the facility had conducted investigations to identify this behavior as potential abuse. Review of Resident #1's Psychiatric Services notes revealed the resident's behaviors toward peers and staff dated back to 2012. Per the Psychiatric Services notes, Resident #1 displayed aggression, yelling, lability, severe mood swings, verbal outbursts, had increased flirtation and poor boundaries with male peers, was sexually intrusive, and made inappropriate comments toward male caregivers. Record review revealed on [DATE] Resident #1 was discovered in Resident #2's room with his/her hand under Resident #2's sheet touching and fondling Resident #2. Interview with Resident #2 revealed the touching by Resident #1 made him/her feel uncomfortable. Interview with the Social Service Director (SSD), on [DATE] at 9:00 AM, revealed she had been told about Resident #1's history of sexually inappropriate behavior, but was not aware of any incidents since she started, on [DATE], and was unaware of the incident on [DATE] of Resident #1's behavior toward Resident #2. On [DATE] at 10:24 AM, interview with Interim DCS revealed Resident #1's behaviors were not documented on the 24 hour report, which was used for the morning meetings. If the behaviors were not documented, she stated she would not know the behaviors had occurred and therefore Resident #1's behaviors would not be addressed. Interview, on [DATE] at 12:35 PM, with the Interim ED revealed the SSD, DCS and the ED should have been notified and an investigation completed regarding the incident on [DATE]. Continued interview, on [DATE] at 2:58 PM, revealed the Quality Assurance (QA) committee met on [DATE] and there was no evidence abuse by Resident #1 toward Resident #2 was discussed. Further interview with the SSD, on [DATE] at 9:00 AM, revealed she had witnessed Resident #1 kiss Resident #2 in the hallway by the shower on [DATE], but did not intervene or interview Resident #2 as to whether or not it was mutual. Interview with Licensed Practical Nurse (LPN) #5, on [DATE] at 9:01 AM, revealed she knew of two (2) or three (3) incidents of kissing/touching in the last six (6) months. However, LPN #5 stated she had not reported it because she had not actually witnessed the incidents. Per interview, she saw Resident #1 touch Resident #2's arm, which caused Resident #2 to grimace. However, she did not think it was something to put on an incident report. LPN #5 stated all the incidents should have been charted. Review of Resident #1's and #2's medical record revealed the incidents the LPN was discussing were not charted. Further review of Resident #1's chart revealed a Psychiatrist note, dated [DATE], indicating a verbal exchange occurred between Resident #1 and Resident #3. No further information was recorded. However, review of Resident #1's medical record revealed the resident began complaining of arm pain on [DATE] and an X-ray revealed a right shoulder dislocation with inferior subluxation. Interview with the House Supervisor, on [DATE] at 12:59 PM, revealed she was working as House Supervisor the night of [DATE] and was notified of a verbal and physical altercation between Resident #1 and Resident #3 outside in the courtyard. The House Supervisor revealed an incident report was completed, the previous ED #2 was notified and statements were written. Interview with the SSD, on [DATE] at 9:00 AM, revealed the incident on [DATE] was not reported to her and she found out about it by overhearing conversation from staff. The SSD revealed it was not investigated, but looked into as a behavioral incident. Further interview, on [DATE] at 2:00 PM, revealed she did not know what happened to the statements written by the Supervisor or the SRNA and did not know they ever existed. The SSD revealed ED #2 did the abuse investigations at that time and would have interviewed the staff. The SSD revealed she did interview Residents #1 and #3, but they stated it was just yelling and denied hitting each other. The SSD revealed she did attend the morning meetings where incidents were discussed. The SSD revealed Resident #1 had been discussed regarding refusal of care and cussing, but she had never been informed of the other behaviors and had not seen any documentation in the charts. Interview with the current DCS, on [DATE], at 3:12 PM, revealed she was not able to find any investigations regarding the incident with Residents #1 and #3 on [DATE]. Further interview with the SSD, on [DATE] at 10:32 AM, revealed the Regional DCS was aware of the incident from [DATE] because the previous ED #2 called the Regional DCS for advice on that incident involving Resident #1 and #3. Interview with previous Regional DCS, on [DATE] at 3:22 PM, revealed the current Regional DCS was training with her, on [DATE], and they received a call from a previous DCS about a reportable involving an altercation with actual body contact between Resident #1 and #3, and #1 actually had to go out for an evaluation due to an injury. The previous Regional DCS revealed she told the facility to report it, write up a plan, and send a copy for review. The previous Regional DCS revealed they received a call from previous ED #2 later that day to discuss this, because he did not want to report the incident, and that he had done his own investigation and did not feel it needed to be reported. The previous Regional DCS revealed the previous ED #2 was told it fell under the guidelines and needed to be reported, and it was always better to error on the side of caution. The previous Regional DCS revealed that was the last she heard from the facility as it was given to another person. The previous Regional DCS confirmed the current Regional DCS was present at the time of the conversation, which was on speaker so both could hear the conversation, and was knowledgeable of what had occurred. Interview with the current Interim ED, on [DATE] at 3:00 PM, revealed the morning meeting QA minutes from [DATE] had the incident with Resident #1 and #3 listed as a reportable incident. The ED revealed he was told by Corporate staff to report to the State Survey Agency that the previous ED #2 was told to report the incident to the SSA, but he had chosen not to. The Regional DCS read the notes listed on the minutes stating it read resident hit another resident. The ED revealed there were no other [MEDICATION NAME] listed or evidence of any tracking on Resident #1's behaviors. 3. Interview with MDS Director #1, on [DATE] at 10:09 AM, revealed another incident had occurred involving Resident #19 and the Activities Director. The MDS Director revealed she overheard the verbal altercation and reported the incident to the SSD by phone as an allegation of verbal abuse and never heard back from anyone regarding the investigation or that it had been reported. Interview with the SSD, on [DATE] at 10:32 AM, revealed she was notified on a verbal argument between Resident #19 and the Activities Director by the Psychiatric Advanced Registered Nurse (ARNP). The SSD revealed she had witnesses write statements and turned them in to the ED and the current Interim ED completed the investigation. The SSD revealed the Incident occurred [DATE] and the Activities Director was suspended until the State Survey Agency entered the building on [DATE]. The SSD revealed the ED had the Activities Director come in and retrieve the requested Resident Council Minutes and told her the incident was not substantiated. Interview with the Activities Director (AD), on [DATE] at 3:56 PM, revealed she was put on suspension until [DATE] and received education at that time to not argue back with the residents. Interview with the current Interim ED, on [DATE] at 9:22 AM, revealed he was responsible for the investigation from the incident on [DATE]. The ED revealed they were speaking loudly because of the distance between the two (2) and this was based on the statements that were turned in from the witnesses. He stated his investigation consisted of the statements from the witnesses, and he did not talk to any of the witness. Per interview, he was not aware the MDS Director and the ARNP reported the incident as an allegation of verbal abuse, and did not interview any of the residents to ensure they had not been affected or victim to any type of abuse from the AD. The ED reported he would have to refer to the SSD's notes because he could not speculate as to who he talked to or what he looked at to base a decision on as to the outcome of his investigation. The ED indicated he was not familiar with the reporting requirements and would have to let the law speak for itself. The ED further revealed the incident was not investigated as an abuse allegation because it was seen more as a customer service issue and therefore the incident was not reported. 4. Interview on [DATE] at 4:32 PM, with the current

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) Regional DCS revealed that on [DATE], the Assistant Director of Nurses, Unit Manager, Director of Clinical Services, Staff Development Coordinator and the third shift Supervisor conducted audits of resident records, conducted interviews with residents and staff, and discovered there was a problem with abuse in the facility. Per interview, there was no evidence the incidents discovered in the audit had been investigated for potential abuse. Based on this audit, the facility reported some concerns to the State Survey Agency on [DATE]. Review of the concerns from the audit provided by the facility revealed the following: Resident #10 received and unwelcomed kiss from Resident #9, on [DATE]. There was no documented evidence the incident was investigated by the facility and there was no evidence the facility implemented interventions to prevent reoccurrence and to protect residents from potential abuse. Resident #15 and Resident #16 were in a physical altercation (as defined by the OIG report) and a altercation as identified in the nurses note on [DATE]. There was no harm alleged. Resident #15 thrust his/her arm into the back of Resident #16's wheelchair. The incident was not investigated by the facility as potential abuse towards Resident #16 and no evidence the facility implemented interventions to prevent reoccurrence. Resident #13 made verbally threatening remarks to Resident #14, on [DATE]. Resident #13 was cursing and arguing with Resident #14 then threatened Resident #14 that he/she would stab him/her with a long handled shoe horn. Resident #14 yelled to Resident #13 he/she was going to knock his/her M----- F------ ass out that wheelchair. The incident was not investigated by the facility as potential abuse and no evidence the facility implemented interventions to prevent reoccurrence between Resident #13 and Resident #14 or to protect other residents from potential abuse. Resident #11 threw a bowl of soup that landed on Resident #12, on [DATE]. Social Services documented Resident #11 was angry and continued to be angry in the dining room. Resident #11 was upset with the meal and picked up the soup and threw it at Resident #12 and yelled shut up, when it landed on Resident #12. The staff did not assess Resident #12 for any injury until a skin assessment was completed on [DATE], two (2) days later. The incident was not investigated by the facility and there was no evidence the facility took action to address Resident #11's physical abuse towards Resident #12. The facility also reported a physical altercation that occurred on [DATE] between Resident #17 and Resident #18. The nurse turned the TV off and Resident #17 stated he/she was watching the TV. Approximately ten (10) minutes later the nurse overheard yelling that does not belong to you. When the nurse entered the room she found both residents standing breast to breast. The residents were separated and no injury was alleged. However, the facility did not complete an investigation to determine a root cause to prevent an altercation from occurring again. Review of the facility's list of key personnel listed the SSD as the Abuse Coordinator. However, interview with the SSD, on [DATE] at 2:06 PM, revealed she was not aware she was the Abuse Coordinator. The SSD revealed she was never appointed to that position; however, the SSD stated she had been completing investigations since May of 2013 when the previous ED #1 left. Interview with the current interim ED, on [DATE] at 10:22 AM, revealed the SSD handled all the investigations when he became the ED on [DATE] and assumed since that was the system in place she was the Abuse Coordinator. The ED revealed it was obvious the system was broken. The ED reported there were a lot of offices and a lot of paper in the building and he would have to go through all of them to find out how many had been reported, otherwise he would have to speculate on the accuracy of his memory as to how many abuse allegation there had been and he would have to let the record speak for itself. 5. Review of the facility's policy regarding Resident Abuse, revised [DATE], under the section titled screening, revealed the facility would screen any persons applying for employment for a history of abuse, neglect or mistreating residents by checking references from previous or current employers, criminal background checks, abuse checks with appropriate licensing board and registries prior to hire, sworn disclosure statements prior to hire, and verification of license or registration prior to hire. Review of the facility's policy regarding Licensure and Certification Verification, reviewed [DATE], revealed all staff requiring licensure or certification would produce a current license, certification, or other authorization to practice in the state they are employed. A designated facility representative would be responsible to ensure the policy was followed. Additionally, a copy of the electronic version of an individual's current license/certification would be maintained in the personnel file. Review of the facility's policy regarding Eligibility for Employment, reviewed [DATE], revealed any individual who had been convicted of any offense involving theft may not be eligible for hire. Review of the personnel file for State Registered Nurse Aide (SRNA) #10 revealed the facility hired the SRNA on [DATE]. The facility completed a Nurse Aide Abuse Registry check on [DATE], seven (7) days after date of hire. Review of the personnel file for the Activities Assistant revealed the facility hired her on [DATE]. A Nurse Aide Abuse Registry check and reference checks were not completed until [DATE], or sixty-eight (68) days late. Review of SRNA #5's personnel file revealed the facility hired the SRNA on [DATE]. Reference checks for the aide were not completed by the facility as of [DATE], or one hundred seventy-six (176) days. Review of the personnel file for the previous Director of Clinical Services (DCS) #1 revealed the facility hired the previous DCS on [DATE] and the first day of work was on [DATE]. The facility verified the DCS nursing license and Nurse Aide Abuse Registry check on [DATE], thirty-four (34) days late. Review of previous Interim Executive Director (ED) #3's personnel file revealed the facility hired the ED on [DATE]. The facility conducted the criminal background check on [DATE], fourteen (14) late. A Nurse Aide Abuse Registry check was not completed by the facility as of [DATE], or three hundred and ten (310) days. Review of previous ED #2's personnel file revealed the facility hired him on [DATE] and was present during the incident of physical abuse between Resident #1 and #3. The facility did not complete a Nurse Aide Abuse Registry check as of [DATE], or two hundred and six (206) days. Review of the personnel file for the current Interim ED revealed the facility hired him on [DATE] and was present during the incident of verbal abuse between the Activities Director and Resident #19. A Nurse Aide Abuse Registry check was not completed as of [DATE]. Review of the personnel file for the previous Interim DCS revealed the facility hired the DCS on [DATE] and present during the incident of sexual abuse between Resident #1 and #2. The facility completed a criminal background check on [DATE] that revealed a charge of Theft by Unlawful Taking, disposed as Indictment by Grand Jury. Interview, on [DATE] at 10:24 AM, with the current Interim DCS revealed the nurse aide abuse registry checks for new personnel should be completed prior to new hires entering the building; however, the Activities Assistant did not need to be a SRNA, and therefore would not need an abuse registry check. However, review of the facility's policy revealed any persons applying for employment would be screened for a history of abuse, neglect, and mistreating residents. She stated the Staff Development Coordinator (SDC) was responsible to complete the nurse aide abuse registry checks for nursing, and Human Resources (HR) would complete the checks for non-nursing staff. The DCS indicated she directly supervised the SDC. The DCS stated criminal background checks and references should also be completed. She further stated the Activities Assistant had only worked at the facility for a couple of hours in classroom orientation and had never returned. The DCS indicated if the facility did not verify an individual's license then it was possible to have unlicensed personnel in a licensed position. She stated this was a safety issue and not completing the required checks allowed the potential for residents to be unsafe in the facility. Interview with the Staff Development Coordinator (SDC), on [DATE] at 1:25 PM, revealed she was responsible to complete license and NAR checks for nurses and aides, and background checks were completed by HR. The SDC stated she began to complete the license and NAR checks in the previous month. She indicated if the required checks were not completed, a new staff member could have an expired license. She further indicated she was supervised by the DCS; however, did not submit staff checks to the DCS for review prior to submittal to the HR. The DCS stated she began to conduct reference checks in the last couple of weeks as the checks were not being conducted timely by the receptionist. Interview, on [DATE] on 2:35 PM, with the Payroll/HR Coordinator revealed she was responsible for Payroll/ HR from [DATE] to [DATE], and again from [DATE] to present. The Payroll/HR Coordinator stated during the month of [DATE] the HR position was vacant and someone from another facility completed only the payroll. She indicated to her knowledge, no one completed the required personnel checks during that time. She further indicated if the Kentucky Board of Nursing (KBN) checks were not completed, the staff member could be a danger to residents as the staff could potentially be unlicensed and not have the required education. She stated the KBN would verify the KY abuse registry. The HR Coordinator stated she was responsible to ensure SRNA #9's KBN check was completed. Interview with SRNA #4, on [DATE] at 1:01 PM, revealed she was the previous SDC for the facility from ,[DATE] to [DATE]. She stated she was responsible to complete reference checks on staff applicants and the previous HR Coordinator was responsible to complete all of the required checks. She indicated the purpose of conducting the required checks was to ensure the staff member had no reported background of abuse, neglect, drug charges, and theft. On [DATE] at 1:55 PM, interview with the previous Accounts Payable/Payroll Coordinator (PC) revealed she left the faciity on [DATE]. She stated she conducted background and KBN checks for every employee of the facility. She stated each department conducted their own reference checks. She stated she conducted monthly audits and when she left the facility everything was up to date. The PC stated when she left the facility in October, no one had replaced her; however, someone from another facility filled in to complete payroll. She further indicated all of the required checks should be completed prior to a new employee entering the building for new employee

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 9) orientation. She stated if the background check listed theft, the applicant could not be hired. The PC stated the purpose of the checks was to ensure employees hired would not abuse and neglect residents. On [DATE] at 12:35 PM, interview with the Interim ED revealed HR was responsible to ensure personnel files were complete. He stated if reference checks or abuse registry checks were conducted after the new employee had started working at the facility on [DATE], then it could mean those documents were lost or they were not completed. The ED stated the personnel checks, which included background checks, license verification, and abuse registry checks, should be completed prior to a new employee's hire to keep residents of the facility safe. He indicated the facility should ensure staff were not listed on the abuse registry. The ED further indicated he would use a checklist to ensure all documents and checks had been completed; however, he had not implemented one. He stated he would also conduct periodic and random checks of employee files; however, he had not done any at the facility in his time employed. Interview with the Corporate Human Resources, on [DATE] at 2:24 PM, revealed 360 staffing was contracted to supply interim EDs and DCSs. 360 does all screening and these screenings specify a yes or a no for eligibility for hire. The form does not specify any details of the background search or who the information is obtained from. She further stated she would have to call 360 to obtain the actual hire dates of the EDs. The facility provided an Allegation of Compliance (AOC) on [DATE] alleging the Immediate Jeopardy (IJ) was removed on [DATE]; the facility took the following immediate steps to remove the IJ: 1. Resident #1 was discharged to the hospital for a psychiatric evaluation on [DATE]. 2. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on [DATE]. 3. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on [DATE]. 4. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on [DATE], which included a medical record review. 5. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on [DATE]. 6. The incident involving Resident #3, on [DATE], was reported to the State Survey Agency (SSA), on [DATE] via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on [DATE]. 7. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on [DATE] which included a medical record review and a care plan review. 8. The incident on [DATE] involving Resident #2 was reported to the SSA on [DATE] via a 24 hour report. A 5 day Report was submitted to the SSA on [DATE]. 9. Resident #2 was interviewed on [DATE] by the SSD and the DCS regarding the incident on [DATE] and [DATE]. 10. Current resident chart reviews completed , on [DATE] and [DATE] by the DCS, ADCS, Unit Manager and RDCS and staff interviews on [DATE] and [DATE] by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on [DATE]. B. Increased supervision was initiated on [DATE] and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on [DATE]. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on [DATE]. D. Had documentation of behavior reviewed daily since [DATE] by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 11. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an 8 or above were interviewed by the Social Services on [DATE] to ensure they had not been abused or neglected. 12. All residents were assessed by nurses via skin sweeps for suspicious injuries on [DATE], [DATE], and on [DATE] with no injuries found. 13. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the facility's investigation, and policies regarding Resident Abuse and Resident Abuse-Resident to Resident, it was determined the facility failed to have an effective system to ensure policies and procedures were implemented related to abuse for fourteen (14) of the twenty-two (22) sampled residents (Resident's #1, #2, #3, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, and #19). The facility failed to ensure staff reported allegations of abuse, failed to investigate allegations of abuse, failed to prevent the potential for further abuse, and failed to report allegations to the appropriate State Agencies per the facility's policy and procedures. (Refer to F223 and F225) On 07/17/13, Resident #1 was found in Resident #2's room with his/her hand under Resident #2's sheet. Resident #2 was telling Resident #1 to stop, after Resident #1 continued to play with Resident #2, the resident got mad and threw a pack of cookies at Resident #1. Resident #1 then started to throw items at Resident #2. Attempts by staff to remove Resident #1 from the room resulted in Resident #1 refusing to leave Resident #2's doorway for twenty (20) minutes while yelling and arguing with staff. The incident was not reported to the Abuse Coordinator or the State Survey Agency (SSA), and no investigation was completed. On 11/08/13, revealed a verbal exchange occurred between Resident #1 and Resident #3, that escalated in to a physical altercation. Resident #1 was verbally assaulting Resident #3. Resident #3 hit Resident #1 with the walker and fell to the ground. Resident #1 then kicked Resident #3 in the head multiple times. On 11/06/13, Resident #1 complained of arm pain and an X-ray revealed a dislocated shoulder. This incident was never reported to the SSA or investigated as abuse. On 12/30/13, the facility's Activities Director was observed, by the adult Psychiatric Advanced Registered Nurse Practitioner (ARNP), yelling and screaming at Resident #19. The ARNP reported an allegation of verbal abuse to the Social Service Director; however, the facility failed to report the allegation to the SSA or complete an abuse investigation. Record review and interview revealed incidents of physical and/or verbal altercations between residents which were not reported to the State Agencies, with no documented evidence the incidents were investigated to identify potential abuse and no documented evidence actions were taken to protect residents from further potential abuse. This failure affected ten (10) residents (Residents #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18). In addition, review of eighteen (18) employee records revealed eight (8) employees files did not contain the required registry checks, criminal back ground checks, and/or references for abuse prohibition. The facility's failure to implement abuse policies regarding identifying, investigating, reporting, and protection of residents from abuse placed residents in a situation that has caused, or was likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy (IJ) was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14 as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E with continued noncompliance while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Resident Abuse, revised 01/01/12, revealed each resident would be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. Any employee who witnessed or had knowledge of an act of abuse to a resident was obligated to report such information to the Clinical Nurse in charge, Director of Clinical Services (DCS) and the Executive Director. All reported events would be investigated by the DCS. Patterns or trends would be identified that might constitute abuse. This information would be forwarded to the Executive Director, who would serve as the facility's Abuse Coordinator, and an abuse investigation would be conducted. In the absence of the Executive Director, the DCS will serve as the Abuse Coordinator. All incidents of abuse were to be reported immediately and the prescribed forms were to be completed and delivered to the Abuse Coordinator. The Abuse Coordinator was responsible for reporting to the appropriate officials in accordance with Federal and State Regulation. The Abuse Coordinator or designee would investigate all reports of suspected abuse. Immediately upon report of an incident the suspect would be segregated from the resident. The DCS would perform and document a thorough nursing assessment and notify the physician. An incident report would be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. The Abuse Coordinator and/or DCS would take statements from the victims, the suspects and all possible witnesses including all other employees in the vicinity of the alleged abuse. Once the investigation was completed the report would be reviewed by the DCS, the Abuse Coordinator, and one other Administrative staff member. Review of the facility's policy Resident Abuse-Resident to Resident, revised 01/01/09, revealed residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. If applicable, the staff

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) was to move the resident causing the danger to another room or unit, pending investigation of the incident. Closely monitor and document the behavior and condition of the residents involved to evaluate for any injury and to prevent recurrence of the incident. Notification to the doctor and responsible party must be made to the following of all residents involved in the incident. A documented investigation by the Executive Director, DCS, or designee must be initiated within twenty-four (24) hours of knowledge of the alleged incident. The investigation included talking to all involved (directly or indirectly), any family involved, all residents involved, and any visitors or volunteers involved. The Executive Director, DCS, or their designee must notify Adult Protective Services, the local Ombudsman, and law enforcement (if criminal act) of any alleged abuse. The facility must develop measures to prevent reoccurrence and document these measures in the resident's medical record to include revision of the plan of care. 1. Interview and record review revealed physical altercations involving Resident #1 and two other residents. On 07/17/13, Resident #1 was observed in Resident #2's room with his/her hand under Resident #2's sheet. Resident #2 was telling Resident #1 to stop, after Resident #1 continued to play with Resident #2. On 11/05/13, Resident #1 and Resident #3 were in a verbal and physical altercation in which Resident #1 kicked Resident #3 in the head multiple times. On 01/06/14, the Social Services Director (SSD) witnessed Resident #1 kiss Resident #2 in the hallway by the shower on 01/06/14, but did not intervene or interview Resident #2 as to whether or not it was mutual. There was no evidence the facility completed an incident report, or investigated the incidents as potential abuse per the facility's policy. Interview with the current DCS, on 01/09/14, at 3:12 PM, revealed she was not able to find any investigations regarding the incidents with Resident #1. However, the facility's policy and procedures stated all incidents of abuse were to be reported immediately, and Abuse Coordinator or designee would investigate all reports of suspected abuse. Interview with the current Interim ED, on 01/10/14 at 3:00 PM, revealed the morning meeting QA minutes from 11/06/13 had the incident with Resident #1 and #3 listed as a reportable incident. The ED revealed the previous ED #2 was told to report the incident to the SSA, but he had chosen not to, even though the facility's policy stated all incidents of abuse would be reported to the appropriate officials in accordance with Federal and State Regulation. 2. Interview and record review revealed a verbal altercation between the Activities Director and Resident #19 on 12/30/13. Interview with the with MDS Director #1, on 01/14/14 at 10:09 AM, revealed she reported the incident to the SSD by phone as an allegation of verbal abuse, but never heard back from anyone regarding the investigation or that it had been reported. Interview with the adult Psychiatric Advanced Registered Nurse Practitioner (ARNP), on 01/14/14 at 12:01 PM, revealed she witnessed the Activities Director and Resident #19 yelling at each other. The ARNP revealed she told the Activities Director to walk away and not engage the resident, but she didn't, and the Unit Manager ended up intervening and removed the resident. The ARNP revealed she reported it to the SSD. Interview with the SSD, on 01/14/14 at 10:32 AM, revealed she was notified of a verbal argument between Resident #19 and the Activities Director. However, she stated the current Interim ED completed the investigation. Interview with the current Interim ED, on 01/15/14 at 9:22 AM, revealed he was responsible for the investigation from the incident on 12/30/13. The ED stated his investigation consisted of the statements from the witnesses; however, he did not talk to any of the witness, and was not aware the MDS Director and the ARNP reported the incident as an allegation of verbal abuse to the SSD. In addition, he did not interview any of the residents to ensure they had not been affected or victim to any type of abuse from the AD. The ED revealed the incident was not investigated as an abuse allegation because it was seen more as a customer service issue; and therefore it was not reported. 3. Interview on 010/14/14 at 4:32 PM, with the current Regional DCS revealed that on 01/08/14, and audit of resident records revealed several incidents of resident to resident abuse with no evidence the incidents had been reported to the State Agencies or investigated. However, the facility's policy on Resident to Resident abuse revealed the staff was to move the resident causing the danger to another room or unit, pending investigation of the incident. Closely monitor and document the behavior and condition of the residents involved to evaluate for any injury and to prevent recurrence of the incident. A documented investigation by the Executive Director, DCS, or designee must be initiated within twenty-four (24) hours of knowledge of the alleged incident. The investigation included talking to all involved (directly or indirectly), any family involved, all residents involved, and any visitors or volunteers involved. The Executive Director, DCS, or their designee must notify Adult Protective Services, the local Ombudsman, and law enforcement (if criminal act) of any alleged abuse. The facility must develop measures to prevent reoccurrence and document these measures in the resident's medical record to include revision of the plan of care. The facility reported concerns from the audit which affected ten (10) residents (Residents #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18). Interview with LPN #5, on 01/15/14 at 1:52 PM, revealed there was no set system for reporting allegations of abuse; some nurses had access via computer to the corporate lawyer; and, some nurses just wrote it on the Accident/Incident Report Form (Attorney/Client Worksheet). Review of the facility's list of key personnel listed the SSD as the Abuse Coordinator. However, interview with the SSD, on 01/10/14 at 2:06 PM, revealed she was not aware she was the Abuse Coordinator. The SSD revealed she was never appointed to the position. Interview with the current DCS, on 01/10/14 at 2:17 PM, revealed she was unaware the policy stated the DCS was one of the responsible persons to report abuse allegations. Interview with the current interim ED, on 01/19/14 at 10:22 AM, revealed he could not speak to the corporations formal policy regarding abuse procedures. He further could not verbalize the types of abuse and reporting requirements. He stated the policies were in the manual; however, there was no manual, and all policies were found on the Internet. The ED revealed it was obvious the system was broken. 4. Review of the facility's policy regarding Resident Abuse, revised 01/01/12, under the section titled screening, revealed the facility would screen any persons applying for employment for a history of abuse, neglect or mistreating residents by checking references from previous or current employers, criminal background checks, abuse checks with appropriate licensing board and registries prior to hire, sworn disclosure statements prior to hire, and verification of license or registration prior to hire. Review of the facility's policy regarding Licensure and Certification Verification, reviewed 08/16/13, revealed all staff requiring licensure or certification would produce a current license, certification, or other authorization to practice in the state they are employed. A designated facility representative would be responsible to ensure the policy was followed. Additionally, a copy of the electronic version of an individual's current license/certification would be maintained in the personnel file. Review of the facility's policy regarding Eligibility for Employment, reviewed 03/01/11, revealed any individual who had been convicted of any offense involving theft may not be eligible for hire. Review of eight (8) of eighteen (18) sampled personnel files revealed the facility failed to verify staff licenses, complete nurse aide abuse registry (NAR) checks, complete reference checks, and/or ensure criminal background checks per facility policy. Interview, on 01/07/14 at 10:24 AM, with the current Interim DCS revealed the nurse aide abuse registry checks for new personnel should be completed prior to new hires entering the building. She stated the Staff Development Coordinator (SDC) was responsible to complete the nurse aide abuse registry checks for nursing, and Human Resources (HR) would complete the checks for non-nursing staff. However, there was no documented evidence the facility had a process in place to ensure this background checks were completed prior to hire. On 01/07/14 at 12:35 PM, interview with the Interim ED revealed background checks, license verification, and abuse registry checks should be completed prior to a new employee's hire to keep residents of the facility safe. The ED further indicated a system had not been implemented to ensure all documents and checks had been completed. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 2. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 3. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 4. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 5. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 6. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 7. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 8. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 Hour Report. A 5 day Report was submitted to the SSA on 01/13/14. 9. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 10. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 11. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an eight or above were interviewed by the Social Services on 01/07/14 to ensure they had not been abused or neglected. 12. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 13. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 14. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to determine if there were any incidents that were reportable and/or needed further investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 15. The facility's concern book was reviewed by the Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 16. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6) discrepancies identified were corrected with missing Criminal Background Checks and Reference checks by 01/12/14. 17. All current Department Head staff along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116 employees) were educated by the Corporate Administrative Registered Nurses on abuse screening, training, prevention, identification, investigation, protection, reporting and response, F223 and the facility's Policy and Procedure for Resident Abuse, on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 and completed a post test. No staff members worked beyond 01/12/14 without having already been educated prior to the start of their shift. 18. The Human Resource/Payroll Coordinator was reeducated by the Regional Director of Human Resources on 01/12/14 that newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. 19. The ED and DCS were re-educated by the Vice President of Clinical Services on 01/11/14 and 01/12/14 to ensure newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. The ED will validate and sign that Newly Hired Employees have had all the required checks. 20. Mock Survey Rounds consisting of care plan review and implementation, behavior documentation, and staff interviews were completed by the IDT on 01/13/14, 01/14/14, and 01/15/14 that included resident interviews regarding potential abuse issues. 21. All facility staff was educated by the Corporate Administrative Registered Nurse on identification of behaviors to include but not limited to sexual and physical behavior on 01/12/14. Residents with behaviors will be discussed weekly at the Behavior Management Meeting to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The Nurse will document the behaviors on the 24 Hour Report to be shared during the morning meeting. 22. The facility's Administrative staff (ED/Abuse Coordinator and DCS) have been educated by the Corporate Administrative Registered Nurse on 01/12/14 that abuse allegations which are reported to them by employees must be investigated and reported to the appropriate officials in accordance with Federal and State Regulation. 23. The QAPI Committee had an Ad-Hoc QAPI meeting on 01/10/14 to discuss IJ citations and on 01/15/14 to discuss performance improvement opportunities and to review the facility's Abuse policy. The attendees consisted of the Interim Director of Clinical Services, Dietary Manager, Business Office Manager, Director of Admissions, Medical Records, Central Supply, Regional Case Mix Coordinator, Regional Director of Human Resources, Regional Director of Business Services, Regional Director of Clinical Services, Corporate Administrative RN, Director of Rehabilitation Services, Clinical Ambassador, Corporate Director of Education, Regional Vice President of Operations, Vice President of Operations, Vice President of Clinical Services, Vice President of Admissions & Marketing, Corporate Operations Team Member and Executive Director via telephone. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 01/21/14-01/22/14 prior to exit as follows: 1. Review of the Resident #1 closed medical record revealed the resident was discharged from the facility and sent to the hospital for a psychiatric evaluation on 01/07/14. 2. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse's notes back to 07/17/13 identified three (3) residents with behaviors requiring increased monitoring through 1:1. Review and observation confirmed 1:1 was occurring and documented The RDCS revealed Resident #3 was identified as one of these residents. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed Resident #3 was listed as one of the residents assessed. 3. Interview with the Vice President of Clinical Operations (VPCO), on 01/22/14 at 2:48 PM, revealed resident's identified with behaviors from the chart audits, on 01/07/14 through 01/08/14 and staff interviews on 01/11/12 through 01/12/14, had interventions put in place during the care plan review. Observation of Resident #3, on 01/21/14 at 4:12 PM, revealed 1:1 supervision was provided with a SRNA #8. 4. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #3 was listed with identified behaviors, medications, and interventions. 5. Review of Resident #3's Care plan revealed an intervention for 1:1 supervision on 01/13/14. 6. Review of the faxed communication with the SSA from the facility revealed the incident involving Resident #3 and #1, on 11/05/13 was reported on 01/08/14 and a 5 day report was submitted on 01/13/14. 7. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #2 was reviewed to include a medical record review and care plan review. Interview with the Corporate Administrative Registered Nurse (CARN), on 01/22/14 at 1:27 PM, revealed Resident #2 did not need increased monitoring was not exhibiting behaviors. 8. Review of the faxed communications to the SSA from the Facility revealed the incident on 07/17/13 with Resident #1 and #2 was reported on 01/08/14 and a 5 day follow up was submitted on 01/13/14. 9. Interview with Resident #2, on 01/22/14 at 2:03, revealed he/she did have a conversation with the DCS and SSD regarding the incident on 07/17/13 and 01/06/14. Resident #2 revealed being asked if he/she felt safe and what had occurred. 10. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse notes back to 07/17/13 identified three (3) residents (#3, #13, and #21) with behaviors requiring increased monitoring. A. Review of the Behavior Management Meeting notes, dated 01/12/14, revealed the three (3) identified were Residents #3, #13, and #21 were included in the meeting. B. Review of the three (3) identified resident's care plan (#3, #13, and #21) revealed interventions to increase supervision using 1:1 was added. C. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed two (2) of the three (3) residents (Residents #13 and #21) had medications and behaviors reviewed. D. Review of the nursing notes and 24 hour report book, revealed the three (3) residents (#3, #13, and #21) were monitored daily with documented behaviors observed. 11. Interview on 01/21/14 with twelve (12) residents, identified as interviewable with a BIMS of 8 or greater, revealed they felt safe at the facility and had been interviewed by the SSD. 12. Review of the facility skin sweeps, dated 01/07/14, 01/08/14, and on 01/15/14, revealed the facility's 89 residents were assessed with [REDACTED]. 13. Interview with sixteen (16) facility staff, Certified Occupational Therapy Assistant (COTA) #1 on 01/20/14 at 2:30 PM; COTA #2 on 01/20/14 at 2:30 PM; LPN #7 on 01/21/14 at 3:25 PM; Maintenance Director on 01/21/14 at 3:30 PM; Dietary Cook on 01/21/14 at 3:35 PM; Dietary Aide on 01/21/14 at 3:37 PM; LPN #8 on 01/21/14 at 3:39 PM; SRNA #10 on 01/21/14 at 4:00 PM; SRNA #8 on 01/21/14 at 4:12 PM; Medical Records on 01/22/14 at 12:58 PM; Payroll/HR on 01/22/14 at 12:50 PM; Business Office Manager on 01/22/14 at 3:11 PM; LPN #5 on 01/22/14 at 1:01 PM; Housekeeper on 01/22/14 at 12:52 PM; SRNA #12 on 01/22/14 at 4:23 PM; and SRNA #11 on 01/22/14 at 4:05 PM, revealed they were asked to identify any residents who exhibited behaviors, abuse and/or neglect that had not been reported. Review of the Behavior Monitoring tool revealed staff was to document who identified a behavior, which resident, and the behavior identified. 14. Review of the faxed communication and facility investigations revealed the seven (7) identified incidents were reported to the SSA on 01/08/14. The expanded sample included five incidents involving Residents #9 and 10, #11 and 12, #13 and 14, #15 and 16, and #17 and 18. 15. Interview with the RDCS, on 01/22/14 at 1:08 PM, revealed the resident's concerns (grievances) were reviewed for potential allegations and none were identified. 16. Interview with RDCS and DCS, on 01/21/14 at 2:30 PM, revealed personnel files were audited on 01/12/14 for: two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, Criminal Record Checks, and abuse acknowledgment. RDCS and DCS revealed audits compared to current staff roster and the facility had no new hires for review. Review of two (2) SRNAs, the ED and Activities Assistant personnel files revealed they were accurate. 17. Review of the

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (See #16) on 01/21/14 and 01/22/14, verified abuse education was completed and followed by an abuse post-test. 18. Interview with the Human Resource/Payroll Coordinator, on 01/22/14 at 12:50 PM, revealed she was educated on required screening components for new hires. Components to include Criminal background checks, two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, and abuse acknowledgment. 19. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the training. A separate training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. 20. Interview with the RDCS and the DCS, on 01/21/14 at 2:20 PM, revealed resident interviews regarding potential abuse issues, and mock surveys consisting of care plan review and implementation, behavior documentation, and staff interviews, were completed on all halls on 01/13/14, the F Hall on 01/14/14, E and F Halls on 01/15/13. Mock surveys continued on 01/16/14 for A, C, E, and F Halls, 01/17/14 for E, A, B, F Halls, and A Hall was done again on 01/18/14. 21. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Performance Improvement Committee, Indicators, Performance Improvement Committee, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, F280, F282, F323, F514, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation and care plan interventions contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (see #16) on 01/21/14 and 01/22/14, verified education was completed and followed by a post-test. 22. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the training. A separate training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. 23. Interview with the Vice President of Operations, on 01/22/14 at 12:45 PM, revealed an AD-Hoc QA meeting occurred on 01/10/14 to discuss the IJ citations. Interview with the Regional DCS and the DCS, on 01/21/14 at 2:30 PM, revealed the facility's abuse policy and procedure was reviewed and discussed on 01/15/14 in the QA meeting. The Regional DCS revealed no changes were made to the policy as it was determined the facility had a system problem and changes were made in the facility's system to follow the abuse policy. Review of the QA signature sheets and agenda, on 01/15/14, revealed twenty-three (23) people were in attendance and all IJ citations were reviewed and discussed. The QA committee reviewed the facilities policies for Abuse, Resident to Resident Abuse, Behavior Monitoring, Behavior Management, Incidents and Accidents, Performance Improvement, and Morning Meeting. Review of the QA sign in sheet and agenda, on 01/20/14, revealed seven (7) members were in attendance including the Medical D
F 0250 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policies; Social Services, Resident Abuse, Resident Abuse-Resident to Resident, and Resident to Resident Related Concerns, it was determined the facility failed to have an effective system in place to ensure staff communicated the behaviors of the residents to Social Services through the 24 Hour Report, Behavior Sheets, Nurses' Notes, Incident Reports, and access to the Kiosk (State Registered Nursing Assistant (SRNA) computer documentation) to enable Social Services to assess and provide medically-related social services to meet the residents' highest practicable physical, mental and psychosocial well being; and, revise the care plans based on the behaviors of fourteen (14) of twenty-two (22) sampled residents. (Residents #1, #2, #3, #9, #10, #11, #13, #14, #15, #16, #17, #18, #19 and #22). (Refer to F280 and 323) The facility's failure to have an effective system in place to ensure Social Services received communication from all aspects of behavior monitoring to ensure medically-related social services was provided; and, failure to ensure revision of care plans for residents with a change in mental, physical or emotional status placed residents at risk in a situation that has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14 as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Social Services, revised 09/01/11, revealed Social Services as a member of the Interdisciplinary Team, would participate in planning the overall care of the resident including completing periodic reviews of the assessment as necessary, but at least once quarterly and documenting progress in the Social Service Progress Notes and respond to changes in a resident's mental, physical, or emotional status. Review of the facility's policy regarding Resident Abuse-Resident to Resident, revised 01/01/09, revealed residents would be closely monitored and behavior documented. Per the policy, the facility must develop measures to prevent reoccurrence and document these measures in the resident's medical record to include revision of the plan of care. Review of the facility's policy regarding Behavior Monitoring, revised 01/03/13, revealed any resident who exhibited any of the following behaviors would have a Behavior/Intervention Monthly Flow Record initiated which required documentation every shift, as well as a synopsis on Weekly Nursing Progress Notes: violent behavior; endangering him/herself; sexual, verbal physical behavior toward other residents/others; sexual aggression, verbal physical abuse toward staff; indecent exposure; abusive yelling screaming; slapping/hitting/spitting/biting/kicking; aggression during walking or wheeling; any other behavior which posed a harm to other residents/others; frequent refusal of care and treatment. The type of behavior should be noted along with the time it was observed and attempted interventions. Outcomes and side effects observed should be documented. The form is maintained in the Medication Administration Record of the resident being observed. Any resident receiving psychoactive medications would have a Behavior/Intervention Monthly Flow Record. 1. Review of Resident #1's clinical record revealed the facility admitted the resident on 06/22/11. The Minimum Data Set (MDS), dated [DATE], revealed no behaviors had occurred during the look back period. The facility assessed the resident's behaviors using the MDS, dated [DATE], indicating no behaviors had occurred other than some rejection of care. However, the Nurses' Notes identified behaviors had occurred between these two (2) assessments. Review of the Behavior Chart Detail Report from 07/11/13 to 01/07/14, revealed only one (1) verbal incident. However, the Behavior/Intervention Monthly Flow Record (BOP) was completely blank in the Medication Administration Book for January 2014. Further review revealed no other BOP sheet in the resident's clinical record, except for September 2013 which was also blank. Review of the resident's Comprehensive Plan of Care, revised 11/25/13, revealed the resident displayed flirtatious behavior with male residents and aggressive behavior toward staff including hitting, grabbing, and throwing items. Further review of Resident #1's record revealed a Progress Note from Psychiatric Services, dated 07/13/13, stating the resident had verbally threatening behavior and reported no further aggression, but remained sexually intrusive and made inappropriate comments toward male caregivers. Review of a Nursing Note, written 07/17/13 at 10:25 PM, indicated Resident #1 was assessed with [REDACTED]. Resident #1 was observed in Resident #2's (BIMS score of 1) room with his/her hand under Resident #2's sheet. Resident #2 was telling Resident #1 to stop. After Resident #1 continued to play with Resident #2, the resident got mad and threw a pack of cookies at Resident #1. Resident #1 then started to throw items at Resident #2. Resident #1 was removed from the room and began arguing with staff and refused to leave Resident #2's doorway for twenty (20) minutes while yelling and arguing with staff. (Refer to F223 and F226) Interview with the Social Service Director (SSD), on 01/07/14 at 9:00 AM, revealed she had been told about Resident #1's history of sexually inappropriate behavior, but she was not aware of any incidents since she started at the facility, on 02/18/13. During the interview with the SSD, she stated she had witnessed Resident #1 kiss Resident #2 in the hallway by the shower, on 01/06/14; however, she did not interview Resident #2 as to whether or not the kiss was mutual. The SSD revealed behaviors should be recorded in the 24 Hour Report Book to be discussed in the morning meetings with the Interdisciplinary Team. The SSD stated she was aware the resident had behaviors, but she was not aware of anything specific that had

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F 0250 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) occurred. The SSD revealed she was responsible to assess resident behaviors and revise the care plan. Further interview revealed the lack of documentation indicated there was a lack in communication as well. Resident #1's care plan was not updated to reflect the above behaviors. 2. Review of Resident #2's clinical record revealed the facility admitted the resident, on 03/03/10, with [DIAGNOSES REDACTED]. The facility assessed the resident using the Minimum Data Set (MDS), dated [DATE]. Further review revealed the resident was assessed as having modified independence in cognition, but usually understood, having difficulty with speech and communicating some words or finishing thoughts, but was able if prompted or given time. Review of the Nurse's Notes and Social Service Notes revealed no entries regarding Resident #1's sexual behavior towards Resident #2, nor was the care plan revised to address unwanted sexual behavior from Resident #1. (Refer to F223, 226, 323 and 280) Interview with SSD, on 01/09/14 at 2:00 PM, revealed she did not interview anyone else except Resident #2, who said the kissing was ok and confirmed being touched in the groin, but no sexual relations had occurred. The SSD revealed she did not ask the resident how many times he/she had been touched or if it was consensual. The SSD revealed she was not doing an investigation on the incident and had not been instructed to do so. She stated she didn't have all the facts about the incidents. The SSD and the DCS revealed they were witnesses to the interview with Resident #2. Further interview revealed the SSD did not update either of the resident's care plans, or address these concerns with Resident #2. 3. Interview with the SSD, on 01/07/14 at 9:00 AM, revealed the following incident. On 11/05/13, the incident started with Resident #1 talking about Resident #3's pants sagging down. The SSD revealed Resident #3 fell and Resident #1 put his\her hands up to prevent Resident #3 from falling on Resident #1 and to protect him\her self. The SSD revealed Resident #1 yelled for someone to come help Resident #3. The SSD revealed she spoke with both residents and SRNA #3. The SSD revealed the incident was never reported to her and she found out about it by overhearing conversations from staff. The SSD revealed it was not investigated, but looked into as a behavioral incident through interview with both residents. However, the resident's care plans were not updated Further interview, on 01/09/14 at 2:00 PM, revealed she did not know what happened to the statements written by the supervisor or the SRNA. She stated she did not know they ever existed. The SSD revealed the previous ED #2 told her SRNA #3 was actually in the courtyard by the Therapy Department and was not even in the same courtyard as the residents. The SSD revealed she was aware of the x-ray results, but was told by the previous DCS that subluxation and dislocation were the same thing and they knew she had subluxation of that shoulder. However, earlier interview with the SSD revealed she did in fact talk with SRNA #3. The SSD revealed she did interview Residents #1 and #3, but they stated it was just yelling and denied hitting each other. Further interview with the SSD revealed she did attend the morning meetings where falls and/or incidents were discussed. The SSD revealed Resident #1 had been discussed regarding refusal of care and cussing. The SSD stated the other behaviors she had never been informed of and had not seen any documentation in the charts. The SSD stated she did not have access to the Kiosk to view the behavior charting, even though she was responsible for the assessment of behaviors for the MDS, for tracking and trending behaviors in the Psychiatric Behavior Meeting; and, was responsible for creating the behavior care plans. However, the MDS Director had been creating the behavior care plans when the SSD was overwhelmed. Review of Resident #3's clinical record revealed no information recorded for the incident with Resident #1. Interview with the SSD, on 01/09/14 at 4:24 PM, revealed the incident on 11/05/13 between Resident #1 and #3 should have been investigated and a new behavior plan started. Interview with the current DCS, on 01/09/14, at 3:12 PM, revealed she was not able to find any evidence of an investigation regarding the incident with Residents #1 and #3 on 11/05/13 or that it was ever reported. Interview with the SSD, on 01/14/14 at 10:32 AM, revealed she actually knew the incident on 11/05/13 was a physical altercation and she talked with both residents and documented the conversation in the resident's records as a verbal argument. She stated the Regional DCS was aware of the incident from 11/05/13, because the previous ED #2 called the Regional DCS for advice on that incident involving Residents #1 and #3. (Refer to F223, 226, 280 and 323) 4. Interview with the SSD, on 01/14/14 at 10:32 AM, revealed she was notified of a verbal argument between Resident #19 and the Activities Director by the ARNP on 12/30/13. The SSD stated the ARNP walked to her office and told her someone needed to remove the Activities Director. The SSD revealed the Interim ED completed the investigation, and she had witnesses write statements and turned them in to the ED. However, she did not revise the care plan to address the verbal altercation. Interview with the SSD, on 01/16/14 at 4:33 PM, revealed the Advanced Registered Nurse Practitioner (ARNP) came to her office to inform her of what was going on with the Activities Director (AD), and then she received a phone call from MDS Director #1. The SSD stated she took the information as an allegation of verbal abuse and talked with the AD who said she let her temper get the best of her. The SSD stated she reported the incident to the DCS and ED. The SSD revealed the ED agreed to take over the investigation so she could handle another situation. (Refer to F223, 226, 280 and 323) 5. The facility reported to OIG five (5) incidents that were found during an audit on 01/08/14 of current clinical records involving ten (10) residents. Record review revealed the SSD did not revise the care plans for Residents #9 and #10, Resident #15 and #16, Resident #13 and #14, Resident #11, Resident #17 and 18, after verbal, physical and sexual abuse occurred. (Refer to F226, 280 and F323.) 6. Review of Resident #22's clinical record revealed the resident displayed verbally and physically aggressive behavior, verbal abuse, symptoms of psychosis, and hallucinations/delusions. The resident physically injured a staff member on 01/11/14. Further review of the clinical record revealed the care plan had not been updated since 11/04/13. Further interview with the SSD on 01/09/14 at 2:00 PM revealed she did attend the morning meetings where incidents were discussed. However, the SSD stated she did not have access to the Kiosk to view the behavior charting, even though she was responsible for the assessment of behaviors for the MDS, for tracking and trending behaviors in the Psychiatric Behavior Meeting; and, responsible for creating the behavior care plans. However, the MDS Director had been creating the behavior care plans when the SSD was overwhelmed. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 and SRNA #2 were immediately separated on 12/31/13 by staff. 2. The police were notified of the incident on 12/31/13. 3. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 4. SRNA #2 was suspended immediately on 12/31/13. 5. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 6. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 7. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 8. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 9. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 10. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 11. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 hour report. A 5 day Report was submitted to the SSA on 01/13/14. 12. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 13. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 14. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an eight or above were interviewed by the Social Services on 01/07/14 to ensure they had not been abused or neglected. 15. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 16. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 17. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to determine if there were any incidents that were reportable and/or needed further investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 18. The facility's concern book was reviewed by the

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F 0250 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 19. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6) discrepancies identified were corrected with missing Criminal Background Checks and Reference checks by 01/12/14. 20. All current Department Head staff along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116 employees) were educated by the Corporate Administrative Registered Nurses on abuse screening, training, prevention, identification, investigation, protection, reporting and response, F223 and the facility's Policy and Procedure for Resident Abuse, on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 and completed a post test. No staff members worked beyond 01/12/14 without having already been educated prior to the start of their shift. 21. The Human Resource/Payroll Coordinator was reeducated by the Regional Director of Human Resources on 01/12/14 that newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. 22. The ED and DCS were re-educated by the Vice President of Clinical Services on 01/11/14 and 01/12/14 to ensure newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. The ED will validate and sign that Newly Hired Employees have had all the required checks. 23. Mock Survey Rounds consisting of care plan review and implementation, behavior documentation, and staff interviews were completed by the IDT on 01/13/14, 01/14/14, and 01/15/14 that included resident interviews regarding potential abuse issues. 24. A Behavior Meeting was conducted by the IDT on 01/12/14 to review the current residents with known behaviors to discuss the behaviors, interventions, and medication. The nine (9) residents identified as having some type of behavior were referred to the physician and interventions were updated on the care plans by the IDT on 01/15/14. 25. Social Service notes were reviewed and Care Plans updated by the Corporate Social Services on 01/15/14. 26. The Social Service Director (SSD) was re-educated by the Corporate Administrative Registered Nurse on F250 and the facility's Policy and Procedures for Abuse and Behaviors on 01/12/14. 27. The Social Service Department consisting of the Corporate Social Services, Corporate Administrative Registered Nurse had daily oversight on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 with review of resident and family concerns daily in the morning meeting to ensure department managers were working towards resolution. 28. All facility staff was educated by the Corporate Administrative Registered Nurse on identification of behaviors to include but not limited to sexual and physical behavior on 01/12/14. Residents with behaviors will be discussed weekly at the Behavior Management Meeting to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The Nurse will document the behaviors on the 24 hour report to be shared during the morning meeting. 29. All facility staff were educated, on 01/12/14, 01/13/14, 01/14/14, 01/15/14, by the Corporate Administrative Registered Nurses, that revisions are made to the resident's care plan to include interventions for behaviors. The staff was instructed to follow the care plan for specific interventions for resident's interventions. Education was also provided on identification of accidents which can include behaviors, intervene, and report sexual and physical behavior to the resident's nurse for documentation in the medical record and follow up with the Physician. The nurse will also document in the 24 hour report to share information in the morning meeting. In addition all staff was educated on F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. 30. All resident care plans were reviewed and/or updated by the Regional Case Mix Coordinator on 01/11/14 and 01/12/14 to ensure they were accurate as compared to the Minimum Data Set and physician's orders [REDACTED]. 31. The facility's Administrative staff (ED/Abuse Coordinator and DCS) have been educated by the Corporate Administrative Registered Nurse on 01/12/14 that abuse allegations which are reported to them by employees must be investigated and reported to the appropriate officials in accordance with Federal and State Regulation. 32. The QAPI Committee had an Ad-Hoc QAPI meeting on 01/10/14 to discuss IJ citations and on 01/15/14 to discuss performance improvement opportunities and to review the facility's Abuse policy. The attendees consisted of the Interim Director of Clinical Services, Dietary Manager, Business Office Manager, Director of Admissions, Medical Records, Central Supply, Regional Case Mix Coordinator, Regional Director of Human Resources, Regional Director of Business Services, Regional Director of Clinical Services, Corporate Administrative RN, Director of Rehabilitation Services, Clinical Ambassador, Corporate Director of Education, Regional Vice President of Operations, Vice President of Operations, Vice President of Clinical Services, Vice President of Admissions & Marketing, Corporate Operations Team Member and Executive Director via telephone. 33. The ED and DCS were re-educated by the Corporate Administrative Registered Nurse on 01/12/14, regarding the regulations for F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 01/21/14-01/22/14 prior to exit as follows: 1. Review of Resident #1's closed medical record and the facility's investigation revealed Resident #1 and SRNA #2 were immediately separated. 2. Review of the facility's investigation revealed the Police were notified of the incident on 12/31/13. 3. Review of the Resident #1 closed medical record revealed the resident was discharged from the facility and sent to the hospital for a psychiatric evaluation on 01/07/14. 4. Review of the facility's investigation revealed the SRNA was immediately suspended and removed from the facility on 12/31/13. 5. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse's notes back to 07/17/13 identified three (3) residents with behaviors requiring increased monitoring through 1:1. Review and observation confirmed 1:1 was occurring and documented The RDCS revealed Resident #3 was identified as one of these residents. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed Resident #3 was listed as one of the residents assessed. 6. Interview with the Vice President of Clinical Operations (VPCO), on 01/22/14 at 2:48 PM, revealed resident's identified with behaviors from the chart audits, on 01/07/14 through 01/08/14 and staff interviews on 01/11/12 through 01/12/14, had interventions put in place during the care plan review. Observation of Resident #3, on 01/21/14 at 4:12 PM, revealed 1:1 supervision was provided with a SRNA #8. 7. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #3 was listed with identified behaviors, medications, and interventions. 8. Review of Resident #3's Care plan revealed an intervention for 1:1 supervision on 01/13/14. 9. Review of the faxed communication with the SSA from the facility revealed the incident involving Resident #3 and #1, on 11/05/13 was reported on 01/08/14 and a 5 day report was submitted on 01/13/14. 10. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #2 was reviewed to include a medical record review and care plan review. Interview with the Corporate Administrative Registered Nurse (CARN), on 01/22/14 at 1:27 PM, revealed Resident #2 did not need increased monitoring was not exhibiting behaviors. 11. Review of the faxed communications to the SSA from the Facility revealed the incident on 07/17/13 with Resident #1 and #2 was reported on 01/08/14 and a 5 day follow up was submitted on 01/13/14. 12. Interview with Resident #2, on 01/22/14 at 2:03, revealed he/she did have a conversation with the DCS and SSD regarding the incident on 07/17/13 and 01/06/14. Resident #2 revealed being asked if he/she felt safe and what had occurred. 13. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse notes back to 07/17/13 identified three (3) residents (#3, #13, and #21) with behaviors requiring increased monitoring. A. Review of the Behavior Management Meeting notes, dated 01/12/14, revealed the three (3) identified were Residents #3, #13, and #21 were included in the meeting. B. Review of the three (3) identified resident's care plan (#3, #13, and #21) revealed interventions to increase supervision using 1:1 was added. C. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed two (2) of the three (3) residents (Residents #13 and #21) had medications and behaviors reviewed. D. Review of the nursing notes and 24 hour report book, revealed the three (3) residents (#3, #13, and #21) were monitored daily with documented behaviors observed. 14. Interview on 01/21/14 with twelve (12) residents, identified as interviewable with a BIMS of 8 or greater, revealed they felt safe at the facility and had been interviewed by the SSD. 15. Review of the facility skin sweeps, dated 01/07/14, 01/08/14, and on 01/15/14, revealed the facility's 89 residents were assessed with [REDACTED]. 16. Interview with sixteen (16) facility staff, Certified Occupational Therapy Assistant (COTA) #1 on 01/20/14 at 2:30 PM; COTA #2 on 01/20/14 at 2:30 PM; LPN #7 on 01/21/14 at 3:25 PM; Maintenance Director on 01/21/14 at 3:30 PM; Dietary Cook on 01/21/14 at 3:35 PM; Dietary Aide on 01/21/14 at 3:37 PM; LPN #8 on 01/21/14 at 3:39 PM; SRNA #10 on 01/21/14 at 4:00 PM; SRNA #8 on 01/21/14 at 4:12 PM; Medical Records on 01/22/14 at 12:58 PM; Payroll/HR on 01/22/14 at 12:50 PM; Business Office Manager on 01/22/14 at 3:11 PM; LPN #5 on 01/22/14 at 1:01 PM; Housekeeper on 01/22/14 at 12:52 PM; SRNA #12 on 01/22/14 at 4:23 PM; and SRNA #11 on 01/22/14 at 4:05 PM, revealed

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	**2141 SYCAMORE AVENUE LOUISVILLE, KY 40206**

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F 0250 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 15) they were asked to identify any residents who exhibited behaviors, abuse and/or neglect that had not been reported. Review of the Behavior Monitoring tool revealed staff was to document who identified a behavior, which resident, and the behavior identified. 17. Review of the faxed communication and facility investigations revealed the seven (7) identified incidents were reported to the SSA on 01/08/14. The expanded sample included five incidents involving Residents #9 and 10, #11 and 12, #13 and 14, #15 and 16, and #17 and 18. 18. Interview with the RDCS, on 01/22/14 at 1:08 PM, revealed the resident's concerns (grievances) were reviewed for potential allegations and none were identified. 19. Interview with RDCS and DCS, on 01/21/14 at 2:30 PM, revealed personnel files were audited on 01/12/14 for: two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, Criminal Record Checks, and abuse acknowledgment. RDCS and DCS revealed audits compared to current staff roster and the facility had no new hires for review. Review of two (2) SRNAs, the ED and Activities Assistant personnel files revealed they were accurate. 20. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (See #16) on 01/21/14 and 01/22/14, verified abuse education was completed and followed by an abuse post-test. 21. Interview with the Human Resource/Payroll Coordinator, on 01/22/14 at 12:50 PM, revealed she was educated on required screening components for new hires. Components to include Criminal background checks, two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, and abuse acknowledgment. 22. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the training. A separate training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. 23. Interview with the RDCS and the DCS, on 01/21/14 at 2:20 PM, revealed resident interviews regarding potential abuse issues, and mock surveys consisting of care plan review and implementation, behavior documentation, and staff interviews, were completed on all halls on 01/13/14, the F hall on 01/14/14, E and F halls on 01/15/13. Mock surveys continued on 01/16/14 for A, C, E, and F halls, 01/17/14 for E, A, B, F halls, and A hall was done again on 01/18/14. 24. Review of the Behavior Management Meeting, dated 01/12/14, revealed twenty-four (24) residents were reviewed. Review of the psychiatric ARNP notes, dated 01/15/14, revealed nine (9) residents were reviewed which included review of medications. 25. Review of the chart audits, dated 01/15/14, revealed care plans were updated according to concerns noted in SSD notes. Review of 24 resident care plans revealed they had been updated. 26. Review of the facil
F 0280 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to revise the Comprehensive Care Plan to include aggressive behaviors for ten (10) of twenty-two (22) sampled residents. Residents #1, #3, #9, #11, #13, #14, #15, #16, #17 and #19 after aggressive incidents occurred. The facility failed to revise the plan of care for Resident #1 to include physical or sexual behaviors towards other residents and/or staff; failed to revise Resident #3's care plan to include physical aggression toward peers; and, failed to revise the care plan for Resident #19 to include updated interventions for verbal aggression. In addition, the facility failed to revise the plan of care for Residents #9, #11, #13, #14, #15, #16, and #17 for behaviors. This is repeat deficiency from the 08/01/13 Standard Health Survey. On 07/17/13, Resident #1 was found in Resident #2's room with his/her hand under Resident #2's sheet. Resident #2 was telling Resident #1 to stop, after Resident #1 continued to play with Resident #2, the resident got mad and threw a pack of cookies at Resident #1. Resident #1 then started to throw items at Resident #2. Attempts by staff to remove Resident #1 from the room resulted in Resident #1 refusing to leave Resident #2's doorway for twenty (20) minutes while yelling and arguing with staff. On 11/08/13, revealed a verbal exchange occurred between Resident #1 and Resident #3, that escalated to a physical altercation. Resident #1 was verbally assaulting Resident #3. Resident #3 hit Resident #1 with the walker and fell to the ground. Resident #1 then kicked Resident #3 in the head multiple times. On 11/06/13, Resident #1 complained of arm pain and an x-ray revealed a dislocated shoulder. On 12/31/13, State Registered Nurse Aide (SRNA) #2 and Resident #1 were overheard yelling and screaming at each other by Licensed Practical Nurse (LPN) #2, LPN #3 and LPN #4. LPN #3 revealed he approached the SRNA #2 and Resident #1 and stood between them in an attempt to separate the two. When Resident #1 touched SRNA #2 on the arm, both the SRNA and the Resident began hitting each other in the A/D Hall Television room. LPN #3 revealed it took him, LPN #2 and LPN #4 to separate the two. The SRNA was taken outside to the courtyard, but continued to try and get inside the building while the resident was cursing at the SRNA and hitting the staff trying to get to the SRNA in the courtyard. On 12/30/13, the facility's Activities Director was observed, by the Adult Psychiatric Advanced Registered Nurse Practitioner (ARNP), yelling and screaming at Resident #19. Resident #10 received an unwelcomed kiss from Resident #9, on 07/28/13. Resident #9's care plan was not updated to reflect unwanted kissing of residents. Resident #15 and Resident #16 were in a physical altercation on 11/30/13. Neither of their care plans were updated to reflect the incident. Resident #13 made verbally threatening remarks to Resident #14, on 09/07/13. Neither care plan was updated to reflect the incident. Resident #11 threw a bowl of soup that landed on Resident #12, on 10/24/13. Neither of the residents' care plans were updated to reflect the incident. On 01/09/14 a physical altercation between Resident #17 and Resident #18 occurred and the care plan was not revised to prevent reoccurrence. The facility's failure to have an effective system in place to revise the comprehensive care plans placed residents at risk in a situation that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14, as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Care Plans, reviewed 09/01/11, revealed an interdisciplinary care plan would be established for every resident of the facility and updated in accordance to state and federal regulatory requirements, and as needed. The Director of Clinical Services (DCS) would review and update for events that occurred and would sign off on the added interventions to a problem identified in the care plan. A facility Resident Care Plan Coordinator must be a nurse and was responsible for the resident care plan. The Resident Care Plan Coordinator would be responsible to develop the current care plan by addressing all unresolved problems from the previous care plan and noting any new problems and approaches with target dates. Additionally, the Resident Care Plan Coordinator should review the Twenty-four (24) Hour Report daily for significant changes and add minor changes to the existing care plan on a daily basis. Note: the corporation and the facility identified the MDS staff as the MDS Coordinators. 1. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 06/22/11 with [DIAGNOSES REDACTED]. The resident was also diagnosed with [REDACTED]. The facility completed a Quarterly MDS assessment for Resident #1 on 11/25/13 and assessed the resident to have a Brief Interview Mental Status (BIMS) score of 11. The Comprehensive Care Plan, dated 09/04/13 and revised 11/25/13, revealed the facility's care plan for Resident #1 included behaviors of verbal abuse and flirtatious behavior with male residents. Interventions included: talk to the resident in a calm manner; do not argue with the resident; and, re-direct the resident when the resident was being verbally abusive or using inappropriate language/profanity. The care plan was updated 12/31/13 to include the resident had been in an altercation with a tendency for aggressive behaviors. Added interventions included Social Services notified and involved, one (1) on one (1) with decreased supervision to every fifteen (15) minutes, and psych services to follow. The facility completed a behavior care plan, dated 10/16/12 and revised 03/16/13, which revealed the same Comprehensive Care Plan and interventions. However, on 03/16/13 an added problem of aggressive behavior toward staff, hitting, grabbing at staff, and throwing items was added with no additional interventions added. Continued review of Resident #1's clinical record revealed four (4) incidents of aggression between the resident and three (3) other residents and one (1) staff member. A Psychiatric Progress Note, dated 01/02/14, revealed the resident had been aggressive with a staff member. The Psychiatrist noted the resident baited the staff member to get her to react. Additionally, the resident found pleasure when the incident occurred. Review of a Psychiatric Note, dated 11/08/13 by the Advanced Registered Nurse Practitioner (ARNP),

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) revealed the resident had been in a verbal altercation, which had been misinterpreted as physical, with another resident of the facility. A Nurse's Note, dated 07/17/13 at 10:25 PM, revealed Resident #1 was in Resident #2's room with his/her hand under Resident #2's sheet. Additionally, Resident #2 indicated to Resident #1 to stop handling him/her and threw cookies at Resident #1. Staff intervened to attempt to remove Resident #1 from Resident #2's room. A Psychiatric Note, dated 04/12/13, revealed Resident #1 had been aggressive with a peer and hit someone young and stupid. Observation of Resident #1, on 01/03/14 at 10:29 AM, revealed the resident was in his/her room, sitting in a wheelchair. Observation, on 01/06/14 at 1:48 PM, revealed the resident propelled him/her self with the right arm and foot. The resident was observed to propel down the hallway to the Payroll office and asked staff where Resident #2 was and if she had seen the resident. The Payroll/ Human Resources Coordinator told Resident #1 that Resident #2 was with a staff member. Continued observation, on 01/06/14 at 1:54 PM, revealed the resident seated in a wheelchair and able to self-propel backwards down the hallway using only the right foot. Observation, on 01/07/14 at 3:24 PM, of Resident #1 revealed the resident was yelling wanting to go outside to smoke. At 4:04 PM, Resident #1 was yelling emergency while self-propelling down the hallway. Continued observation at 4:06 PM revealed Resident #1 was near the nurse's station for the A and D Halls. The resident was yelling at a staff member, cursing, and had positioned his/her wheelchair to corner the staff member between the nurse's station and resident rooms without a way to remove herself from the resident. Interview with Resident #1, on 01/03/14 at 10:29 AM and on 01/06/14 at 1:54 PM, revealed he/she had been involved in a verbal and physical altercation with an aide at the facility on New Year's Eve. The resident stated the aide hit him/her in the face and made a motion of an open claw. Interviews with Licensed Practical Nurse (LPN) #1, on 01/03/14 at 1:56 PM, with LPN #2, on 01/03/14 at 2:19 PM, with LPN #3, on 01/03/14 at 2:37 PM, and LPN #4, on 01/06/14 at 10:37 PM, all revealed they had each witnessed State Registered Nurse Aide (SRNA) #2 and Resident #1 in a verbal and physical altercation with each other that had occurred at the facility on 12/31/13. Interview with LPN #5, on 01/09/14 at 9:01 AM, revealed Resident #1 was very unpredictable and had outbursts of yelling and screaming. She stated the resident had been sexually inappropriate with Resident #2, trying to kiss him/her. She indicated she was unaware of the incident related to the 04/12/13 Psych Note. The nurse stated she vaguely remembered Resident #1 and the incident with Resident #2, where Resident #1 had his/her hand under Resident #2's sheet. She stated the floor nurse would complete an initial care plan on admission and the MDS Coordinator would complete a resident's Comprehensive Care Plan. The nurse indicated as changes in a resident's care occurred, the floor nurses were responsible to update the care plan so MDS would be aware when the Comprehensive Care Plan was updated during the resident's review. The LPN stated she did not attend resident care plan meetings and did not know who represented nursing in those meetings. She indicated after the care plan meeting was conducted, the resident's care plan was updated by the MDS Coordinators. She stated Resident #1's current care plan, dated 11/25/13, revealed the care plan did not have interventions for physical altercation and this should have been added. The LPN indicated if a care plan was not updated to reflect physical behaviors, then an incident like what had happened between the aide and Resident #1 could occur again. Additionally, the nurse stated if she had known about the incident on 07/17/13 where Resident #1 had his/her hand under Resident #2's sheet that was unwelcomed, she would have handled Resident #1's encounters with Resident #2 differently. She indicated she had been trained by the facility to update resident care plans. On 01/06/14 at 9:04 AM, interview with the Social Services Director (SSD) revealed she had been the SSD when she was hired on 02/08/13. The SSD stated Resident #1 had previous verbal aggression and yelling at other residents. The SSD stated she conducted the facility's investigations for the verbal and physical aggression between SRNA #2 and Resident #1 that occurred, on 12/31/13. She indicated the resident touched the aide and the aide then became physically and verbally aggressive. She further indicated Resident #1 stated he/she had also been physically and verbally involved with the aide. Continued interview, on 01/07/14 at 8:57 AM, revealed she had no knowledge of the incident referenced in a Psych Note, dated 04/12/13. The SSD stated she was unaware of the incident on 07/17/13 with Resident #1's hand under Resident #2's sheet. She indicated she had previously seen Resident #1 and Resident #2 kissing in the hallway. Additionally, the SSD stated the Psych Note, dated 11/08/13, was a verbal altercation between Resident #1 and Resident #3, which had been misinterpreted as a physical altercation in which Resident #3 lost his/her balance and fell . Interview, on 01/10/14 at 1:55 PM, revealed the SSD began to create resident behavior care plans about three (3) weeks prior. She stated the behavior care plans were previously completed by the MDS Coordinators. She indicated the care plans were updated during the MDS assessments for annual, significant changes, and as needed in the morning meetings. The SSD stated Resident #1's care plan was updated on 03/16/13 for aggressive behaviors; however, the interventions were not updated to reflect hitting behaviors by the resident. Additionally, when Resident #1's care plan was revised 11/25/13 the physical behaviors were no longer on the care plan. She indicated the care plan was updated 12/31/13 with interventions added including one (1) to one (1) every fifteen (15) minute checks, and psych services following. She stated additional interventions should have been included for physical behaviors. Further interview with the SSD, revealed she attended the morning meeting on 01/12/14 and Resident #1's care plan was not revised during the meeting and it should have been. The SSD indicated flirtatious behavior was not specific to know what the resident was doing to be flirtatious. She further indicated Resident #1's care plan should say what the resident was doing in order to know what boundaries the resident had crossed. She stated the MDS Coordinators were responsible to indicate the specifics. Interview, on 01/06/14 at 10:37 AM, with LPN #4 revealed Resident #1 would become verbally aggressive when the resident felt challenged or if staff could not do as the resident wanted. The nurse stated the resident's care plans were maintained by the MDS Coordinators; however, the nurses should update the care plan through the process of care of the resident. On 01/07/14 at 10:24 AM, interview with the Interim Director of Clinical Services (DCS) revealed she had been employed at the facility on 11/05/13 as the Assistant DCS (ADCS) and became the facility's Interim DCS on 11/2013. The DCS stated Resident #1 would often antagonize staff; however, she was unsure if the resident would antagonize other residents. She indicated SRNA #2 had been terminated due to the verbal and physical aggression with Resident #1, who was also verbally and physically aggressive with the aide. She indicated the Psych Note, dated 04/12/13, indicated physical aggression; however, she was unaware of Resident #1 being physically aggressive. The DCS further indicated the Nurse's Note, dated 07/17/13, should have been treated as sexual aggression by Resident #1 and reported on the 24 Hour Report and discussed in the morning meeting. She stated the incident in the Psych Note, dated 11/08/13, that a verbal altercation was misinterpreted as physical would warrant further looking into by the facility. The DCS indicated she was unaware of any incidents involving Resident #1 prior to her employment at the facility. Continued interview with the DCS, on 01/09/14 at 11:06 AM, revealed she was unable to locate any information in the facility related to the Psych Note on 04/12/13. She stated she attended care plan meetings at times. She indicated the reference to flirtatious behavior in Resident #1's care plan was a broad term and she could not define what it meant in the care plan. She further indicated staff could misinterpret what inappropriate behavior could be. The DCS stated in the morning meetings resident care plans would be updated as needed if the nurse had not already updated the care plan. She stated the nurses had been trained to update care plans and the kardex for the aides. On 01/13/14 at 8:29 AM, interview with the MDS Director #1 revealed she had been employed with the facility since August 2013. She stated the MDS Coordinators were responsible for resident care plans, other than what the SSD would complete. However, the MDS Director stated she would complete the SSD portion of the care plan when the SSD would become overwhelmed. She indicated the SSD portion of the care plan included behaviors. She stated care plans were updated annually and quarterly. Additionally, she indicated she attended the morning meetings and would discuss if a resident had new behaviors and update the care plan for new interventions. The MDS Director stated she had written Resident #1's 12/31/13 updates to the care plan. She indicated the morning meeting did discuss the 12/31/13 incident. She further indicated written interventions listed did not specify when the resident would advance from one (1) to one (1) to fifteen (15) minute checks. She also stated there were no additional interventions put into place after the incident occurred. The MDS Director stated if care plan interventions were not updated then it was not possible to know if interventions worked and needed to be put into place. Continued interview at 9:30 AM revealed the MDS Director indicated the nurses were not updating the care plans. Interview, on 01/14/14 at 10:08 AM, revealed Resident #1's current care plan with flirtatious behavior was carried over from the previous care plan. She stated she did not know what flirtatious behavior meant. 2. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 12/03/12 with [DIAGNOSES REDACTED]. The facility completed a Significant Change MDS, on 10/14/13 with a Brief Interview for Mental Status (BIMS) score of 2 by staff, as moderately impaired. The Comprehensive Care Plan, dated 10/04/13, revealed the behavior care plan included interventions to not argue with the resident, to keep a safe distance when behaviors occurred, and to ensure safety of other resident and others. The Comprehensive Care Plan for falls, dated 10/04/13 and revised 11/12/13, revealed the resident had a history of [REDACTED]. Observation, on 01/06/14 at 10:42 AM, of Resident #3 revealed the resident sitting in a chair. The resident was approachable, sitting in the TV room on the A and D Unit. Interview with

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BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 17) Resident #3, on 01/06/14 at 10:42 AM and on 01/08/14 at 5:17 PM, revealed he/she was in a fight with someone a couple of months ago. The resident stated they both swung at each other and yelled at each other; however, there had not been any other problems since. Resident #3 indicated he/she and Resident #1 were arguing in the courtyard and Resident #1 hit him/her. The resident further indicated he/she did not remember if he/she fell . Resident #3 stated Resident #1 had not ever touched him/her before. Interview, on 01/07/14 at 8:57 AM, with the SSD revealed Resident #3 had been involved in a verbal altercation with Resident #1 about the time a Psych Note, dated 11/08/13 was written. The SSD stated it was misinterpreted as a physical altercation, but it was a verbal incident. She indicated Resident #1 was being verbally aggressive toward Resident #3, who attempted to sit on a bench in the courtyard and fell when attempting to sit. The care plans were not updated for either resident. On 01/07/14 at 10:24 AM, interview with the Interim DCS revealed she began employment at the facility on 11/05/13 as the Assistant DCS (ADCS) and was unaware of the incident between Resident #3 and Resident #1 on 11/05/13. Interview with the Interim ED, on 01/07/14 at 12:35 PM, revealed the incident on 11/05/13 between Resident #3 and Resident #1 was a verbal altercation misinterpreted as a physical altercation. He stated the incident would require further looking into. He indicated he was unaware of any resident behaviors prior to his employment at the facility on 12/06/13. 3. Review of the clinical record for Resident #19 revealed the facility admitted the resident on 09/18/13 with [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 12/20/13, revealed the resident displayed verbally aggressive behavior. The care plan interventions included diversional activities by activities staff, do not argue with the resident, talk to the resident in a calm voice when behavior is disruptive and remove resident from public area when behavior is disruptive or unacceptable. Interview with Resident #19, on 01/17/14 at 4:20 PM, revealed he/she had been in an argument with a female staff member in activities about three (3) weeks ago. Interview with the DCS, on 01/14/14 at 4:22 PM, revealed she was not present when the incident between Resident #19 and the AD occurred. She stated she was unaware of the outcome of the incident. Interview, on 01/19/14 at 10:36 AM, revealed they did a one month look back on 01/12/14 of Resident #19's behaviors and it was determined the behaviors were stable. The care plan was not revised until 01/14/14, although the incident occurred 12/30/13. Review of the care plan for Resident #19, dated 12/20/13, revealed an addendum (dated 01/14/14) for Behavior Management Meeting on 01/12/14. Resident history of verbalizations but none recently. Resident has been stable. An additional Note, dated 01/15/14, revealed the resident became upset and spoke inappropriately to the Activities Director on 12/30/13. Two interventions were added to the care plan in hand writing and dated 01/12/14. However, these were copies of interventions already in place and no new interventions had been added. Talk to resident in a calm voice and remove from public when disruptive or behavior is unacceptable. These interventions were not effective as they were not followed by staff. 4. Review of the clinical record for Resident #9 revealed the facility admitted the resident on 02/22/13 with [DIAGNOSES REDACTED]. The Comprehensive Behavior Care Plan, dated 02/22/13 and revised 07/23/13, revealed the resident's behaviors included removing clothing and grabbing at staff which had improved. Care plan interventions included to give the resident papers to shuffle, keep at safe distance when behaviors occur, and take to a quiet location as necessary. Review of a Nurse's Note, dated 07/28/13 at 7:35 PM, revealed Resident #9 kissed Resident #10's hand. After redirection from staff, Resident #9 kissed Resident #10 on the lips and inserted his/her tongue in the resident's mouth. There was no evidence of a revised care plan that addressed the aggressive behavior towards the female resident. 5. Review of the clinical record for Resident #11 revealed the facility admitted the resident on 05/24/12 with [DIAGNOSES REDACTED]. The facility completed a Quarterly MDS assessment, on 09/03/13, and assessed the resident with a BIMS score of 8, as oriented with confusion. The Comprehensive Care Plan, dated 12/02/13, revealed the resident would often use profanity or vulgarity and call people names. Interventions included remind the resident calling people offensive names was inappropriate, provide a supportive environment, and redirect inappropriate decisions. A SSD Note, dated 10/25/13, revealed the resident threw a bowl of soup in the dining room during the meal and some of the soup hit the resident sitting next to him/her. There was no evidence of a revised care plan to address the aggressive behavior towards another resident. 6. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 06/27/11 with a [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 12/17/12 and revised 10/29/13, revealed the resident exhibited sexually inappropriate behavior and suggestive/ inappropriate comments to female staff. The care plan interventions included explain when behavior was inappropriate, praise positive behavior, and set limits in behavior. A Nurse's Note, dated 09/07/13 at 5:00 PM, revealed the resident was arguing with another resident and threatened to stab him/her with a shoe horn and was asked by staff to leave the shoe horn in his/her room. At 5:20 PM, the Nurse's Note revealed Resident #13 had threatened the other resident. There was no evidence of a revised care plan to address the threatening behavior towards another resident. 7. Review of Resident #14's clinical record revealed the facility admitted the resident on 12/06/12 with a [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 08/05/13 and revised 08/23/13, revealed the resident would consume alcohol without staff awareness. Interventions included monitor for alcohol consumption to determine cause, intervene to ensure safety, set limits, and watch for behavioral cues, such as body language and tone of voice. Review of a Nurse's Note, dated 09/07/13 at 3:00 PM, revealed the resident was arguing with another resident and threatened him/her. There was no evidence of a revised care plan to address the threatening behavior towards another resident. 8. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 05/13/11 with [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 02/21/13 and revised 10/22/13, revealed the facility did not care plan the resident for behaviors. 9. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 07/17/10 with a [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 11/25/13, revealed the resident would hide clothing and state the clothes were missing; claim being physically abused, and throw him/herself on the floor. A Nurse's Note, dated 11/30/13 at 9:00 PM, revealed the resident's back was assessed for injury from an altercation with another resident. There was no evidence of documentation in the clinical record the incident occurred, no date, or time. There was no evidence of a revised care plan to address the altercation with another resident. 10. Review of Resident #17's clinical record revealed the facility admitted the resident on 08/20/13 with a [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 09/03/13 and revised 11/14/13, revealed the resident had a history of [REDACTED]. Interventions included to observe the resident's behavior to assist in determining cause of refusal per behavior flow sheet, intervene to ensure resident safety, and ensure safety of resident and others. Review of a Behavior Sheet, dated October 2013, revealed the resident had wandering behavior which was noted to be monitored. There was no evidence of a revised care plan to address the incident of wandering behaviors. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 and SRNA #2 were immediately separated on 12/31/13 by staff. 2. The police were notified of the incident on 12/31/13. 3. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 4. SRNA #2 was suspended immediately on 12/31/13. 5. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 6. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 7. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 8. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 9. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 10. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 11. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 hour report. A 5 day Report was submitted to the SSA on 01/13/14. 12. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 13. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 14. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an eight or above were interviewed by the Social Services on 01/07/14 to ensure they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 18) had not been abused or neglected. 15. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 16. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 17. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to determine if there were any incidents that were reportable and/or needed further investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 18. The facility's concern book was reviewed by the Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 19. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 staff followed the Comprehensive Care Plan for four (4) of twenty-two (22) sampled residents, Resident #1, #3, #5 and #19. State Registered Nurse Aide (SRNA) #2 failed to follow Resident #1's Comprehensive Care Plan for verbal aggression that led to the SRNA becoming physically and verbally abusive toward Resident #1. The facility staff failed to follow the plan of care for Resident #3 when a physical altercation occurred with Resident #1. The facility staff failed to follow the care plan for Resident #19 when a verbal altercation occurred with the Activites Director (AD). Additionally, the staff failed to provide showers to Resident #5 according to the Comprehensive Care Plan for hygiene and bathing resulting in nine (9) missed showers. The facility's failure to ensure an effective system was implemented to ensure a resident's comprehensive care plan was followed placed residents at risk in a situation that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14, as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Care Plans, reviewed 09/01/11, revealed all staff must be familiar with each resident's care plan and all approaches must be implemented. Additionally, all direct care staff must always know, understand, and follow a resident's care plan. If a staff member was unable to implement any part of a resident's care plan, the staff member was to notify the Clinical Nurse or Care Planning Coordinator. 1. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 06/22/11 with [DIAGNOSES REDACTED]. The resident was also diagnosed with [REDACTED]. The facility completed a quarterly MDS assessment for Resident #1 on 11/25/13 and assessed the resident to have a Brief Interview Mental Status (BIMS) score of 11. Review of the Comprehensive Care Plan, dated 09/04/13 and revised 11/25/13, revealed the facility's care plan for Resident #1 included behaviors of verbal abuse and interventions included: talk to the resident in a calm manner; do not argue with the resident; and re-direct the resident when the resident is being verbally abusive or using inappropriate language/profanity. Interview with the Social Services Director, on 01/09/14 at 4:04 PM, revealed she had determined the cause of the incident to be how the aide reacted to the resident. She further stated if the aide had intervened appropriately, the incident could have turned out differently. Interview with the Interim Director of Clinical Services, on 01/07/14 at 10:24 AM and on 01/09/14 at 11:06 AM, revealed the care plan for Resident #1, which stated, flirtatious behavior was a broad term and she could not define it. She indicated it was possible for staff to misinterpret what flirtatious behavior could mean in relation to Resident #1 and staff with different backgrounds/views would have difficulty knowing how to follow the care plan. Observation of Resident #1, on 01/03/14 at 10:29 AM, revealed the resident in his/her room, sitting in a wheelchair. Continued observation, on 01/06/14 at 1:54 PM, revealed the resident was seated in a wheelchair and able to self-propel backwards down the hallway using only the right foot. Observation, on 01/07/14 at 3:24 PM, of Resident #1 revealed the resident was yelling about wanting to go outside to smoke. At 4:04 PM, Resident #1 was yelling emergency while self-propelling down the hallway. Continued observation at 4:06 PM revealed Resident #1 was near the nurse's station for the A and D Halls. The resident was yelling at a staff member and cursing. The resident positioned his/her wheelchair to corner the staff member between the nurse's station and resident rooms, not giving the staff a way to remove herself from the resident. Interview with LPN #4, on 01/06/14 at 10:37 AM, revealed when Resident #1 would become verbally abusive she would walk away. She stated if a resident was combative or aggressive, staff should not escalate the situation or engage the resident. She stated the aides would have information about residents' behaviors on the kardex, which was maintained by the nurses. Additionally, LPN #4 stated the MDS Coordinators maintained the resident care plans; however, the nurses updated the care plans as needed. On 01/07/14 at 12:41 PM, interview with SRNA #2 revealed she could have handled the situation better. The aide stated she should have informed Resident #1's nurse and it all could have been avoided. The aide indicated she had been trained how to work with combative residents and to tell the resident's nurse if a resident becomes aggressive. The aide further indicated the aides have access to the resident care plans at the nurse's station. She stated she was unaware of Resident #1's care plan and interventions and would have to look at the resident's care plan to know what to do for the resident when he/she was exhibiting behaviors. Interview with Licensed Practical Nurse (LPN) #5, on 01/09/14 at 9:01 AM, revealed resident care plans were maintained in a book at the nurse's station. She stated she had been trained to follow a resident's care plan and how to handle resident behaviors. Preliminary care plans were completed by the admitting nurse, then the MDS staff completed the Comprehensive Care Plan which was kept in the care plan book at the desk. However, after the LPN reviewed the care plan and her knowledge of what happened on 07/17/13, she stated she should have known what was on there to prevent it from happening again. The LPN stated the floor nurses do not go to the care plan meetings to share information that witnessed, but not documented. The LPN stated she did not know who even went to care plan meetings that represented the nursing department. 2. Review of Resident #3's medical record revealed the facility admitted the resident on 12/03/12, with [DIAGNOSES REDACTED]. The facility assessed the resident using the Minimum Data Set, dated dated [DATE], revealed the resident was assessed as having verbal and other behaviors directed towards others. Review of the resident's medications revealed an antipsychotic medication of [MEDICATION NAME] given twice a day. The resident's comprehensive care plan revealed problems with behaviors and psychosocial well-being. The care plan revealed the resident was noted to be physically combative and socially inappropriate. Interventions included: warm approach; do not argue; keep safe distance ensure safety of others; consult with psychiatric services; talk calmly and divert attention. Observation and interview with Resident #3, on 01/06/14 at 10:42 AM, revealed the resident sitting in a chair in the A/D Hall television room. The resident revealed getting into a fight with Resident #1, who the resident frequently refers to Resident #1 as being the opposite gender. Resident #3 revealed they were outside and they started swinging at each other. The resident revealed both of them were yelling and screaming at each other. 3. Review of the clinical record for Resident #19 revealed the facility admitted the resident on 09/18/13 with [DIAGNOSES REDACTED]. The comprehensive care plan, dated 12/20/13, revealed the resident displayed verbally aggressive behavior. The care plan interventions included diversional activities by activities staff, do not argue with the resident, and talk to the resident in a calm voice. Interview with the Activities Director (AD), on 01/14/14 at 3:56 PM, revealed she had been involved in a verbal altercation with Resident #19 on 12/30/13. She stated they had been talking and she was unable to meet the resident's request related to withdrawing money from the bank. The AD indicated the resident had become angry and began to yell. She indicated she had raised her voice to the resident and spoke with a forceful tone. The AD stated she was aware the resident had a history of [REDACTED]. The AD further indicated she had no knowledge of Resident #19's care plan. Additionally, she stated if she had known what interventions the resident was care planned for, it may have helped her in this situation. The AD stated she was part of the morning meetings; however, she was unaware if the incident with Resident #19 was discussed and documented. The AD further stated she had been trained at other facilities regarding how to handle behaviors, but not there. The AD stated she did not know how the resident was care planned regarding behaviors and none of the nursing staff had ever educated her on how to handle Resident #19's behaviors. The AD stated she did not document the incident in the medical record. Continued interview on, 01/15/14 at 11:56 AM, with the AD revealed she raised her voice, it was loud and with a forceful tone, she

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 19) wanted Resident #19 to know she not going to allow him/her to speak to her that way. Interview, on 01/07/14 at 10:24 AM and 01/09/14 at 11:06 AM, with the Interim Director of Clinical Services (DCS) revealed the care plan for Resident #1 regarding flirtatious behavior was a broad term and she could not define it. She indicated it was possible for staff to misinterpret what flirtatious behavior could mean in relation to Resident #1 and with different views/ backgrounds the staff would have difficulty knowing how to follow the care plan. She further indicated she began employment at the facility on 11/05/13 as the Assistant DCS (ADCS) and became the Interim DCS on 11/12/13 or 11/13/13. The DCS stated she had not completed any monitoring or follow up to the POC from the standard survey on 08/01/13. She also stated she had never reviewed the POC and was unable to locate the information. The DCS indicated she had last requested the POC for review prior to the Thanksgiving holiday; however, no one was able to locate the State Survey Book. She further indicated she should have been aware of previous issues and felt she could not do her job effectively with the information she had been given. Interview with the interim Executive Director (ED), on 01/16/14 at 9:25 AM, revealed Resident #19 had become very loud with the AD during their conversation, and the AD's tone matched the resident's. He stated when the AD returned to work a few days later he educated her on personal space. Continued interview, on 01/16/14 at 10:22 AM, the ED stated he viewed and investigated the incident as a customer service issue and not a resident care problem, which would require interventions. The ED further stated he was unaware the reason, when, or by whom the incident with the AD and Resident #19 had become a care concern and reported to the State Survey Agency. He indicated the record should speak for itself. 4. Review of Resident #5's medical record revealed the facility admitted the resident, on 10/21/05, with the [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident's Range of Motion was impaired on both sides of the upper and lower extremities and the resident required total assistance with bathing. Review of the facility's Nurse Tech Information Kardex for Resident #5 revealed the resident was to receive showers on Tuesdays and Fridays. Review of the resident's comprehensive care plan revealed the resident was to receive showers per the schedule. Observation and interview with Resident #5, on 01/02/14 at 11:17 AM, revealed he/she was having problems receiving baths and showers as scheduled. Review of the Resident Bathing Type by Day Chart, for 10/17/13 to 01/02/14, revealed the resident had only received twelve (12) showers with no showers recorded as given from 12/04/13 to 01/02/14. Review of the facility's shower schedule revealed the resident should have received two (2) showers a week for a total of nine (9) showers that were missed. Interview with State Registered Nursing Assistant (SRNA) #6, on 01/03/14 at 2:35 PM, revealed that Resident #5 was supposed to receive showers on day shift twice a week and could only remember a few instances when it was not done. The SRNA revealed Nurse Tech Information Kardex and the shower schedule kept in the shower binder, directed when and how often the showers were to be done. The SRNA revealed the procedure when showers were not completed, was to notify the nurse and pass the information on to the next shift to be done. The SRNA revealed she did not follow up to ensure showers were completed and did not always have time to document in the Care Tracker system when they are done. The SRNA revealed the shower book was to be signed and complete the Skin Sweep paper, which was kept in the shower book and done at the time of the shower, and then turned in to the nurse. Interview with Licensed Practical Nurse (LPN) #6, on 01/03/14 at 2:50 PM, revealed she did not check to ensure SRNA charting was complete or ensure bathing was done as care planned. The LPN revealed she signed off on the Skin Sweep forms and turned them in to the Unit Manager. However, the LPN was unable to find the Skin Sweeps or any evidence the showers were done. Further interview with the LPN, on 01/03/14 at 3:00 PM, revealed she had not reviewed Resident #5's care plan or ensured it was followed as care planned for shower needs. Interview with the Unit Manager, on 01/03/14 at 4:05 PM, revealed she was not aware Resident #5 voiced a concern about not receiving showers and had not been monitoring to ensure showers were being completed per the resident's plan of care. Interview with the Director of Clinical Services (DCS), on 01/03/14 at 4:15 PM, revealed the purpose of the care plan was to direct the residents care and she relied on the Unit Manager to monitor showers. The DCS revealed she completed random audits of the care plans. However, she stated she was not aware the Unit Manager was not monitoring showers and did not complete chart reviews to ensure showers were being done or care plans followed. Further interview with the DCS, on 01/09/14 at 11:06 AM, revealed all nurses have been trained to update the care plan and the Kardex to reflect any changes. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 and SRNA #2 were immediately separated on 12/31/13 by staff. 2. The police were notified of the incident on 12/31/13. 3. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 4. SRNA #2 was suspended immediately on 12/31/13. 5. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 6. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 7. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 8. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 9. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 10. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 11. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 hour report. A 5 day Report was submitted to the SSA on 01/13/14. 12. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 13. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 14. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an eight or above were interviewed by the Social Services on 01/07/14 to ensure they had not been abused or neglected. 15. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 16. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 17. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to determine if there were any incidents that were reportable and/or needed further investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 18. The facility's concern book was reviewed by the Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 19. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6) discrepancies identified were corrected with missing Criminal Background Checks and Reference checks by 01/12/14. 20. All current Department Head staff along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116 employees) were educated by the Corporate Administrative Registered Nurses on abuse screening, training, prevention, identification, investigation, protection, reporting and response, F223 and the facility's Policy and Procedure for Resident Abuse, on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 and completed a post test. No staff members worked beyond 01/12/14 without having already been educated prior to the start of their shift. 21. The Human Resource/Payroll Coordinator was reeducated by the Regional Director of Human Resources on 01/12/14 that newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. 22. The ED and DCS were re-educated by the Vice President of Clinical Services on 01/11/14 and 01/12/14 to ensure newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. The ED will validate and sign that Newly Hired Employees have had

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 20) all the required checks. 23. Mock Survey Rounds consisting of care plan review and implementation, behavior documentation, and staff interviews were completed by the IDT on 01/13/14, 01/14/14, and 01/15/14 that included resident interviews regarding potential abuse issues. 24. A Behavior Meeting was conducted by the IDT on 01/12/14 to review the current residents with known behaviors to discuss the behaviors, interventions, and medication. The nine (9) residents identified as having some type of behavior were referred to the physician and interventions were updated on the care plans by the IDT on 01/15/14. 25. Social Service notes were reviewed and Care Plans updated by the Corporate Social Services on 01/15/14. 26. The Social Service Director (SSD) was re-educated by the Corporate Administrative Registered Nurse on F250 and the facility's Policy and Procedures for Abuse and Behaviors on 01/12/14. 27. The Social Service Department consisting of the Corporate Social Services, Corporate Administrative Registered Nurse had daily oversight on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 with review of resident and family concerns daily in the morning meeting to ensure department managers were working towards resolution. 28. All facility staff was educated by the Corporate Administrative Registered Nurse on identification of behaviors to include but not limited to sexual and physical behavior on 01/12/14. Residents with behaviors will be discussed weekly at the Behavior Management Meeting to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The Nurse will document the behaviors on the 24 hour report to be shared during the morning meeting. 29. All facility staff were educated, on 01/12/14, 01/13/14, 01/14/14, 01/15/14, by the Corporate Administrative Registered Nurses, that revisions are made to the resident's care plan to include interventions for behaviors. The staff was instructed to follow the care plan for specific interventions for resident's interventions. Education was also provided on identification of accidents which can include behaviors, intervene, and report sexual and physical behavior to the resident's nurse for documentation in the medical record and follow up with the Physician. The nurse will also document in the 24 hour report to share information in the morning meeting. In addition all staff was educated on F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. 30. All resident care plans were reviewed and/or updated by the Regional Case Mix Coordinator on 01/11/14 and 01/12/14 to ensure they were accurate as compared to the Minimum Data Set and physician's orders [REDACTED]. 31. The facility's Administrative staff (ED/Abuse Coordinator and DCS) have been educated by the Corporate Administrative Registered Nurse on 01/12/14 that abuse allegations which are reported to them by employees must be investigated and reported to the appropriate officials in accordance with Federal and State Regulation. 32. The QAPI Committee had an Ad-Hoc QAPI meeting on 01/10/14 to discuss IJ citations and on 01/15/14 to discuss performance improvement opportunities and to review the facility's Abuse policy. The attendees consisted of the Interim Director of Clinical Services, Dietary Manager, Business Office Manager, Director of Admissions, Medical Records, Central Supply, Regional Case Mix Coordinator, Regional Director of Human Resources, Regional Director of Business Services, Regional Director of Clinical Services, Corporate Administrative RN, Director of Rehabilitation Services, Clinical Ambassador, Corporate Director of Education, Regional Vice President of Operations, Vice President of Operations, Vice President of Clinical Services, Vice President of Admissions & Marketing, Corporate Operations Team Member and Executive Director via telephone. 33. The ED and DCS were re-educated by the Corporate Administrative Registered Nurse on 01/12/14, regarding the regulations for F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 01/21/14-01/22/14 prior to exit as follows: 1. Review of Resident #1's closed medical record and the facility's investigation revealed Resident #1 and SRNA #2 were immediately separated. 2. Review of the facility's investigation revealed the Police were notified of the incident on 12/31/13. 3. Review of the Resident #1 closed medical record revealed the resident was discharged from the facility and sent to the hospital for a psychiatric evaluation on 01/07/14. 4. Review of the facility's investigation revealed the SRNA was immediately suspended and removed from the facility on 12/31/13. 5. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse's notes back to 07/17/13 identified three (3) residents with behaviors requiring increased monitoring through 1:1. Review and observation confirmed 1:1 was occurring and documented. The RDCS revealed Resident #3 was identified as one of these residents. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed Resident #3 was listed as one of the residents assessed. 6. Interview with the Vice President of Clinical Operations (VPCO), on 01/22/14 at 2:48 PM, revealed resident's identified with behaviors from the chart audits, on 01/07/14 through 01/08/14 and staff interviews on 01/11/12 through 01/12/14, had interventions put in place during the care plan review. Observation of Resident #3, on 01/21/14 at 4:12 PM, revealed 1:1 supervision was provided with a SRNA #8. 7. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #3 was listed with identified behaviors, medications, and interventions. 8. Review of Resident #3's Care plan revealed an intervention for 1:1 supervision on 01/13/14. 9. Review of the faxed communication with the SSA from the facility revealed the incident involving Resident #3 and #1, on 11/05/13 was reported on 01/08/14 and a 5 day report was submitted on 01/13/14. 10. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #2 was reviewed to include a medical record review and care plan review. Interview with the Corporate Administrative Registered Nurse (CARN), on 01/22/14 at 1:27 PM, revealed Resident #2 did not need increased monitoring was not exhibiting behaviors. 11. Review of the faxed communications to the SSA from the Facility revealed the incident on 07/17/13 with Resident #1 and #2 was reported on 01/08/14 and a 5 day follow up was submitted on 01/13/14. 12. Interview with Resident #2, on 01/22/14 at 2:03, revealed he/she did have a conversation with the DCS and SSD regarding the incident on 07/17/13 and 01/06/14. Resident #2 revealed being asked if he/she felt safe and what had occurred. 13. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse notes back to 07/17/13 identified three (3) residents (#3, #13, and #21) with behaviors requiring increased monitoring. A. Review of the Behavior Management Meeting notes, dated 01/12/14, revealed the three (3) identified were Residents #3, #13, and #21 were included in the meeting. B. Review of the three (3) identified resident's care plan (#3, #13, and #21) revealed interventions to increase supervision using 1:1 was added. C. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed two (2) of the three (3) residents (Residents #13 and #21) had medications and behaviors reviewed. D. Review of the nursing notes and 24 hour report book, revealed the three (3) residents (#3, #13, and #21) were monitored daily with documented behaviors observed. 14. Interview on 01/21/14 with twelve (12) residents, identified as interviewable with a BIMS of 8 or greater, revealed they felt safe at the facility and had been interviewed by the SSD. 15. Review of the facility skin sweeps, dated 01/07/14, 01/08/14, and on 01/15/14, revealed the facility's 89 residents were assessed with [REDACTED]. 16. Interview with sixteen (16) facility staff, Certified Occupational Therapy Assistant (COTA) #1 on 01/20/14 at 2:30 PM; COTA #2 on 01/20/14 at 2:30 PM; LPN #7 on 01/21/14 at 3:25 PM; Maintenance Director on 01/21/14 at 3:30 PM; Dietary Cook on 01/21/14 at 3:35 PM; Dietary Aide on 01/21/14 at 3:37 PM; LPN #8 on 01/21/14 at 3:39 PM; SRNA #10 on 01/21/14 at 4:00 PM; SRNA #8 on 01/21/14 at 4:12 PM; Medical Records on 01/22/14 at 12:58 PM; Payroll/HR on 01/22/14 at 12:50 PM; Business Office Manager on 01/22/14 at 3:11 PM; LPN #5 on 01/22/14 at 1:01 PM; Housekeeper on 01/22/14 at 12:52 PM; SRNA #12 on 01/22/14 at 4:23 PM; and SRNA #11 on 01/22/14 at 4:05 PM, revealed they were asked to identify any residents who exhibited behaviors, abuse and/or neglect that had not been reported. Review of the Behavior Monitoring tool revealed staff was to document who identified a behavior, which resident, and the behavior identified. 17. Review of the faxed communication and facility investigations revealed the seven (7) identified incidents were reported to the SSA on 01/08/14. The expanded sample included five incidents involving Residents #9 and 10, #11 and 12, #13 and 14, #15 and 16, and #17 and 18. 18. Interview with the RDCS, on 01/22/14 at 1:08 PM, revealed the resident's concerns (grievances) were reviewed for potential allegations and none were identified. 19. Interview with RDCS and DCS, on 01/21/14 at 2:30 PM, revealed personnel files were audited on 01/12/14 for: two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, Criminal Record Checks, and abuse acknowledgment. RDCS and DCS revealed audits compared to current staff roster and the facility had no new hires for review. Review of two (2) SRNAs, the ED and Activities Assistant personnel files revealed they were accurate. 20. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (See #16) on 01/21/14 and 01/22/14, verified abuse education was completed and followed by an abuse post-test. 21. Interview with the Human Resource/Payroll Coordinator, on 01/22/14 at 12:50 PM,

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 21) revealed she was educated on required screening components for new hires. Components to include Criminal background checks, two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, and abuse acknowledgment. 22. Rev
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of the twenty-two (22) sampled residents received appropriate hygiene (Resident #5). The facility failed to provide Resident #5, a dependent resident, scheduled showers despite the resident filing grievances for not receiving showers. The findings include: The facility did not provide a policy regarding hygiene or showers. Review of Resident #5's medical record revealed the facility admitted the resident, on 10/21/05, with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident's Range of Motion was impaired on both sides of the upper and lower extremities and the resident required total assistance with bathing. Observation and interview with Resident #5, on 01/02/14 at 11:17 AM, revealed the resident was sitting in an electric wheelchair and stated he/she was a quadriplegic with some control of his/her fingers. The resident identified problems receiving baths and showers as scheduled. Review of the facility's Nurse Tech Information Kardex for Resident #5 revealed the resident was marked for a shower on Tuesdays and Fridays. Review of the resident's care plan revealed the resident was to receive showers per the schedule. Further interview with Resident #5, on 01/03/14 at 9:00 AM, revealed the resident had not refused showers in a long time, and stated the showers had not even been offered, to afford him/her an opportunity to refuse. Review of the Resident Bathing Type by Day Chart, for 10/17/13 to 01/02/14, revealed the resident only had ten (10) days recorded where showers were given with no showers recorded from 12/04/13 to 01/02/14. Review of the Facility's shower schedule revealed the resident should have received two (2) showers a week for a total of nine (9) consecutively missed showers. Interview with State Registered Nursing Assistant (SRNA) #6, on 01/03/14 at 10:43 AM, revealed shower or bath refusals were charted in the Kiosk which prompted the SRNA to document why a bath was not given stating refusal was an option. Continued interview, on 01/03/14 at 2:35 PM, revealed showers were also documented in the shower book and on the skin sweep paper which was given to the nurse. The SRNA reported she was told not to accept a shower refusal and to notify the nurse if this occurred. However, she could recall two (2) occasions when she was not able to get the resident's shower completed and just told the next shift and not the nurse. The SRNA revealed hygiene was important and could play a part in infection control. Interview with SRNA #3, on 01/03/14 at 1:04 PM, revealed Resident #5 received showers on the day shift. SRNA #3 revealed she worked second shift and provided the resident with pericare, hand washing, and face washing which was documented in the kiosk. The SRNA stated once a shower was completed, the shower book was signed and the skin sweep papers were completed and placed in the Unit Manager's office. The SRNA indicated she did not remember ever being told the resident did not receive scheduled showers. Interview with Licensed Practical Nurse (LPN) #6, on 01/02/14 at 10:40 AM, revealed Resident #5 would occasionally refuse a shower. However, review of the Resident Bathing Type by Day Chart revealed no showers were documented as refused. Continued interview, on 01/03/14 at 2:50 PM, revealed she was aware the baths and showers were not always completed and did not monitor SRNA documentation in the kiosk. The LPN revealed the skin sweep forms were completed at the time of the shower, she signed off on them, and placed them in the Unit Manager's office. However, observation of the box in the Unit Manager's office on 01/02/14 with LPN #6 revealed the box was empty and no completed forms could be found. Interview with the Unit Manager, on 01/03/14 at 4:05 PM, revealed she did not have time to monitor the shower book or the skin sweeps to ensure the baths and showers were completed. In addition, the Unit Manager revealed she was unable to locate any of the facility's completed skin sweeps that were done during resident showers. The Unit Manager revealed she was not aware Resident #5 had voiced any concerns regarding showers. Interview with the Director of Clinical Services (DCS), on 01/03/14 at 4:15 PM, revealed she was not aware of Resident #5's concerns regarding showers and was unable to find any evidence the nursing department was ever notified of this concern. The DCS revealed, in November 2013, the shower routine was changed to each SRNA would be responsible for their own showers instead of using a shower aide. The DCS revealed she was monitoring compliance with showers by monitoring skin sweeps and the shower book, which the Unit Manager was responsible to ensure was being completed. However, the DCS revealed she was unable to locate any facility skin sweeps done during showers as evidence showers were being completed. In addition, the DCS revealed she was not aware the Unit Manager was not monitoring to ensure showers were being completed.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, Accident and Incident Investigation, Behavior Monitoring, and education materials, it was determined the facility failed to have an effective system in place to ensure staff adequately supervised residents with behaviors for fifteen (15) of twenty-two (22) sampled residents. The facility failed to identify and monitor all exhibited behaviors by Residents #1, #2, #3, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #22. Additionally, the facility failed to monitor Resident #1's behavior of physical, sexual, and verbal abuse to provide needed care and treatment in an attempt to maintain a safe environment for other residents in the facility. This is a repeat deficiency from the Standard Health Survey of 08/01/13 cited at a G level. On 07/17/13, Resident #1 was found in Resident #2's room with his/her hand under Resident #2's sheet. Resident #2 was telling Resident #1 to stop, after Resident #1 continued to play with Resident #2, the resident got mad and threw a pack of cookies at Resident #1. Resident #1 then started to throw items at Resident #2. Attempts by staff to remove Resident #1 from the room resulted in Resident #1 refusing to leave Resident #2's doorway for twenty (20) minutes while yelling and arguing with staff. On 11/08/13, a verbal exchange occurred between Resident #1 and Resident #3, that escalated in to a physical altercation. Resident #1 was verbally assaulting Resident #3. Resident #3 hit Resident #1 with the walker and fell to the ground. Resident #1 then kicked Resident #3 in the head multiple times. On 11/06/13, Resident #1 complained of arm pain and an x-ray revealed a dislocated shoulder. On 12/31/13, State Registered Nurse Aide (SRNA) #2 and Resident #1 were overheard yelling and screaming at each other by Licensed Practical Nurse (LPN) #2, LPN #3, and LPN #4. LPN #3 revealed he approached SRNA #2 and Resident #1 and stood between them in an attempt to separate them. When Resident #1 touched SRNA #2 on the arm, both the SRNA and the resident began hitting each other in the A/D Hall Television room. LPN #3 revealed he was unable to separate SRNA #2 and the resident and it took him, LPN #2 and LPN #4 to separate the two. The SRNA was taken outside to the courtyard, but continued to try to get inside the building while the resident was cursing at the SRNA and hitting the staff trying to get to SRNA #2 in the courtyard. On 12/30/13, the facility's Activities Director was observed, by the Adult Psychiatric Advanced Registered Nurse Practitioner (ARNP), yelling and screaming at Resident #19. On 07/28/13, Resident #10 received an unwelcomed kiss from Resident #9. On 11/30/13, Resident #15 and Resident #16 were in a physical altercation. On 09/07/13, Resident #13 made verbally threatening remarks to Resident #14. On 10/24/13, Resident #11 threw a bowl of soup that landed on Resident #12. On 01/09/14, Resident #17 and Resident #18 were involved in an altercation. The facility's failure to have an effective system in place to ensure residents were free from abuse, were adequately supervised and monitored for behaviors placed residents at risk in a situation that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 01/16/14, as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Accident and Incident Investigation, reviewed 12/27/13, revealed certain incidents would be investigated to determine root cause and to provide an opportunity to decrease future occurrences of the event. Any event that was not of the facility's routine operations or care of a resident should have the completion of an incident report. Additionally, certain events would also require the completion of designated investigation forms, including behavior outburst with using the Behavioral Outburst Assault of another Resident or Staff. The Executive Director (ED), Director of Clinical Services (DCS) or designee should begin a documented investigation to

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 22) include interviews with the resident, staff involved, and others who may be able to help with the investigation. Additionally, results of the investigation would be reviewed by the DCS to ensure it was completed and thorough. Review of the facility's policy regarding Behavior Monitoring, reviewed 01/03/13, revealed any resident that exhibited behaviors would have a Behavior/ Intervention Monthly Flow Record (Behavior Sheet) initiated. The Behavior Sheet required documentation every shift as well as a summary in a weekly progress note. Behaviors listed included: violent behavior/striking other residents, sexual, verbal, or physical behavior toward other residents, sexual aggression, verbal or physical abuse toward staff, abusive yelling or screaming, kicking, aggression during walking/wheeling, and any other behavior which posed harm to other residents. The documentation should include the specific type of behavior being monitored, i.e. kicking, hitting, yelling. Additional documentation included: the number of times the behavior was observed during the shift; the code for the first attempted intervention; non-pharmacological interventions; the code for the outcome; and the code for any side effects observed. The Behavior Sheet was to be maintained with the Medication Administration Record (MAR) for the resident. Behavior monitoring may be discontinued when the resident's behavior was no longer necessary to be observed, or the resident was no longer on medication requiring behavior monitoring. The policy also revealed any resident that received psychoactive medications, would have a Behavior Sheet. The medication being monitored and the specific behavior that indicated the use of the medication should be noted. Review of the facility's abuse education materials describing abuse prevention techniques, included: identification of residents at risk would include those with behaviors and communication deficits. Interventions included knowledge of care plan approaches for each resident, avoid arguing, distractions, and to be mindful of tone of voice and other body language. Interview with the Staff Development Coordinator (SDC), on 01/06/14 at 2:28 PM and 3:20 PM, revealed orientation was conducted for new employees as well as annual competencies. She stated these trainings included resident behaviors as part of the facility's abuse training. 1. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 06/22/11, with [DIAGNOSES REDACTED]. The resident was also diagnosed with [REDACTED]. The facility completed a Quarterly Minimum Data Set (MDS) assessment for Resident #1 on 11/25/13, and assessed the resident to have a Brief Interview Mental Status (BIMS) score of 11, indicating the resident was interviewable. Review of the Comprehensive Care Plan, dated 09/04/13 and revised 11/25/13, revealed the care plan for Resident #1 included behaviors of verbal abuse and flirtatious behavior with male residents. Interventions included talking to the resident in a calm manner, not arguing with the resident, and re-direct the resident when the resident was being verbally abusive or using inappropriate language/profanity. Continued review of Resident #1's clinical record revealed a Medication Administration Record (MAR) for January 2014; however, a Behavior Sheet for January 2014 was not provided by the facility. Review of a Behavior Sheet, dated October 2013, for Resident #1 revealed the form was blank, with no behaviors listed or any other documentation. Review of a Psychiatric Note, dated 01/02/14, revealed the resident had been aggressive with staff. Additionally, it stated the resident baited staff to get them to react and the resident found some pleasure in the fact that the staff member reacted. A Psychiatric Note, dated 04/12/13, revealed Resident #1 had become aggressive with a peer and hit someone young and stupid. A Nurse's Note, dated 07/17/13, revealed the resident had been in Resident #2's room with his/her hand under Resident #2's sheet. Resident #2 threw cookies at Resident #1 when the resident would not stop fondling him/her. Resident #1 was removed from the room by staff. A Psychiatric Note, dated 11/08/13, revealed the resident had been in a verbal altercation with Resident #3, which the facility determined was misinterpreted as a physical altercation. On 01/09/14 at 9:01 AM and 10:12 AM, interview with LPN #5 revealed it was sexually inappropriate behavior for Resident #1 to kiss Resident #2, and it was usually unwelcomed behavior. She stated Resident #2 could not push Resident #1 away as Resident #2 only had the use of one (1) arm; however, the resident could say no. The Nurse stated she had told Resident #1 to back off and leave the room. She indicated when Resident #1 left the room, Resident #2 would say thank you. LPN #5 further indicated she did not think Resident #2 liked it when Resident #1 would become affectionate, as Resident #2 would make a face at Resident #1. She indicated she was unaware of the incident between the residents on 07/17/13; however, after review of Resident #1's Nurse's Note it appeared to be sexual abuse. The Nurse stated if she had known about the incident on 07/17/13, then when she had seen Resident #1 touch Resident #2 she would have handled it differently and reported the interaction to the SSD. The LPN indicated the facility used behavior sheets if the resident was prescribed psychiatric medications and there was no other place in the record to document resident behaviors. She further indicated the resident had behaviors which included yelling and screaming. The Nurse stated the resident's care plan had not been updated to reflect physical aggression, which could lead to another similar incident that occurred on 12/31/13. Observation, of Resident #1, on 01/07/14 at 3:24 PM, revealed the resident was yelling, wanting to go outside to smoke. At 4:04 PM, Resident #1 was yelling emergency while self-propelling down the hallway. Continued observation at 4:06 PM revealed Resident #1 was near the nurse's station for the A and D Halls. The resident was yelling at a staff member, cursing. The resident positioned his/her wheelchair to corner the staff member between the nurse's station and the resident rooms, not leaving the staff a way to remove herself from the resident. The DCS placed the resident on 1:1 supervision with LPN #9, the resident asked LPN #9 what are you looking at? At 4:17 PM, the resident propelled self into Unsampled Resident B's room with the resident in the room and closed the door. LPN #9 yelled down the hall to get someone now. LPN #9 continued to stand in the hall and not attempt to remove Resident #1. At 4:19 PM, the resident removed him/her self from the room and no staff person entered Unsampled Resident B's room to ensure his/her safety. Interview with State Registered Nurse Aide (SRNA) #1, on 01/03/14 at 12:00 PM, revealed Resident #1 was uncooperative with his/her care and was difficult when working with him/her. She stated the resident had been verbally aggressive and had called her names. She stated she did not take behaviors too seriously. Interview, on 01/03/14 at 2:19 PM, with Licensed Practical Nurse (LPN) #2 revealed he had worked with Resident #1. LPN #2 stated at times the resident was difficult. On 01/06/14 at 8:52 AM, interview with the Unit Manager (UM) revealed she had also worked with Resident #1 while a floor nurse. She stated the resident at times would argue and yell at her. She stated the resident had never been physically aggressive with her or anyone at the facility. She stated the resident liked to smoke at times other than the supervised scheduled smoke breaks. The UM indicated when she would redirect the resident, Resident #1 would yell and scream and she would just walk away. Further interview revealed she did not do chart checks to see if behaviors were being monitored even though interview, on 01/19/13 at 10:36 AM, with the DCS revealed the Unit Manager was responsible for chart checks. Interview with the House Supervisor, on 01/10/14 at 1:35 PM, revealed she over heard staff talking about the incident with Residents #1 and #2 and told them to report it. However, she did not report this information to anyone else and she did not follow up to ensure it was reported. Interview with the Social Service Director (SSD), on 01/06/14 at 9:04 AM, revealed Resident #1 had a history of [REDACTED]. She stated the resident had been physically and verbally aggressive with an aide on 12/31/13. In addition, she was aware Resident #1 had behaviors, but staff never reported to her when they occurred. Continued interview on 01/07/14 at 8:57 AM, revealed the SSD indicated she was unaware of an incident noted in a Psychiatric Note, dated 04/12/13, in which the resident was aggressive with a peer and hit someone young and stupid. She indicated she was unaware of the incident on 07/17/13 of the sexual behavior of Resident #1 toward Resident #2. She further indicated an incident between Resident #1 and Resident #3, on 11/05/13, was a verbal altercation that had been misinterpreted as a physical altercation. The SSD stated the nurses should be documenting resident behaviors; however, they do not and she did not provide an explanation as to why. On 01/06/14 at 10:37 AM, interview with LPN #4 revealed Resident #1 at times was verbally abusive. She stated she was aware the resident had been physically abusive in the past; however, she had never witnessed the resident become physically aggressive. Interview, on 01/07/14 with the Interim Director of Clinical Services (DCS) revealed she had witnessed Resident #1 antagonize staff, and was aware the resident had been combative at times. She stated the resident's behaviors were not documented anywhere in the facility. She further stated she was not monitoring the documentation of behaviors because she assumed the UM was doing this and she should have been. The DCS stated resident behaviors should be documented in the chart and the aides should document behaviors in the kiosk (computer for staff to document resident care). She indicated behavior sheets should be in some resident Medication Administration Records (MAR) if certain medications were triggered for the use of the behavior sheet. The DCS stated the resident had been physically and verbally aggressive toward an aide on 12/31/13. She indicated she began employment on 11/05/13 and was unaware of an incident referred in a Psych Note dated 04/12/13. She stated she was surprised the resident had been physically aggressive as no physical aggression had been reported by staff. Additionally, the DCS indicated the sexual aggression on 07/17/13 with Resident #2 should also have been written and dealt with as an incident. She further indicated the incident with Resident #3 on 11/05/13 was not a physical altercation, it was a verbal exchange. Interview, on 01/09/14 at 11:06 AM, with the current DCS revealed a resident's complete chart and the resident's care plans were taken to care plan meetings as well as monthly behavior meetings with the Psychiatrist. She stated if behaviors were not documented

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 23) in the clinical record, then the Psychiatrist would not have a full picture of the resident. Continued interview, on 01/19/14 at 10:36 AM, with current DCS revealed the Unit Manager was responsible for chart checks to ensure behaviors were documented. The DCS revealed she attended the morning meeting where incidents and behaviors would have been discussed, if they were documented. Further interview revealed the SSD documents the resident's behavior in a binder which is used to schedule meetings with the Psychiatrist. However, review of the SSD's binder revealed a list of residents on psychotropic medications and no behaviors had been documented, as well as no tracking of residents with behaviors, who were not receiving psychotropic medications. Continued interview revealed the behavior list was used in QA to monitor behaviors. However, after review of the actual binder content, she stated that was the only tool used and no behavior monitoring was being done. She further stated if residents were not on psychotropic medications, the staff should still have oversight, documenting and monitoring of behaviors. The DCS stated the system to monitor behaviors was not a very effective system. Interview with the Psychiatrist, on 01/09/14 at 1:54 PM, and on 01/10/14 at 2:28 PM, revealed he had spoken to Resident #1 on 01/02/14. He stated the resident had anti-social traits and limited impulse control. The Psychiatrist indicated the resident had been threatening to others and could be belligerent and hostile. He further indicated Resident #1 reported to him he/she knew he/she was getting under the aide's skin, baited the aide, and was pleased the aide was angry enough to fight the resident. The Psychiatrist stated he had also spoken to the resident about an incident when the resident hit someone young and stupid in reference to a Psych Note dated 04/12/13. He stated he was unaware of the incident on 07/17/13; therefore, had not been able to try and intervene. The Psychiatrist indicated the charting completed by the nurses was used in the monthly behavior meetings. On 01/14/14 at 10:08 AM, interview with MDS Coordinator #1 revealed she had not seen an increase in behavior for Resident #1 as it was the resident's normal behavior. Interview with the Advanced Registered Nurse Practitioner (ARNP), on 01/14/14 at 12:01 PM, revealed she had provided the facility information on how to best deal with certain behaviors, but that was not always followed. In addition, she stated there were more psychosocial problems than psychiatric. She had told the facility to not tolerate the cursing, yelling and bullying or it would end up like a prison yard. She further told them to document well and then issue a thirty (30) day notice of discharge if the behaviors continued. However, this too was not being done. The ARNP continued, stating she had to continuously bring up what to do, how to approach and document, but this still was not done. 2. Record review for Resident #1 and Resident #2 revealed no documented evidence of the incident when Resident #1 kissed Resident #2. Observation of Resident #1, on 01/06/14 at 1:48 PM, revealed the resident propelled him/her self with the right arm and foot, the resident was also able to travel backwards. The resident was observed to propel down the hallway to the Payroll office and asked staff where Resident #2 was and if she had seen the resident. The Payroll/ Human Resources Coordinator told Resident #1 that Resident #2 was with a staff member. Interview with SRNA #1, on 01/03/14 at 10:20 AM, revealed she had observed Resident #1 kissing and touching Resident #2, and stated Resident #1 entices him/her; however, she had not reported this behavior to the nurse. Interview with LPN #5, on 01/09/14 at 10:12 AM, revealed she stated around 12/31/13, or within a couple of days, Resident #1 was seen by a staff member to enter Resident #2's room and was observed kissing him/her. Interview with the SSD, on 01/06/14 at 9:04 AM, revealed she had seen Resident #1 and Resident #2 kissing each other recently. Interview with Resident #2, on 01/07/13 at 5:12 PM, revealed they were not girlfriend/boyfriend and the kissing was not reciprocal. 3. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 12/03/12 with [DIAGNOSES REDACTED]. The facility completed a Significant Change MDS, on 10/14/13, which indicated the resident was assessed to have a BIMS score of two (2), and as being cognitively moderately impaired. Review of the Comprehensive Care Plan, dated 10/04/13, revealed the care plan for behaviors included interventions to not argue with the resident and to ensure safety of other resident and others. A Psychiatric Note, dated 11/08/13, revealed the resident had been in a verbal altercation with another resident, which had been misinterpreted as physical aggression. Interview with the Social Services Director, on 10/07/14 at 8:57 AM, revealed the altercation between Resident #1 and Resident #3 was a verbal exchange that the facility determined had been misinterpreted as a physical altercation. She further stated on 11/08/13, Resident #1 was verbally abusing Resident #3. Resident #3 hit Resident #1 with the walker and fell to the ground. Resident #1 then kicked Resident #3 in the head multiple times. On 11/06/13, Resident #1 complained of arm pain and an x-ray revealed a dislocated shoulder. Interview, on 01/09/14 at 3:08 PM, with SRNA #3 revealed she witnessed the incident between Resident #1 and Resident #3 on 11/05/13. She stated she heard Resident #1 verbally aggravating Resident #3, who then became physically aggressive toward Resident #1, who then became physically aggressive toward Resident #3. The aide indicated Resident #1 often picked at Resident #3 and felt Resident #3 had enough that evening. Continued interview with SRNA #2, on 01/07/14 at 12:41 PM, revealed she indicated Resident #1 had been in an altercation with Resident #3 in the past in which Resident #1 had kicked Resident #3. Observation, on 01/06/14 at 10:42 AM, of Resident #3 revealed the resident was approachable, sitting in the Television Room on the A and D Unit. Interview, on 01/07/14 at 8:57 AM, with the SSD revealed the altercation between Resident #1 and Resident #3 was a verbal exchange that the facility determined had been misinterpreted as a physical altercation. On 01/07/14 at 10:24 AM, interview with the Interim DCS revealed at the time of the incident on 11/05/13 between Resident #3 and Resident #1, she was the ADCS at the facility and was unaware of the circumstances of the incident. She stated physical abuse was physical contact between two (2) people and verbal abuse could be anything said that was demeaning to another person. During interview, on 01/08/14 at 11:06 AM, the DCS stated the Psychiatrist attended behavior meetings for residents; however, the Psychiatrist could not get a full picture of residents in the behavior meetings when the residents' behaviors were not documented. Interview with the Interim ED, on 01/07/14 at 12:35 PM, revealed he had been in this role and with the facility since 12/06/13. The ED stated the incident on 11/05/13 was a verbal altercation misinterpreted as a physical altercation between Resident #1 and Resident #3. He stated the incident would warrant further looking into. Continued interview, on 01/18/14 at 10:59 AM, revealed the ED indicated abuse would include an altercation between residents. Interview with the Advanced Registered Nurse Practitioner (ARNP), on 01/14/14 at 12:01 PM revealed she was aware of a physical altercation between Resident #1 and Resident #3. She stated the facility later informed her it was not physical but a verbal altercation. On 01/15/14 at 4:51 PM, interview with the Vice President (VP) of Clinical Operations revealed while reviewing the facility's QA Binder, she reviewed a Note, dated 11/05/13, that contained documentation that Resident #1 hit and was hit by another resident. In addition, there was another Note, not dated, that indicated Resident #3 hit another resident and was hit by another resident on 11/05/13. There was no documented evidence of any action taken by the QA Committee. 4. Review of the OIG Long Term Care self reported incident form, dated 01/01/14, revealed on 12/31/13, State Registered Nurse Aide (SRNA) #2 and Resident #1 were overheard yelling and screaming at each other by Licensed Practical Nurse (LPN) #2, LPN #3, and LPN #4. LPN #3 revealed he approached SRNA #2 and Resident #1 and stood between them in an attempt to separate them. When Resident #1 touched SRNA #2 on the arm, both the SRNA and the Resident began hitting each other in the A/D Hall Television room. LPN #3 revealed he was unable to separate SRNA #2 and the resident and it took him, LPN #2 and LPN #4 to separate the two. The SRNA was taken outside to the courtyard, but continued to try to get inside the building while the resident was cursing at the SRNA and hitting the staff trying to get to SRNA #2 in the courtyard. Review of the clinical record for Resident #1 revealed no documented evidence of this incident. Interview with SRNA #2, on 01/07/14 at 12:41 PM, revealed the Aide had been involved in a physical and verbal altercation with Resident #1 on 12/31/13. She stated the resident was physically and verbally aggressive with her. Additionally, the aide stated she had witnessed Resident #1 cursing at people, but nothing physical. The SRNA stated she should have reported it to the nurse, but she did not. The SRNA stated the whole fight could have been avoided if she had told the nurse about the resident's behaviors. 5. Review of Resident #9's clinical record revealed the facility admitted the resident on 02/22/13 with [DIAGNOSES REDACTED]. Review of the Comprehensive Behavior Care Plan, dated 02/22/13, and revised 07/23/13, revealed the resident's behaviors included removing clothing and grabbing at staff which had improved. Care plan interventions included giving the resident papers to shuffle, keep safe distance when behaviors occur, and take the resident to a quiet location as necessary. Review of a Nurse's Note, dated 07/28/13 at 7:35 PM, revealed the resident kissed a female resident's hand and after redirection from staff the resident kissed the female resident on the lips and inserted his/her tongue in his/her mouth. There was no documented evidence in the clinical record that the facility completed a Behavior Sheet. 6. Review of Resident #10's clinical record revealed the facility admitted the resident on 04/27/09 with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 10/07/13 and revised 01/02/14, revealed the resident would place him/herself on the floor to get attention from staff. Interventions included re-educate resident to appropriate behaviors to get staff's attention and possible injury and remind resident to use call light. There was no documented evidence the facility completed a Behavior Sheet in the clinical record. 7. Review of the clinical record for Resident #11 revealed the facility admitted the resident on 05/24/12 with [DIAGNOSES REDACTED]. The facility completed a Quarterly MDS assessment, on

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 24) 09/03/13, and assessed the resident with a BIMS score of 8, and as being oriented with confusion. Review of the Comprehensive Care Plan, dated 12/02/13, revealed the resident would often use profanity or vulgarity and call people names. Interventions included remind the resident calling people offensive names was inappropriate, provide a supportive environment, and redirect inappropriate decisions. A SSD note, dated 10/25/13, revealed the resident threw a bowl of soup in the dining room during the meal and some of the soup hit the resident sitting next to him/her. There was no documented evidence the facility completed a Behavior Sheet in the clinical record. 8. Review of the clinical record for Resident #12 revealed the facility did not assess for injury until a skin assessment, dated 10/26/13, that stated no areas noted. However, the incident occurred on 10/24/13 when the soup was thrown on the resident. 9. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 06/27/11 with a [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 12/17/12, and revised 10/29/13, revealed the resident exhibited sexually inappropriate behavior and suggestive/ inappropriate comments to female staff. The Care Plan interventions included explain when behavior was inappropriate, praise positive behavior, and set limits in behavior. Review of a Nurse's Note, dated 09/07/13 at 5:00 PM, revealed the resident was arguing with another resident and threatened to stab him/her with a shoe horn. The resident was asked by staff to leave the shoe horn in his/her room. At 5:20 PM, the Nurse's Note revealed Resident #13 had again threatened the other resident. There was no documented evidence the facility completed a Behavior Sheet in the clinical record. 10. Review of Resident #14's clinical record revealed the facility admitted the resident on 12/06/12 with a [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 08/05/13 and revised 08/23/13, revealed the resident would consume alcohol without staff awareness. Interventions included to monitor for alcohol consumption to determine cause, intervene to ensure safety, set limits, and watch for behavioral cues, such as body language and tone of voice. Review of a Nurse's Note, dated 09/07/13 at 3:00 PM, revealed the resident was arguing with another resident and threatened him/her. There was no documented evidence the facility completed a Behavior Sheet in the clinical record. 11. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 05/13/11, with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 02/21/13 and revised 10/22/13, revealed the facility did not care plan the resident for behaviors or have evidence of a completed Behavior Sheet. The facility care planned behaviors of self-removal of stool. 12. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 07/17/10 with a [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 11/25/13, revealed the resident would hide clothing and state the clothes were missing, claimed he/she was being physically abused, and throw him/herself on the floor. Review of a Nurse's Note, dated 11/30/13 at 9:00 PM, revealed the resident's back was assessed for injury from an altercation with another resident. There was no documented evidence in the clinical record the that the incident had occurred, no date, or time. There was no documented evidence the facility completed a Behavior Sheet in the clinical record. 13. Review of Resident #17's clinical record revealed the facility admitted the resident on 08/20/13, with a [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 09/03/13 and revised 11/14/13, revealed the resident had a history of [REDACTED]. Interventions included to observe resident's behavior to assist in determining cause of refusal per behavior flow sheet, intervene to ensure resid
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of the facility's Abuse policy and investigations, it was determined the facility's Administration failed to ensure the facility policy and procedures were implemented in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident. The facility's Administration failed to have an effective system in place to ensure policy and procedures were implemented to protect residents from abuse; failed to ensure staff was knowledgeable of the facility's policy and procedures related to abuse; and failed to provide guidance and oversight during abuse investigations. The Administration failed to provide guidance to Social Services to ensure assessments of resident behaviors were completed and care plans updated. The Administration further failed to ensure staff were knowledgeable of resident behaviors, monitored and documented the behaviors to ensure communication to Social Services. The Administration also failed to ensure the residents' clinical record was complete and accurate related to verbal, physical, and/or sexual behaviors exhibited by the residents. (Refer to F223, F225, F226, F250, F280, F282, F323, F514). In addition, the facility's Administration failed to ensure the facility maintained substantial compliance per the facility's Plan of Correction as evidenced by repeat deficiencies from the standard survey conducted on 08/01/13 at F203, F280, F323, F514, and F520. (Refer to F520) The facility's failure to ensure the facility policy and procedures were implemented in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident placed residents in a situation that was likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy (IJ) was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14 as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the Administrator's job description, undated, revealed the Administrator was responsible for the resident's condition of health and an essential function and responsibility was to review all accidents and incidents in the facility, maintain all records, funds, and licensing standards and requirements, and participate in on-going quality assurance of the facility. The Administrator through leadership evaluates and recognizes priorities, selects effective team members, and recognizes the need for and provides adequate resources. 1. Review of the facility's policy regarding Resident Abuse, revised 01/01/12, revealed each resident would be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, and/or misappropriate of property. Any employee who witnessed or had knowledge of an act of abuse to a resident was obligated to report such information to the Clinical Nurse in charge, Director of Clinical Services (DCS) and the Executive Director. All reported events would be investigated by the DCS. This information would be forwarded to the Executive Director, who would serve as the facility's Abuse Coordinator, and an abuse investigation would be conducted. In the absence of the Executive Director, the DCS will serve as the Abuse Coordinator. The Abuse Coordinator was responsible for reporting to the appropriate officials in accordance with Federal and State Regulation. Immediately upon report of an incident the suspect would be segregated from the resident. An incident report would be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. The Abuse Coordinator and/or DCS would take statements from the victims, the suspects and all possible witnesses including all other employees in the vicinity of the alleged abuse. Once the investigation was completed the report would be reviewed by the DCS, the Abuse Coordinator, and one other Administrative staff member. Interview and record review revealed the facility failed to have an effective system in place to ensure residents were free from abuse for four (4) of twenty-two (22) sampled residents (Resident #1, #2, #3 and #19). Record review revealed Resident #1 had a history of [REDACTED]. The facility's failure to address Resident #1's abusive behavior affected Resident #2 and Resident #3. Resident #19 was victim of verbal abuse by a staff member. (Refer to F223) Interview and record review revealed the facility failed to have an effective system in place to ensure incidents of potential abuse were investigated and reported immediately to the appropriate State Survey Agency (SSA) for fourteen (14) of twenty-two (22) sampled residents (Resident #1, #2, #3, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18 and #19). The facility failed to investigate and report allegations of verbal, physical and sexual abuse by resident to resident and staff to resident. The facility also failed to prevent further potential abuse by failing to conduct investigations. (Refer to F225 and F226) Review of the list of the facility's Key Personnel provided to the state survey agency on 01/06/14 revealed the Social Service Director (SSD) was the facility's Abuse Coordinator. A revised list, provided on 01/16/14 at 8:50 AM, revealed the facility's Abuse Coordinator was the Interim ED. Interview with the Social Service Director on 01/07/14 at 8:57 AM, on 01/09/14 at 1:54 PM, and on 01/10/14 at 1:55 PM revealed she took over reviewing the investigations from a previous Administrator in May 2013. However, the facility incident reports would be turned in to the DCS and she had never seen a facility incident report. Per interview, the SSD was unaware she was identified on the list of Key Personnel as the Abuse Coordinator. Interview with the current Interim ED, on 01/9/14 at 12:29 PM, revealed the SSD was the Abuse Coordinator during some of the allegations discussed and he did not know when he had become the facility's current Abuse Coordinator. He indicated he began at the facility as the Interim ED on 12/06/13, and in that timeframe did not know how many allegations of abuse had been reported to him. The ED stated he did not know what could be verbal or mental abuse and he would need to pull the state law to know what the regulations were for abuse. Interview, on 01/08/14 at 4:15 PM, with the Regional Director of Clinical Services revealed the facility discovered after the state survey agency entered the

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 25) facility on 01/02/14, that the facility had a problem with abuse. 2. Review of the facility's policy regarding Resident Abuse, revised 01/01/12, under the section titled screening, revealed the facility would screen any persons applying for employment for a history of abuse, neglect or mistreating residents by checking references from previous or current employers, criminal background checks, abuse checks with appropriate licensing board and registries prior to hire, sworn disclosure statements prior to hire, and verification of license or registration prior to hire. Interview and record review revealed the facility failed to have an effective system in place for abuse screening and prevention for eight (8) of eighteen (18) sampled personnel files. The facility failed to verify staff licenses, complete nurse aide abuse registry (NAR) checks, complete reference checks, and/or criminal background checks were conducted or contained negative information regarding theft. (Refer to F225) On 01/07/14 at 12:35 PM, interview with the Interim ED revealed HR was responsible to ensure personnel files were complete. The ED further indicated he would use a checklist to ensure all documents and checks had been completed; however, he had not implemented one. He stated he would also conduct periodic and random checks of employee files; however, he had not done any at the facility in his time employed. 3. Review of the facility's policy regarding Social Services, revised 09/01/11, revealed Social Services as a member of the Interdisciplinary Team, would participate in planning the overall care of the resident including completing periodic reviews of the assessment as necessary, but at least once quarterly and documenting progress in the Social Service Progress Notes and respond to changes in a resident's mental, physical, or emotional status. Interview and record review revealed the facility failed to have an effective system in place to ensure staff communicated the behaviors of the residents to Social Services through the 24 Hour Report, Behavior Sheets, Nurses' Notes, Incident Reports, and access to the Kiosk (State Registered Nurse Aides (SRNA) computer documentation) to enable Social Services to assess and provide medically-related social services to meet the residents' highest practicable physical, mental and psychosocial well being; and, revise the care plans based on the behaviors of fourteen (14) of twenty-two (22) sampled residents. (Residents #1, #2, #3, #9, #10, #11, #13, #14, #15, #16, #17, #18, #19 and #22). (Refer to F250 and F280) Interview with the SSD on 01/09/14 at 2:00 PM revealed she was responsible for the assessment of behaviors for the MDS and was responsible for creating the behavior care plans. She also tracked and trended behaviors for the Psychiatric Behavior Meeting. She obtained information from the morning meetings where incidents were discussed. However, the she did not have access to the Kiosk to view the behavior charting. Interview with the ED, on 01/16/14 at 4:05 PM, revealed he supervised Social Services by talking with her every day. 4. Review of the facility's policy regarding Accident and Incident Investigation, reviewed 12/27/13, revealed certain incidents would be investigated to determine root cause and to provide an opportunity to decrease future occurrences of the event. Any event that was not of the facility's routine operations or care of a resident should have the completion of an incident report. Additionally, certain events would also require the completion of designated investigation forms, including behavior outburst with using the Behavioral Outburst Assault of another Resident or Staff. The Executive Director (ED), Director of Clinical Services (DCS) or designee should begin a documented investigation to include interviews with the resident, staff involved, and others who may be able to help with the investigation. Additionally, results of the investigation would be reviewed by the DCS to ensure it was completed and thorough. Review of the facility's policy regarding Behavior Monitoring, reviewed 01/03/13, revealed any resident that exhibited behaviors would have a Behavior/ Intervention Monthly Flow Record (Behavior Sheet) initiated. The Behavior Sheet required documentation every shift as well as a summary in a weekly progress note. Behaviors listed included: violent behavior/striking other residents, sexual, verbal, or physical behavior toward other residents, sexual aggression, verbal or physical abuse toward staff, abusive yelling or screaming, kicking, aggression during walking/wheeling, and any other behavior which posed harm to other residents. The documentation should include the specific type of behavior being monitored, i.e. kicking, hitting, yelling. Additional documentation included: the number of times the behavior was observed during the shift; the code for the first attempted intervention; non-pharmacological interventions; the code for the outcome; and the code for any side effects observed. The Behavior Sheet was to be maintained with the Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. The policy also revealed any resident that received psychoactive medications would have a Behavior Sheet. The medication being monitored and the specific behavior that indicated the use of the medication should be noted. Interview and record review revealed the facility failed to have an effective system in place to ensure staff adequately supervised residents with behaviors for fifteen (15) of twenty-two (22)sampled residents. The facility failed to identify and monitor all exhibited behaviors by Residents #1, #2, #3, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #22. Additionally, the facility failed to monitor Resident #1's behavior of physical, sexual, and verbal abuse to provide needed care and treatment in an attempt to maintain a safe environment for other residents in the facility. (Refer to F282, F323, and F514) On 01/08/14 at 4:15 PM, interview with the Regional DCS revealed the facility audited residents' charts and discovered a problem with abusive behaviors. 5. Review of the annual survey dated 08/01/13 revealed the facility had been cited in Admission, Transfer and Discharge (F203 S/S D), Resident Assessment (F280 S/S D), Quality of Care (F323 S/S G), and Administration (F514 S/S D, F520 S/S G). The facility alleged compliance as of 09/13/13. The facility did not provide any evidence the Plan of Correction was monitored for continued compliance after the revisit date of 09/19/13. (Refer to F520) Interview with the Vice President of Clinical Operations, on 01/14/14 at 5:20 PM, revealed the facility was unable to attest that the Plan of Correction was utilized. Further interview with the Executive Director, on 01/19/14 at 11:37 AM, revealed he reviewed the previous Plan of Correction on his own, and as an interim put together a transition binder for the new administrator coming on which included prior surveys. The ED further stated he kept the facility's systems in place when he started because the worst thing an interim could do was change systems around. However, the ED then stated the facility obviously had a broken system, but didn't want to change everything. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 and SRNA #2 were immediately separated on 12/31/13 by staff. 2. The police were notified of the incident on 12/31/13. 3. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 4. SRNA #2 was suspended immediately on 12/31/13. 5. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 6. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 7. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 8. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 9. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 10. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 11. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 hour report. A 5 day Report was submitted to the SSA on 01/13/14. 12. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 13. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 14. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an 8 or above were interviewed by the Social Services on 01/07/14 to ensure they had not been abused or neglected. 15. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 16. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 17. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to determine if there were any incidents that were reportable and/or needed further investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 18. The facility's

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 26) concern book was reviewed by the Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 19. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6) discrepancies identified were corrected with missing Criminal Background Checks and Reference checks by 01/12/14. 20. All current Department Head staff along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116 employees) were educated by the Corporate Administrative Registered Nurses on abuse screening, training, prevention, identification, investigation, protection, reporting and response, F223 and the facility's Policy and Procedure for Resident Abuse, on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 and completed a post test. No staff members worked beyond 01/12/14 without having already been educated prior to the start of their shift. 21. The Human Resource/Payroll Coordinator was reeducated by the Regional Director of Human Resources on 01/12/14 that newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. 22. The ED and DCS were re-educated by the Vice President of Clinical Services on 01/11/14 and 01/12/14 to ensure newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. The ED will validate and sign that Newly Hired Employees have had all the required checks. 23. Mock Survey Rounds consisting of care plan review and implementation, behavior documentation, and staff interviews were completed by the IDT on 01/13/14, 01/14/14, and 01/15/14 that included resident interviews regarding potential abuse issues. 24. A Behavior Meeting was conducted by the IDT on 01/12/14 to review the current residents with known behaviors to discuss the behaviors, interventions, and medication. The nine (9) residents identified as having some type of behavior were referred to the physician and interventions were updated on the care plans by the IDT on 01/15/14. 25. Social Service notes were reviewed and Care Plans updated by the Corporate Social Services on 01/15/14. 26. The Social Service Director (SSD) was re-educated by the Corporate Administrative Registered Nurse on F250 and the facility's Policy and Procedures for Abuse and Behaviors on 01/12/14. 27. The Social Service Department consisting of the Corporate Social Services, Corporate Administrative Registered Nurse had daily oversight on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 with review of resident and family concerns daily in the morning meeting to ensure department managers were working towards resolution. 28. All facility staff was educated by the Corporate Administrative Registered Nurse on identification of behaviors to include but not limited to sexual and physical behavior on 01/12/14. Residents with behaviors will be discussed weekly at the Behavior Management Meeting to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The Nurse will document the behaviors on the 24 Hour Report to be shared during the morning meeting. 29. All facility staff were educated, on 01/12/14, 01/13/14, 01/14/14, 01/15/14, by the Corporate Administrative Registered Nurses, that revisions are made to the resident's care plan to include interventions for behaviors. The staff was instructed to follow the care plan for specific interventions for resident's interventions. Education was also provided on identification of accidents which can include behaviors, intervene, and report sexual and physical behavior to the resident's nurse for documentation in the medical record and follow up with the Physician. The nurse will also document in the 24 Hour Report to share information in the morning meeting. In addition all staff was educated on F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. 30. All resident care plans were reviewed and/or updated by the Regional Case Mix Coordinator on 01/11/14 and 01/12/14 to ensure they were accurate as compared to the Minimum Data Set and physician's orders [REDACTED]. 31. The facility's Administrative staff (ED/Abuse Coordinator and DCS) have been educated by the Corporate Administrative Registered Nurse on 01/12/14 that abuse allegations which are reported to them by employees must be investigated and reported to the appropriate officials in accordance with Federal and State Regulation. 32. The QAPI Committee had an Ad-Hoc QAPI meeting on 01/10/14 to discuss IJ citations and on 01/15/14 to discuss performance improvement opportunities and to review the facility's Abuse policy. The attendees consisted of the Interim Director of Clinical Services, Dietary Manager, Business Office Manager, Director of Admissions, Medical Records, Central Supply, Regional Case Mix Coordinator, Regional Director of Human Resources, Regional Director of Business Services, Regional Director of Clinical Services, Corporate Administrative RN, Director of Rehabilitation Services, Clinical Ambassador, Corporate Director of Education, Regional Vice President of Operations, Vice President of Operations, Vice President of Clinical Services, Vice President of Admissions & Marketing, Corporate Operations Team Member and Executive Director via telephone. 33. The ED and DCS were re-educated by the Corporate Administrative Registered Nurse on 01/12/14, regarding the regulations for F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 01/21/14-01/22/14 prior to exit as follows: 1. Review of Resident #1's closed medical record and the facility's investigation revealed Resident #1 and SRNA #2 were immediately separated. 2. Review of the facility's investigation revealed the Police were notified of the incident on 12/31/13. 3. Review of the Resident #1 closed medical record revealed the resident was discharged from the facility and sent to the hospital for a psychiatric evaluation on 01/07/14. 4. Review of the facility's investigation revealed the SRNA was immediately suspended and removed from the facility on 12/31/13. 5. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse's notes back to 07/17/13 identified three (3) residents with behaviors requiring increased monitoring through 1:1. Review and observation confirmed 1:1 was occurring and documented. The RDCS revealed Resident #3 was identified as one of these residents. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed Resident #3 was listed as one of the residents assessed. 6. Interview with the Vice President of Clinical Operations (VPCO), on 01/22/14 at 2:48 PM, revealed resident's identified with behaviors from the chart audits, on 01/07/14 through 01/08/14 and staff interviews on 01/11/12 through 01/12/14, had interventions put in place during the care plan review. Observation of Resident #3, on 01/21/14 at 4:12 PM, revealed 1:1 supervision was provided with a SRNA #8. 7. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #3 was listed with identified behaviors, medications, and interventions. 8. Review of Resident #3's Care plan revealed an intervention for 1:1 supervision on 01/13/14. 9. Review of the faxed communication with the SSA from the facility revealed the incident involving Resident #3 and #1, on 11/05/13 was reported on 01/08/14 and a 5 day report was submitted on 01/13/14. 10. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #2 was reviewed to include a medical record review and care plan review. Interview with the Corporate Administrative Registered Nurse (CARN), on 01/22/14 at 1:27 PM, revealed Resident #2 did not need increased monitoring was not exhibiting behaviors. 11. Review of the faxed communications to the SSA from the Facility revealed the incident on 07/17/13 with Resident #1 and #2 was reported on 01/08/14 and a 5 day follow up was submitted on 01/13/14. 12. Interview with Resident #2, on 01/22/14 at 2:03, revealed he/she did have a conversation with the DCS and SSD regarding the incident on 07/17/13 and 01/06/14. Resident #2 revealed being asked if he/she felt safe and what had occurred. 13. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse notes back to 07/17/13 identified three (3) residents (#3, #13, and #21) with behaviors requiring increased monitoring. A. Review of the Behavior Management Meeting notes, dated 01/12/14, revealed the three (3) identified were Residents #3, #13, and #21 were included in the meeting. B. Review of the three (3) identified resident's care plan (#3, #13, and #21) revealed interventions to increase supervision using 1:1 was added. C. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed two (2) of the three (3) residents (Residents #13 and #21) had medications and behaviors reviewed. D. Review of the nursing notes and 24 hour report book, revealed the three (3) residents (#3, #13, and #21) were monitored daily with documented behaviors observed. 14. Interview on 01/21/14 with twelve (12) residents, identified as interviewable with a BIMS of 8 or greater, revealed they felt safe at the facility and had been interviewed by the SSD. 15. Review of the facility skin sweeps, dated 01/07/14, 01/08/14, and on 01/15/14, revealed the facility's 89 residents were assessed with [REDACTED]. 16. Interview with sixteen (16) facility staff, Certified Occupational Therapy Assistant (COTA) #1 on 01/20/14 at 2:30 PM; COTA #2 on 01/20/14 at 2:30 PM; LPN #7 on 01/21/14 at 3:25 PM; Maintenance Director on 01/21/14 at 3:30 PM; Dietary Cook on 01/21/14 at 3:35 PM; Dietary Aide on 01/21/14 at 3:37 PM; LPN #8 on 01/21/14 at 3:39 PM; SRNA #10 on 01/21/14 at 4:00 PM; SRNA #8 on 01/21/14 at 4:12 PM; Medical Records on 01/22/14 at 12:58 PM; Payroll/HR on 01/22/14 at 12:50 PM; Business Office Manager on 01/22/14 at 3:11 PM; LPN #5 on 01/22/14 at 1:01 PM;

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F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 27) Housekeeper on 01/22/14 at 12:52 PM; SRNA #12 on 01/22/14 at 4:23 PM; and SRNA #11 on 01/22/14 at 4:05 PM, revealed they were asked to identify any residents who exhibited behaviors, abuse and/or neglect that had not been reported. Review of the Behavior Monitoring tool revealed staff was to document who identified a behavior, which resident, and the behavior identified. 17. Review of the faxed communication and facility investigations revealed the seven (7) identified incidents were reported to the SSA on 01/08/14. The expanded sample included five incidents involving Residents #9 and 10, #11 and 12, #13 and 14, #15 and 16, and #17 and 18. 18. Interview with the RDCS, on 01/22/14 at 1:08 PM, revealed the resident's concerns (grievances) were reviewed for potential allegations and none were identified. 19. Interview with RDCS and DCS, on 01/21/14 at 2:30 PM, revealed personnel files were audited on 01/12/14 for: two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, Criminal Record Checks, and abuse acknowledgment. RDCS and DCS revealed audits compared to current staff roster and the facility had no new hires for review. Review of two (2) SRNAs, the ED and Activities Assistant personnel files revealed they were accurate. 20. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (See #16) on 01/21/14 and 01/22/14, verified abuse education was completed and followed by an abuse post-test. 21. Interview with the Human Resource/Payroll Coordinator, on 01/22/14 at 12:50 PM, revealed she was educated on required screening components for new hires. Components to include Criminal background checks, two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, and abuse acknowledgment. 22. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the training. A separate training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. 23. Interview with the RDCS and the DCS, on 01/21/14 at 2:20 PM, revealed resident interviews regarding potential abuse issues, and mock surveys consisting of care plan review and implementation, behavior documentation, and staff interviews, were completed on all halls on 01/13/14, the F Hall on 01/14/14, E and F Halls on
F 0493 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**1) Set up a group that is legally responsible for writing and setting up policies for leading and running the nursing home; or 2) hire a properly licensed administrator.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of the facility's policies, it was determined the facility failed to have an established Governing Body or designated persons functioning as the Governing Body of the facility. Based on the findings of the abbreviated and partial extended survey conducted 01/02/14 - 01/22/14, which identified Immediate Jeopardy in Resident Behavior & Facility Practice, Quality of Life, Resident Assessment, Quality of Care, and Administration and Substandard Quality of Care identified at Resident Behavior & Facility Practice, Quality of Life, and Quality of Care it was determined the Governing Body failed to assure the facility was administered in a manner that promoted the health and safety of each resident. The facility failed to have a Governing Body to monitor and implement policies and procedures related to abuse investigations, staff treatment of [REDACTED]. The facility's failure to implement abuse policies regarding identifying, investigating, reporting, and protection of resident's from abuse placed residents at risk in a situation that was likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy (IJ) was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. The findings include: (Refer to F223, F225, F226, F250, F280, F282, F323, F490, F514, and F520) The facility did not provide a policy related to Governing Body. Interview, with one of the facility's Corporate Executive Directors, on 01/16/14 at 4:04 PM, revealed the facility had no policy in writing related to Governing Body. Review of facility's administrative staffing changes provided by the Corporate Human Resources Director, on 01/19/14, revealed between 05/29/13 to 01/22/14 the facility had six (6) different Directors of Clinical Services (DCS's) and from 01/19/13 to 01/22/14 seven (7) different Executive Directors. Further interview with the Executive Director, on 01/19/14 at 11:37 AM, revealed he did not know the definition of Governing Body, but he and the Director of Clinical Services report to the Regional Vice President of Operations and they communicate with the regional consultants. He stated he would need to get a list of the Governing Body members from the Regional Vice President of Operations. Interview with the Regional Vice President of Operations, on 01/16/14 at 1:37 PM, revealed the facility's administrator (Executive Director) was to provide oversight to the building and the final word regarding the operations of the building was the Executive Director's with support from the regional team. On 01/19/14 at 12:32 PM, interview with the Regional Vice President (VP) of Operations revealed he was the Interim ED's direct supervisor and he would take on a consultative role when the ED would ask for guidance. The VP stated there were no real checks and balances in place. He stated the ED was employed to run the business and the facility was not required to send any information directly to him. Additional interview with the Regional Vice President of Operations, on 01/19/14 at 12:32 PM, revealed the management company fulfills the role of the Governing Body and the Executive Director ultimately reports to them. The management company was in charge of the corporation to ensure the Executive Director does what was needed there as an Executive. He further stated there was no real check and balance of forms, they hire the people to do the right thing. When the Executive Director of the facility can't be reached, they contact the Regional Vice President of Operations. Further interview with the Executive Director, on 01/19/14 at 11:37 AM, revealed he kept the facility's systems in place when he started; however, the facility obviously had broken systems, but he didn't want to change everything. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 and SRNA #2 were immediately separated on 12/31/13 by staff. 2. The police were notified of the incident on 12/31/13. 3. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 4. SRNA #2 was suspended immediately on 12/31/13. 5. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 6. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 7. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 8. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 9. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 10. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 11. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 Hour Report. A 5 day Report was submitted to the SSA on 01/13/14. 12. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 13. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 14. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an eight or above were interviewed by the Social Services on 01/07/14 to ensure they had not been abused or neglected. 15. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 16. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 17. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to

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F 0493 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 28) determine if there were any incidents that were reportable and/or needed further investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 18. The facility's concern book was reviewed by the Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 19. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6) discrepancies identified were corrected with missing Criminal Background Checks and Reference checks by 01/12/14. 20. All current Department Head staff along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116 employees) were educated by the Corporate Administrative Registered Nurses on abuse screening, training, prevention, identification, investigation, protection, reporting and response, F223 and the facility's Policy and Procedure for Resident Abuse, on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 and completed a post test. No staff members worked beyond 01/12/14 without having already been educated prior to the start of their shift. 21. The Human Resource/Payroll Coordinator was reeducated by the Regional Director of Human Resources on 01/12/14 that newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. 22. The ED and DCS were re-educated by the Vice President of Clinical Services on 01/11/14 and 01/12/14 to ensure newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. The ED will validate and sign that Newly Hired Employees have had all the required checks. 23. Mock Survey Rounds consisting of care plan review and implementation, behavior documentation, and staff interviews were completed by the IDT on 01/13/14, 01/14/14, and 01/15/14 that included resident interviews regarding potential abuse issues. 24. A Behavior Meeting was conducted by the IDT on 01/12/14 to review the current residents with known behaviors to discuss the behaviors, interventions, and medication. The nine (9) residents identified as having some type of behavior were referred to the physician and interventions were updated on the care plans by the IDT on 01/15/14. 25. Social Service notes were reviewed and Care Plans updated by the Corporate Social Services on 01/15/14. 26. The Social Service Director (SSD) was re-educated by the Corporate Administrative Registered Nurse on F250 and the facility's Policy and Procedures for Abuse and Behaviors on 01/12/14. 27. The Social Service Department consisting of the Corporate Social Services, Corporate Administrative Registered Nurse had daily oversight on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 with review of resident and family concerns daily in the morning meeting to ensure department managers were working towards resolution. 28. All facility staff was educated by the Corporate Administrative Registered Nurse on identification of behaviors to include but not limited to sexual and physical behavior on 01/12/14. Residents with behaviors will be discussed weekly at the Behavior Management Meeting to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The Nurse will document the behaviors on the 24 hour report to be shared during the morning meeting. 29. All facility staff were educated, on 01/12/14, 01/13/14, 01/14/14, 01/15/14, by the Corporate Administrative Registered Nurses, that revisions are made to the resident's care plan to include interventions for behaviors. The staff was instructed to follow the care plan for specific interventions for resident's interventions. Education was also provided on identification of accidents which can include behaviors, intervene, and report sexual and physical behavior to the resident's nurse for documentation in the medical record and follow up with the Physician. The nurse will also document in the 24 hour report to share information in the morning meeting. In addition all staff was educated on F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. 30. All resident care plans were reviewed and/or updated by the Regional Case Mix Coordinator on 01/11/14 and 01/12/14 to ensure they were accurate as compared to the Minimum Data Set and physician's orders [REDACTED]. 31. The facility's Administrative staff (ED/Abuse Coordinator and DCS) have been educated by the Corporate Administrative Registered Nurse on 01/12/14 that abuse allegations which are reported to them by employees must be investigated and reported to the appropriate officials in accordance with Federal and State Regulation. 32. The QAPI Committee had an Ad-Hoc QAPI meeting on 01/10/14 to discuss IJ citations and on 01/15/14 to discuss performance improvement opportunities and to review the facility's Abuse policy. The attendees consisted of the Interim Director of Clinical Services, Dietary Manager, Business Office Manager, Director of Admissions, Medical Records, Central Supply, Regional Case Mix Coordinator, Regional Director of Human Resources, Regional Director of Business Services, Regional Director of Clinical Services, Corporate Administrative RN, Director of Rehabilitation Services, Clinical Ambassador, Corporate Director of Education, Regional Vice President of Operations, Vice President of Operations, Vice President of Clinical Services, Vice President of Admissions & Marketing, Corporate Operations Team Member and Executive Director via telephone. 33. The ED and DCS were re-educated by the Corporate Administrative Registered Nurse on 01/12/14, regarding the regulations for F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 01/21/14-01/22/14 prior to exit as follows: 1. Review of Resident #1's closed medical record and the facility's investigation revealed Resident #1 and SRNA #2 were immediately separated. 2. Review of the facility's investigation revealed the Police were notified of the incident on 12/31/13. 3. Review of the Resident #1 closed medical record revealed the resident was discharged from the facility and sent to the hospital for a psychiatric evaluation on 01/07/14. 4. Review of the facility's investigation revealed the SRNA was immediately suspended and removed from the facility on 12/31/13. 5. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse's notes back to 07/17/13 identified three (3) residents with behaviors requiring increased monitoring through 1:1. Review and observation confirmed 1:1 was occurring and documented. The RDCS revealed Resident #3 was identified as one of these residents. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed Resident #3 was listed as one of the residents assessed. 6. Interview with the Vice President of Clinical Operations (VPCO), on 01/22/14 at 2:48 PM, revealed resident's identified with behaviors from the chart audits, on 01/07/14 through 01/08/14 and staff interviews on 01/11/12 through 01/12/14, had interventions put in place during the care plan review. Observation of Resident #3, on 01/21/14 at 4:12 PM, revealed 1:1 supervision was provided with a SRNA #8. 7. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #3 was listed with identified behaviors, medications, and interventions. 8. Review of Resident #3's Care plan revealed an intervention for 1:1 supervision on 01/13/14. 9. Review of the faxed communication with the SSA from the facility revealed the incident involving Resident #3 and #1, on 11/05/13 was reported on 01/08/14 and a 5 day report was submitted on 01/13/14. 10. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #2 was reviewed to include a medical record review and care plan review. Interview with the Corporate Administrative Registered Nurse (CARN), on 01/22/14 at 1:27 PM, revealed Resident #2 did not need increased monitoring was not exhibiting behaviors. 11. Review of the faxed communications to the SSA from the Facility revealed the incident on 07/17/13 with Resident #1 and #2 was reported on 01/08/14 and a 5 day follow up was submitted on 01/13/14. 12. Interview with Resident #2, on 01/22/14 at 2:03, revealed he/she did have a conversation with the DCS and SSD regarding the incident on 07/17/13 and 01/06/14. Resident #2 revealed being asked if he/she felt safe and what had occurred. 13. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse notes back to 07/17/13 identified three (3) residents (#3, #13, and #21) with behaviors requiring increased monitoring. A. Review of the Behavior Management Meeting notes, dated 01/12/14, revealed the three (3) identified were Residents #3, #13, and #21 were included in the meeting. B. Review of the three (3) identified resident's care plan (#3, #13, and #21) revealed interventions to increase supervision using 1:1 was added. C. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed two (2) of the three (3) residents (Residents #13 and #21) had medications and behaviors reviewed. D. Review of the nursing notes and 24 hour report book, revealed the three (3) residents (#3, #13, and #21) were monitored daily with documented behaviors observed. 14. Interview on 01/21/14 with twelve (12) residents, identified as interviewable with a BIMS of 8 or greater, revealed they felt safe at the facility and had been interviewed by the SSD. 15. Review of the facility skin sweeps, dated 01/07/14, 01/08/14, and on 01/15/14, revealed the facility's 89 residents were assessed with [REDACTED]. 16. Interview with sixteen (16) facility staff, Certified Occupational Therapy Assistant (COTA) #1 on 01/20/14 at 2:30 PM; COTA #2 on 01/20/14 at 2:30 PM; LPN #7 on 01/21/14 at 3:25 PM; Maintenance Director on 01/21/14 at 3:30 PM; Dietary Cook on 01/21/14 at 3:35 PM; Dietary Aide on 01/21/14 at 3:37 PM; LPN #8 on 01/21/14 at 3:39 PM; SRNA #10 on 01/21/14 at 4:00 PM; SRNA #8 on 01/21/14 at 4:12 PM; Medical Records on 01/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0493 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 29) at 12:58 PM; Payroll/HR on 01/22/14 at 12:50 PM; Business Office Manager on 01/22/14 at 3:11 PM; LPN #5 on 01/22/14 at 1:01 PM; Housekeeper on 01/22/14 at 12:52 PM; SRNA #12 on 01/22/14 at 4:23 PM; and SRNA #11 on 01/22/14 at 4:05 PM, revealed they were asked to identify any residents who exhibited behaviors, abuse and/or neglect that had not been reported. Review of the Behavior Monitoring tool revealed staff was to document who identified a behavior, which resident, and the behavior identified. 17. Review of the faxed communication and facility investigations revealed the seven (7) identified incidents were reported to the SSA on 01/08/14. The expanded sample included five incidents involving Residents #9 and 10, #11 and 12, #13 and 14, #15 and 16, and #17 and 18. 18. Interview with the RDCS, on 01/22/14 at 1:08 PM, revealed the resident's concerns (grievances) were reviewed for potential allegations and none were identified. 19. Interview with RDCS and DCS, on 01/21/14 at 2:30 PM, revealed personnel files were audited on 01/12/14 for: two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, Criminal Record Checks, and abuse acknowledgment. RDCS and DCS revealed audits compared to current staff roster and the facility had no new hires for review. Review of two (2) SRNAs, the ED and Activities Assistant personnel files revealed they were accurate. 20. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (See #16) on 01/21/14 and 01/22/14, verified abuse education was completed and followed by an abuse post-test. 21. Interview with the Human Resource/Payroll Coordinator, on 01/22/14 at 12:50 PM, revealed she was educated on required screening components for new hires. Components to include Criminal background checks, two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, and abuse acknowledgment. 22. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the training. A separate training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. 23. Interview with the RDCS and the DCS, on 01/21/14 at 2:20 PM, revealed resident interviews regarding potential abuse issues, and mock surveys consisting of care plan review and implementation, behavior documentation, and staff interviews, were completed on all halls on 01/13/14, the F Hall on 01/14/14, E and F Halls on 01/15/13. Mock surveys continued on 01/16/14 for A, C, E, and F Halls, 01/17/14 for E, A, B, F Halls, and A Hall was done again on 01/18/14. 24. Review of the Behavior Management Meeting, dated 01/12/14, revealed twenty-four (24) residents were reviewed. Review of the psychiatric ARNP notes, dated 01/15/14, revealed nine (9) residents were reviewed which included review of medications. 25. Review of the chart audits, dated 01/15/14, revealed care plans were updated according to concerns noted in SSD notes. Review of 24 resident care plans revealed they had been updated. 26. Review of the facility's education, and review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Performance Improvement Committee, Indicators, Performance Improvement Committee, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F226, F250, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures including the SSD. The SSD was not available for interview. 27. Review of the Morning Minute worksheet provided by the facility as the Social Services oversight revealed concerns identified were addressed. Incident report Investigations were completed by Corporate Social Services. No new incident reports were reported; however, seven (7) incidents identified were reviewed and addressed. 28. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Performance Improvement Committee, Indicators, Performance Improvement Committee, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, F280, F282, F323, F514, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation and care plan interventions contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (see #16) on 01/21/14 and 01/22/14, verified education was completed and followed by a post-test. 29. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F280, F282, F514, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, documentation and care plan interventions contained 116 staff signatures. Interviews with sixteen (16) facility staff members, on 01/21/14 and 01/22/14, verified education was completed and followed by a post-test. Education did include following interventions on the care plan for resident behaviors. 30. Review of the signed census, dated 01/11/14 and 01/12/14, indicated residents had reviews and revisions of their care plan. Care plans for Residents #3, #19 and #21 were reviewed with revisions. 31. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the training. A separate training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. 32. Interview with the Vice President of Operations, on 01/22/14 at 12:45 PM, revealed an AD-Hoc QA meeting occurred on 01/10/14 to discuss the IJ citations. Interview with the Regional DCS and the DCS, on 01/21/14 at 2:30 PM, revealed the facility's abuse policy and procedure was reviewed and discussed on 01/15/14 in the QA meeting. The Regional DCS revealed no changes were made to the policy as it was determined the facility had a system problem and changes were made in the facility's system to follow the abuse policy. Review of the QA signature sheets and agenda, on 01/15/14, revealed twenty-three (23) people were in attendance and all IJ citations were reviewed and discussed. The QA committee reviewed the facilities policies for Abuse, Resident to Resident Abuse, Behavior Monitoring, Behavior Management, Incidents and Accidents, Performance Improvement, and Morning Meeting. Review of the QA sign in sheet and agenda, on 01/20/14, revealed seven (7) members were in attendance including the Medical Director, the Interim ED, Interim DCS, Regional DCS, and Regional Vice President of Operation. The recent survey findings and recommendations were discussed. Interview on 01/21/13 at 2:30 PM, with the Interim DCS revealed there were no changes to the policy and procedure; however, there was a system change to follow the policy. 33. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the Training. A separate Training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. Interview with the DCS on 01/21/14 at 2:30 PM, revealed she was knowledgeable of the regulations requirements for identifying and reporting abuse. Interview with the ED on 01/22/14 at 12:50 PM, revealed training was received and could voice understanding of the regulation, types of abuse, and identification of abuse and reporting abuse requirements.
F 0514 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 clinical records were accurate and complete for fifteen (15) of twenty-two (22) sampled residents. Residents #1, #2, #3, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #22. The facility staff failed to document behaviors of verbal, physical, and/or sexual behaviors toward staff and other residents in the clinical record. (Refer to F323) This is a repeat deficiency from the 08/01/13 Standard Health Survey. The facility's failure to have an effective system in place to ensure clinical records were accurate and complete placed residents in a situation that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was identified on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received on 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14, as alleged, prior to exit on 01/22/14. The scope and severity was lowered to an E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: The facility did not provide a policy regarding accuracy of the clinical record. Review of the facility's policy regarding Behavior Monitoring, reviewed 01/03/13, revealed any resident that exhibited behaviors would have a Behavior/ Intervention Monthly Flow Record (Behavior

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 30) Sheet) initiated. The Behavior Sheet required documentation every shift as well as a summary in a weekly progress note. The documentation should include the specific type of behavior being monitored, i.e. kicking, hitting, yelling. Additional documentation included: the number of times the behavior was observed during the shift, the code for the first attempted intervention, non-pharmacological interventions, the code for the outcome, and the code for any side effects observed. The Behavior Sheet was to be maintained with the Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. The policy also revealed any resident that received psychoactive medications, would have a Behavior Sheet. The medication being monitored and the specific behavior that indicated the use of the medication should be noted. 1. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 06/22/11 with [DIAGNOSES REDACTED]. The resident was also diagnosed with [REDACTED]. The Comprehensive Care Plan, dated 09/04/13 and revised 11/25/13, revealed the facility's care plan and interventions for Resident #1 included behaviors of verbal abuse and flirtatious behavior with male residents. Continued review of Resident #1's clinical record revealed a MAR for January 2014; however, a Behavior Sheet for January 2014 was not provided by the facility. A Behavior Sheet, dated October 2013, for Resident #1 revealed the form was blank, with no behaviors listed or any other documentation. A Psychiatric Note, dated 04/12/13, revealed Resident #1 had become aggressive with a peer and hit someone young and stupid. The Nurse's Notes reviewed from 02/07/13 through 05/23/13 revealed no documentation of Resident #1 in an altercation with a peer, or behavior other than refusing [MEDICAL TREATMENT]. Review of a Psych Note, dated 11/08/13, revealed the resident had been in a verbal altercation with a male peer that was misinterpreted as a physical altercation. However; the Nurse's Note, dated 11/05/13, revealed the resident was happy on the day shift, pleasant on the day and evening shift with no behaviors noted. The Nurse's Note did not include documentation of an incident which Resident #1 had become verbally and/or physically aggressive with a peer. There was no other documented evidence of the events with Resident #1 in the clinical record. The Behavior Chart Detail Report from 07/11/13 through 01/07/14, printed from the SRNA Kiosk for Resident #1, revealed standard behaviors that should be documented included: verbal abuse, verbal alterable, physical abuse, physical alterable, social inappropriate, and social inappropriate alterable. The report contained documentation for one (1) day of verbal alterable behavior. Further review revealed no documented evidence of the other behaviors. Review of the A and D Hall MARs, on 01/06/14 at 11:30 AM, revealed all residents had a Behavior Sheet; however, most of the resident sheets were blank. Resident #1's Behavior Sheet for January 2014 was blank. Review of the A and D Hall MARs, on 01/07/14 at 5:16 PM, revealed the blank Behavior Sheets had been pulled from the MARs and the current Behavior Sheet for Resident #1 was no longer in the MAR. Observation, on 01/07/14 at 3:24 PM, of Resident #1 revealed the resident was yelling wanting to go outside to smoke. At 4:04 PM, Resident #1 was yelling emergency while self-propelling down the hallway. Continued observation at 4:06 PM revealed Resident #1 was near the nurse's station for the A and D Halls. The resident was yelling at a staff member, cursing, and positioned his/her wheelchair to corner the staff member between the nurse's station and resident rooms without a way to remove herself from the resident. The incident at 4:06 PM was not documented in the medical record. 2. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 03/03/10 with [DIAGNOSES REDACTED]. The facility assessed the resident to have no mood or behavioral indicators and having difficulty with communication. Review of the Comprehensive Care Plan, dated 08/20/13 and revised 11/04/13, revealed the resident had an alteration in communication. Review of Resident #1's clinical record of a Nurse's Note, dated 07/17/14 at 10:25 PM, revealed Resident #1 had been in Resident #2's room with his/her hand under Resident #2's sheet touching and fondling Resident #2. The nurse's note further revealed Resident #2 told Resident #1 to stop; however, Resident #1 continued to touch Resident #2 under the sheet. Continued review of Resident #2's clinical record revealed Nurse's Notes from 07/15/13 through 10/21/13 revealed no documented evidence of the incident with Resident #1 on 07/17/13. There was no other documented evidence of the event in Resident #2's clinical record. Interview with the DCS, on 01/09/14 at 11:06 AM, revealed the incident should have been documented in Resident #2's chart, which was used for the monthly behavior meetings with the Psychiatrist. 3. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 12/03/12 with [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 10/04/13, revealed the care plan for behaviors included interventions to not argue with the resident and to ensure safety of the residents and others. A skin assessment of Resident #3, dated 11/05/13, revealed a mark on the left side of the resident's mouth. Continued review of Resident #3's clinical record revealed Daily Skilled Nurse's Notes, dated 11/06/13 and 11/07/13, and narrative notes for November did not identify any aspects of the incident. Additional review of Resident #3's clinical record revealed an Situation, Behavior, Assessment, Recommendation communication form, dated 11/05/13, that revealed the resident was found on the ground in the courtyard due to a fall. A Social Service's Note, dated 11/06/13 by the Social Service Director (SSD), revealed the resident was in a verbal argument with another resident. The SSD indicated Resident #3 stated he/she had become aggravated with the other resident and handled the incident the wrong way. There was no documentation in the Nurse's Notes or clinical record that the event had occurred. The facility did not provide Behavior Sheets for Resident #3. Interview with Medical Records staff, on 01/09/14 at 3:53 PM, revealed the two (2) skilled Nurse's Notes for Resident #3, dated 11/06/13 and 11/07/13, were the only Nurse's Notes for the month of November, and stated that's all there was. 4. Review of the clinical record for Resident #9 revealed the facility admitted the resident on 02/22/13 with [DIAGNOSES REDACTED]. Care plan interventions included give the resident papers to shuffle, keep safe distance when behaviors occur, and take to a quiet location as necessary. A Nurse's Note, dated 07/28/13 at 7:35 PM, revealed the resident kissed a female resident's hand and after redirection from staff the resident kissed the female resident on the lips and inserted his/her tongue in the resident's mouth. There was no documented evidence of a completed Behavior Sheet in the clinical record. 5. Review of Resident #10's clinical record revealed the facility admitted the resident on 04/27/09 with [DIAGNOSES REDACTED]. and possible injury, and remind resident to use the call light. There was no documented evidence of a completed Behavior Sheet in the clinical record. 6. Review of the clinical record for Resident #11 revealed the facility admitted the resident on 05/24/12 with [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 12/02/13, revealed the resident would often use profanity or vulgarity and call people names. A SSD Note, dated 10/25/13, revealed the resident threw a bowl of soup in the direction of Resident #12 and some of the soup hit the resident. There was no evidence of a completed Behavior Sheet in the clinical record. 7. Review of Resident #12's clinical record revealed the facility admitted the resident on 05/07/08 with [DIAGNOSES REDACTED]. A SSD Note, dated 10/25/13, revealed on 10/24/13 another resident who was angry knocked over a bowl of soup which fell into Resident #12's lap and chest area. The SSD note indicated the resident was assessed with [REDACTED].#12. However, there was a skin assessment documented as occurring on 10/26/13. 8. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 06/27/11 with a [DIAGNOSES REDACTED]. A Nurse's Note, dated 09/07/13 at 5:00 PM, revealed the resident was arguing with another resident and threatened to stab him/her with a shoe horn and was asked by staff to leave the shoe horn in his/her room. At 5:20 PM, the Nurse's Note revealed Resident #13 had threatened the other resident again. There was no evidence of a completed Behavior Sheet in the clinical record. 9. Review of Resident #14's clinical record revealed the facility admitted the resident on 12/06/12 with a [DIAGNOSES REDACTED]. Interventions included monitor for alcohol consumption to determine cause, intervene to ensure safety, set limits, and watch for behavioral cues, such as body language and tone of voice. A Nurse's Note, dated 09/07/13 at 3:00 PM, revealed the resident was arguing with another resident and threatened him/her. There was no evidence of a completed Behavior Sheet in the clinical record. 10. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 05/13/11 with [DIAGNOSES REDACTED]. 11. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 07/17/10 with a [DIAGNOSES REDACTED]. A Nurse's Note, dated 11/30/13 at 9:00 PM, revealed the resident's back was assessed for injury from an altercation with another resident. There was no evidence of documentation in the clinical record the incident occurred, no date, or time was noted. There was no evidence of a completed Behavior Sheet in the clinical record. 12. Review of Resident #17's clinical record revealed the facility admitted the resident on 08/20/13 with a [DIAGNOSES REDACTED]. Interventions included observe behavior to assist in determining cause of refusal per behavior flow sheet, intervene to ensure resident safety, and ensure safety of resident and others. A Behavior Sheet, dated 10/13, revealed wandering behavior inconsistently monitored. There was no other evidence in the clinical record for the physically abusive behaviors towards males or any other Behavior Sheets. 13. Review of the clinical record for Resident #18 revealed the facility admitted the resident on 01/08/14 with a [DIAGNOSES REDACTED]. Interventions included praise, positive behavior, do not argue with the resident, and re-approach the resident with refusal. A Nurse's Note, dated 01/09/14 at 4:20 AM, revealed the resident had been wandering into other resident rooms. Additionally, the resident was then found in his/her room yelling and standing face-to-face with his/her roommate which required the nurse to step between them. There was no other evidence in the clinical record for other behaviors or other Behavior Sheets. 14. Review of the clinical record for Resident #19 revealed the facility admitted the resident on

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 31) 09/18/13 with [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 12/20/13, revealed the resident displayed verbally aggressive behavior. The care plan interventions included diversional activities by activities staff, do not argue with the resident, and talk to the resident in a calm voice. An incident on 12/30/13 between the Activity Director (AD) and the resident was not documented in the resident's clinical record. 15. Review of Resident #22's clinical record revealed the facility admitted the resident on 10/24/13 with [DIAGNOSES REDACTED]. The Comprehensive Care Plan, dated 11/04/13, revealed the resident would yell out and use profanity. The care plan also indicated the resident displayed verbally and physically aggressive behavior with interventions to reinforce unacceptability of verbal abuse and talk with resident calmly when behavior was disruptive. The care plan also indicated the resident had symptoms of [MEDICAL CONDITION], hallucinations/[MEDICAL CONDITION] and document target behaviors. There was no evidence of a completed Behavior Sheet in the clinical record that contained monitoring of targeted behaviors. Interview, on 01/07/14 at 8:57 AM and 01/09/14 at 2:01 PM, with the SSD revealed the nurses did not document resident behaviors on the Behavior Sheet. She stated she used the Behavior Sheets and Nurse's Notes for the residents' MDS assessments. The SSD indicated if the nurses did not document the behaviors then she would not be aware of the behaviors that would need to be captured to complete the MDS assessment. She further indicated she was unaware the aides documented resident behaviors and stated she did not have access to the computer in which the aides document the resident behaviors. The SSD stated, after reviewing the Behavior Chart Detail Report from 07/11/13 through 01/07/14 for Resident #1, from her knowledge one (1) incident was not a correct number and there should have been more behaviors documented. On 01/07/14 at 10:24 AM, interview with the Interim Director of Clinical Services (DCS) revealed Resident #1's specific behaviors were not documented anywhere. She stated resident behaviors should be documented by the nurses in the chart for the SSD. She indicated the aides would document in the care tracker. The DCS stated she had told nurses to make sure resident behaviors were documented in the Nurse's Note. She also stated residents would have Behavior Sheets if they had certain medications. Continued interview, on 01/09/14 at 11:06 AM, revealed resident charts and care plans were taken to the monthly behavior meeting that occurred with the Psychiatrist. The DCS stated the behavior meeting with the Psychiatrist did not get a full picture of the resident's behavior when the behaviors were not documented in the resident's chart. Interview, on 01/19/14 at 10:36 AM, with the DCS revealed the Unit Manager (UM) was responsible to check resident charts to ensure everything was being captured that needed to be. She stated, she sometimes would go back and check records as well as the Assistant DCS (ADCS). The DCS did not say when she had last checked the charts. Interview with LPN #5, on 01/09/14 at 9:01 AM, revealed she was unaware if resident behaviors should be documented anywhere other than the 24 Hour Report. She stated if there was no documentation in the resident's charts then it was possible resident issues were not being addressed and the events could happen again. She indicated resident charts were used in resident care plan meetings to update the care plans. Interview, on 01/09/14 at 12:40 PM and 01/10/14 at 2:28 PM, with the Psychiatrist revealed nurses' charting was reviewed during the monthly behavior meetings. The physician stated in addition to medications and dose reduction reviews, behavior interventions were also reviewed. However, interview with the Advanced Registered Nurse Practitioner (ARNP), on 01/18/14 at 10:19 AM, revealed she had told the facility staff continuously to document behaviors and it was just not followed. Interview with the Interim ED, on 01/16/14 at 10:22 AM, revealed he was unaware of what was contained in the facility's records and needed to refer to the records; however, he stated records were either missing or could not be located. Further interview with the ED revealed he could not answer how he administered the facility without records, he reported they were missing and replied that is a good question. On 01/19/14 at 12:32 PM, interview with the Regional Vice President (VP) of Operations revealed he was the Interim ED's direct supervisor and he would take on a consultative role when the ED would ask for guidance. The VP stated there were no real checks and balances in place. He stated the ED was employed to run the business and the facility was not required to send any information directly to him. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 and SRNA #2 were immediately separated on 12/31/13 by staff. 2. The police were notified of the incident on 12/31/13. 3. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 4. SRNA #2 was suspended immediately on 12/31/13. 5. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 6. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 7. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 8. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 9. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 10. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 11. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 hour report. A 5 day Report was submitted to the SSA on 01/13/14. 12. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 13. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 14. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an 8 or above were interviewed by the Social Services on 01/07/14 to ensure they had not been abused or neglected. 15. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 16. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 17. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to determine if there were any incidents that were reportable and/or needed further investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 18. The facility's concern book was reviewed by the Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 19. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6) discrepancies identified were corrected with missing Criminal Background Checks and Reference checks by 01/12/14. 20. All current Department Head staff along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116 employees) were educated by the Corporate Administrative Registered Nurses on abuse screening, training, prevention, identification, investigation, protection, reporting and response, F223 and the facility's Policy and Procedure for Resident Abuse, on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 and completed a post test. No staff members worked beyond 01/12/14 without having already been educated prior to the start of their shift. 21. The Human Resource/Payroll Coordinator was reeducated by the Regional Director of Human Resources on 01/12/14 that newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. 22. The ED and DCS were re-educated by the Vice President of Clinical Services on 01/11/14 and 01/12/14 to ensure newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. The ED will validate and sign that Newly Hired Employees have had all the required checks. 23. Mock Survey Rounds consisting of care plan review and implementation, behavior documentation, and staff interviews were completed by the IDT on 01/13/14, 01/14/14, and 01/15/14 that included resident interviews regarding potential abuse issues. 24. A Behavior Meeting was conducted by the IDT on 01/12/14 to review the current residents with known behaviors to discuss the behaviors, interventions, and medication. The nine (9) residents

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F 0514 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 32) identified as having some type of behavior were referred to the physician and interventions were updated on the care plans by the IDT on 01/15/14. 25. Social Service notes were reviewed and Care Plans updated by the Corporate Social Services on 01/15/14. 26. The Social Service Director (SSD) was re-educated by the Corporate Administrative Registered Nurse on F250 and the facility's Policy and Procedures for Abuse and Behaviors on 01/12/14. 27. The Social Service Department consisting of the Corporate Social Services, Corporate Administrative Registered Nurse had daily oversight on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 with review of resident and family concerns daily in the morning meeting to ensure department managers were working towards resolution. 28. All facility staff was educated by the Corporate Administrative Registered Nurse on identification of behaviors to include but not limited to sexual and physical behavior on 01/12/14. Residents with behaviors will be discussed weekly at the Behavior Management Meeting to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The Nurse will document the behaviors on the 24 Hour Report to be shared during the morning meeting. 29. All facility staff were educated, on 01/12/14, 01/13/14, 01/14/14, 01/15/14, by the Corporate Administrative Registered Nurses, that revisions are made to the resident's care plan to include interventions for behaviors. The staff was instructed to follow the care plan for specific interventions for resident's interventions. Education was also provided on identification of accidents which can include behaviors, intervene, and report sexual and physical behavior to the resident's nurse for documentation in the medical record and follow up with the Physician. The nurse will also document in the 24 hour report to share information in the morning meeting. In addition all staff was educated on F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. 30. All resident care plans were reviewed and/or updated by the Regional Case Mix Coordinator on 01/11/14 and 01/12/14 to ensure they were accurate as compared to the Minimum Data Set and physician's orders [REDACTED]. 31. The facility's Administrative staff (ED/Abuse Coordinator and DCS) have been educated by the Corporate Administrative Registered Nurse on 01/12/14 that abuse allegations which are reported to them by employees must be investigated and reported to the appropriate officials in accordance with Federal and State Regulation. 32. The QAPI Committee had an Ad-Hoc QAPI meeting on 01/10/14 to discuss IJ citations and on 01/15/14 to discuss performance improvement opportunities and to review the facility's Abuse policy. The attendees consisted of the Interim Director of Clinical Services, Dietary Manager, Business Office Manager, Director of Admissions, Medical Records, Central Supply, Regional Case Mix Coordinator, Regional Director of Human Resources, Regional Director of Business Services, Regional Director of Clinical Services, Corporate Administrative RN, Director of Rehabilitation Services, Clinical Ambassador, Corporate Director of Education, Regional Vice President of Operations, Vice President of Operations, Vice President of Clinical Services, Vice President of Admissions & Marketing, Corporate Operations Team Member and Executive Director via telephone. 33. The ED and DCS were re-educated by the Corporate Administrative Registered Nurse on 01/12/14, regarding the regulations for F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 01/21/14-01/22/14 prior to exit as follows: 1. Review of Resident #1's closed medical record and the facility's investigation revealed Resident #1 and SRNA #2 were immediately separated. 2. Review of the facility's investigation revealed the Police were notified of the incident on 12/31/13. 3. Review of the Resident #1 closed medical record revealed the resident was discharged from the facility and sent to the hospital for a psychiatric evaluation on 01/07/14. 4. Review of the facility's investigation revealed the SRNA was immediately suspended and removed from the facility on 12/31/13. 5. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse's notes back to 07/17/13 identified three (3) residents with behaviors requiring increased monitoring through 1:1. Review and observation confirmed 1:1 was occurring and documented. The RDCS revealed Resident #3 was identified as one of these residents. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed Resident #3 was listed as one of the residents assessed. 6. Interview with the Vice President of Clinical Operations (VPCO), on 01/22/14 at 2:48 PM, revealed resident's identified with behaviors from the chart audits, on 01/07/14 through 01/08/14 and staff interviews on 01/11/12 through 01/12/14, had interventions put in place during the care plan review. Observation of Resident #3, on 01/21/14 at 4:12 PM, revealed 1:1 supervision was provided with a SRNA #8. 7. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #3 was listed with identified behaviors, medications, and interventions. 8. Review of Resident #3's Care plan revealed an intervention for 1:1 supervision on 01/13/14. 9. Review of the faxed communication with the SSA from the facility revealed the incident involving Resident #3 and #1, on 11/05/13 was reported on 01/08/14 and a 5 day report was submitted on 01/13/14. 10. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #2 was reviewed to include a medical record review and care plan review. Interview with the Corporate Administrative Registered Nurse (CARN), on 01/22/14 at 1:27 PM, revealed Resident #
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's 08/01/13 Plan of Correction (POC), review of the facility's investigation reports, facility's policies, Performance Improvement Morning Meetings, Comprehensive 24 Hour Report, Performance Improvement Committee, and Clinical Performance Improvement, it was determined the facility's Quality Assurance Committee failed to operationalize their policies regarding the function and attendance of the committee and failed to monitor the 08/01/13 Plan of Correction to ensure continued compliance. The facility failed to identify quality deficiencies, develop a plan of action, and implement the plan of action to keep residents free from abuse, and identify and address behaviors for fifteen (15) of the twenty-two (22) sampled residents (Resident #1, #2, #3, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, and #22). (Refer to F223, F225, F226, F250, F280, F282, F323, F490, F493, and F514) The facility's failure to have an effective system in place to ensure the Quality Assurance Program/Committee functioned according to their policy and identified quality deficiencies, develop plans of action, and implement the plans of action placed residents in a situation that has caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy (IJ) was identified, on 01/10/14 and determined to exist on 07/17/13. The facility was notified of the Immediate Jeopardy on 01/10/14. An acceptable Allegation of Compliance (AOC) was received, 01/20/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 01/16/14, as alleged, prior to exit on 01/22/14. The scope and severity was lowered to a E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes and the plan of correction. The findings include: 1. Review of the facility's policy regarding Performance Improvement Morning Meeting, Revised 09/01/11, revealed the morning meeting would be conducted to provide effective communications to all staff on resident care. The morning meeting consisted of the nursing 24 Hour Report from each Clinical Nurse, report from the mock survey member, reports for previous 24 hours, quality of care status to include decubitus, weights, restraints, resident and/or change in condition or care planning. Review of the facility's policy regarding Comprehensive 24 Hour Report, revised on 09/12/13, revealed clinical services would have a written method for monitoring and communicating clinical information, unusual occurrence information, and administrative matters on a twenty-four (24) hour basis. Examples of additional issues which may be addressed on the report are as follows, but should not be considered all inclusive: residents whose condition required extra attention and supervision; unusual occurrences, resident or facility related; all incidents and accidents; family concerns which have been made know; physician visits and concerns or issues; abnormal labs and x-ray values; IV's; antibiotics; and development of skin issues. The completed reports would be maintained for no more then 30 days in the nursing office for review and use for morning meetings. Review of the facility's policy regarding Performance Improvement Committee, revised on 09/01/11, revealed the Performance Improvement Committee would meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee would direct all activities including approving proposed monitoring, evaluating and review of services. The committee would assure activities had written indicators and standards/thresholds for evaluation, that appropriate actions are implemented, and that such corrections had been evaluated by subsequent monitoring. The committee would assign interdisciplinary performance action teams activities and monitor the teams progress. A Performance Action Team would be developed to collect and evaluate data and to plan and implement needed action under the direction of the Performance Improvement Committee. The

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 33) Committee would review the results of all evaluating and monitoring activities and make appropriate recommendations. Interview with the DCS, on 01/07/14 at 10:50 AM, revealed all resident behaviors should be documented in social service notes and nursing notes so a behavioral investigation could be completed. The DCS revealed behaviors could also be documented in the Care Tracker system. Further interview with the DCS, on 01/17/14 at 3:58 PM, revealed any time there was an allegation, an initial report needed to be filed. The DCS revealed an allegation was anything that someone stated happened. The DCS revealed all incident reports were discussed in the morning QA meeting, which included the Social Service Director (SSD), which was how the SSD became aware of any issues. The 24 Hour Reports and morning minutes are used as well. However, the DCS revealed she was not sure if the facility still had the 24 Hour Reports or the morning minutes. The DCS revealed the SSD documented all behaviors in a binder, which was what the SSD used in the behavior meetings with the Psychiatrist. The DCS retrieved the behavior binder, and review of the binder revealed a list of residents on [MEDICAL CONDITION] medication; however, no behaviors were documented. Interview with DCS on the behavior binder, on 01/17/14 at 5:15 PM, revealed behaviors were not being monitored and tracked. The DCS revealed she was not monitoring to ensure documentation of behaviors were being completed. All the data gathered through the incident reports, 24 Hour Reports and the behavior binder were to be taken to QA by the appropriate staff. However, this data was inconsistent or non-existent and tracking and trending was not completed. Interview with the ED, on 01/09/14 at 12:29 PM, revealed the morning QA meeting consisted of two (2) parts, the clinical portion and the operations portion. The ED revealed the 24 Hour Report was usually discussed in the clinical portion of the meeting and he did not normally attend that portion of the meeting unless he happened to be available, then he would go over the mock survey rounds, staffing, incidents and [MEDICATION NAME]. 2. Based on the findings of the abbreviated survey, the facility failed to maintain substantial compliance based on repeat deficiencies at 42 CFR 482.12 Admission, Transfer, Discharge (F203), 42 CFR 482.20 Resident Assessment (F280), 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F514 and F520). Review of the 08/01/13 Health Survey Plan of Correction revealed the facility would (F203) QI monitor monthly all residents prior to issuing discharge notices to ensure documentation and guidelines are followed according to regulation and policy for development of action plans to ensure written notice of discharges include a valid reason for transfer/discharge from the facility. The facility would monitor (F280) any omissions or revision to the care plans would be addressed at time of daily operations audit and reviewed in QI monthly. The facility would (F323) monitor care plans and Kardexs in the daily operations meeting the next business day following an incident. Any variances will result in correction of the care plan and Kardex. The facility would (F514) QI monitor physician orders [REDACTED]. The facility would (F520) hold a monthly QI meeting to discuss deficient practice, develop and implement action plans. QI monitoring for effectiveness, and then discuss QI monthly findings at the next QI monthly meeting, action plan revision would be developed at this time if applicable. The ED would conduct discussions of the status of the plan of correction to ensure continued compliance. Interview with the DCS, on 01/09/13 at 11:07 AM, revealed she was not aware of what the previous deficiencies were or what was written as the facility's POC. The DCS revealed she had not even looked for the survey book, but did request for someone to find it for her. Observation of the facility's front desk, on 01/09/14 at 11:51 AM, revealed the facility's survey binder was on the desk with the most recent survey results in place. Interview with the Interim Executive Director (ED), on 01/09/14 at 12:29 PM, revealed he did look through the facility's POC and noted an audit in the compliance book, but did not use this tool as he preferred to use his own worksheet for the AM meetings. However, interview with the ED, on 01/15/14 at 9:22 AM, revealed the ED's worksheet was his own and not the facility's and he would have to get permission before he could share the information with the surveyors. No worksheets were ever provided as evidence of audit in the morning QA meetings. Interview with the ED, on 01/09/14 at 5:17 PM, revealed the morning QA meeting minutes and the 24 Hour Reports were only kept for two (2) weeks and stated he did not know how that information made it to the quarterly QA meetings since the information was being purged. Continued interview with the ED, on 01/16/14 at 3:11 PM, revealed the facility continued to purge these notes although the state surveyors requested evidence of the forms. Interview with the Vice President of Clinical Operations, on 01/14/14 at 5:20 PM, revealed the facility was unable to attest that the Plan of Correction was completed. The Vice President of Clinical Operations revealed they were unable to find any evidence to verify any of the reviews, audits, or meetings were done as directed in the POC. Interview with the the Regional Vice President of Operations(RVPO), on 01/19/14 at 12:32 PM, revealed he did not do any follow up related to the POC from the previous survey cited with multiple tags at a S/S of a G. The RVPO revealed he did not follow up from any QA meetings and the facility was not required to send anything regarding QA to him. 3. Review of the facility's policy regarding Performance Improvement-Clinical, revised 09/01/11, revealed the Executive Director would hold the position of chairperson of the QA Committee. The Committee may consist of the Medical Director, Executive Director, Director of Clinical Services, and three (3) other staff persons. Review of the Quality Assurance Meeting signature sheets provided by the facility revealed Quality Assurance meetings were held on the following dates: 08/09/13; 08/16/13; 08/23/13; 09/17/13; 09/27/13; 10/04/13; 10/18/13; and 10/25/13. Further review revealed neither the Medical Director nor any other physician had signed for attendance at any of the meetings listed above. In addition, there was no signature for the DCS to indicate attendance on 08/16/13 or 10/18/13. There was no signature of attendance by the Executive Director on 09/17/13, 10/18/13 or 10/25/13. Interview with the facility's previous Medical Director, on 01/22/14 at 11:06 AM, revealed he was the Medical Director from 11/26/13 to 01/11/14. The previous Medical Director revealed he had never attended a QA meeting, and had never been invited or notified when they were to occur. The previous Medical Director revealed he found out the facility had been notified of the Immediate Jeopardy, on 01/11/14, by the Psychiatrist. The previous Medical Director revealed he had to ask the Vice President of Operations what had caused the IJ status and was told it was no big deal and it concerned some residents from back in July and November. The previous Medical Director revealed he submitted his resignation that day, 01/22/14. The facility provided an Allegation of Compliance (AOC) on 01/20/14 alleging the Immediate Jeopardy (IJ) was removed on 01/16/14; the facility took the following immediate steps to remove the IJ: 1. Resident #1 and SRNA #2 were immediately separated on 12/31/13 by staff. 2. The police were notified of the incident on 12/31/13. 3. Resident #1 was discharged to the hospital for a psychiatric evaluation on 01/07/14. 4. SRNA #2 was suspended immediately on 12/31/13. 5. Resident #3 was referred by the DCS, and seen by the Psychiatric ARNP, on 01/15/14. 6. Resident #3 was placed on increased supervision, 1:1 observation, to redirect impulse behaviors on 01/12/14. 7. Resident #3 was reviewed by the Interdisciplinary Team (IDT) (consisting of the Corporate Administrative Nurse, DCS, Activity Director, and Regional Director of Clinical Services) in the Behavior Management Meeting, on 01/12/14, which included a medical record review. 8. Resident #3's care plan was updated by the Corporate Administrative Registered Nurse on 01/13/14. 9. The incident involving Resident #3, on 11/05/13, was reported to the State Survey Agency (SSA), on 01/08/14 via a 24 Hour Report, investigated and a 5 Day report was submitted to the SSA on 01/13/14. 10. Resident #2 was reviewed in the Behavior Management Meeting by the IDT Corporate Administrative Registered Nurse, DCS, Activity Director, and the Regional Director of Clinical Services on 01/12/14 which included a medical record review and a care plan review. 11. The incident on 07/17/13 involving Resident #2 was reported to the SSA on 01/08/14 via a 24 Hour Report. A 5 day Report was submitted to the SSA on 01/13/14. 12. Resident #2 was interviewed on 01/07/14 by the SSD and the DCS regarding the incident on 07/17/13 and 01/06/14. 13. Current resident chart reviews completed , on 01/07/14 and 01/08/14 by the DCS, ADCS, Unit Manager and RDCS and staff interviews on 01/11/14 and 01/12/14 by Corporate Administrative Registered Nurses to identify residents with behaviors, the facility identified three (3) residents (#3, #13, and #21) as exhibiting sexual or physical behaviors towards others. These three residents were: A. Reviewed in the Behavior Management Meeting by the IDT (Corporate Administrative Registered Nurse, Director of Clinical Services Activity Director, and the Regional Director of Clinical Services) on 01/12/14. B. Increased supervision was initiated on 01/12/14 and the care plans were revised by the Activity Director the Corporate Administrative Registered Nurse and the DCS on 01/13/14. C. Referred to the Psychiatrist for review by the DCS and two (#13 and #21) of three residents were seen on 01/15/14. D. Had documentation of behavior reviewed daily since 01/13/14 by a member of the IDT (to include the DCS, ED, and the Corporate Administrative Registered Nurses). 14. Thirty-nine (39) residents, with a brief interview for mental status (BIMS) of an 8 or above were interviewed by the Social Services on 01/07/14 to ensure they had not been abused or neglected. 15. All residents were assessed by nurses via skin sweeps for suspicious injuries on 01/07/14, 01/08/14, and on 01/15/14 with no injuries found. 16. All Department Heads along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116) were interviewed by the Corporate Administrative Registered Nurse on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 to ensure no one had witnessed any abuse or neglect that had not been previously reported. 17. Current resident charts were reviewed on 01/07 and 01/08/14 by the Director of Clinical Services, Assistant Director of Clinical Services, Staff Educator, Unit Manager, and the Regional Director of Clinical Services to determine if there were any incidents that were reportable and/or needed further

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	185348	A. BUILDING _____ B. WING _____	01/22/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 34) investigation. The seven (7) incidents that were identified during the review were reported on 01/08/14. 18. The facility's concern book was reviewed by the Regional Director of Clinical Services on 01/11/14 for allegations that needed to be reported and no allegations were identified. 19. The current staff members' employee personnel files were reviewed by Regional Director of Human Resources and Facility Human Resources/Payroll Coordinator to ensure that the files were completed with the Criminal Background Check, Kentucky State Board of Nursing/Nurse Aide Abuse Registry check, Office of the Inspector General Check, Telephone Reference Checks and Abuse/Neglect Attestation on 01/11/14 and 01/12/14. The six (6) discrepancies identified were corrected with missing Criminal Background Checks and Reference checks by 01/12/14. 20. All current Department Head staff along with Nursing, Dietary, Housekeeping/Laundry, and Therapy (totaling 116 employees) were educated by the Corporate Administrative Registered Nurses on abuse screening, training, prevention, identification, investigation, protection, reporting and response, F223 and the facility's Policy and Procedure for Resident Abuse, on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 and completed a post test. No staff members worked beyond 01/12/14 without having already been educated prior to the start of their shift. 21. The Human Resource/Payroll Coordinator was reeducated by the Regional Director of Human Resources on 01/12/14 that newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. 22. The ED and DCS were re-educated by the Vice President of Clinical Services on 01/11/14 and 01/12/14 to ensure newly hired employees must have a Criminal Background Check, Kentucky Board of Nursing/Nurse Aide Abuse Registry Screen, Office of the Inspector General Exclusion Check, and Telephone reference checks. The ED will validate and sign that Newly Hired Employees have had all the required checks. 23. Mock Survey Rounds consisting of care plan review and implementation, behavior documentation, and staff interviews were completed by the IDT on 01/13/14, 01/14/14, and 01/15/14 that included resident interviews regarding potential abuse issues. 24. A Behavior Meeting was conducted by the IDT on 01/12/14 to review the current residents with known behaviors to discuss the behaviors, interventions, and medication. The nine (9) residents identified as having some type of behavior were referred to the physician and interventions were updated on the care plans by the IDT on 01/15/14. 25. Social Service notes were reviewed and Care Plans updated by the Corporate Social Services on 01/15/14. 26. The Social Service Director (SSD) was re-educated by the Corporate Administrative Registered Nurse on F250 and the facility's Policy and Procedures for Abuse and Behaviors on 01/12/14. 27. The Social Service Department consisting of the Corporate Social Services, Corporate Administrative Registered Nurse had daily oversight on 01/11/14, 01/12/14, 01/13/14, 01/14/14, and 01/15/14 with review of resident and family concerns daily in the morning meeting to ensure department managers were working towards resolution. 28. All facility staff was educated by the Corporate Administrative Registered Nurse on identification of behaviors to include but not limited to sexual and physical behavior on 01/12/14. Residents with behaviors will be discussed weekly at the Behavior Management Meeting to ensure targeted behaviors are documented, care planned, and appropriate interventions are in place. The Nurse will document the behaviors on the 24 hour report to be shared during the morning meeting. 29. All facility staff were educated, on 01/12/14, 01/13/14, 01/14/14, 01/15/14, by the Corporate Administrative Registered Nurses, that revisions are made to the resident's care plan to include interventions for behaviors. The staff was instructed to follow the care plan for specific interventions for resident's interventions. Education was also provided on identification of accidents which can include behaviors, intervene, and report sexual and physical behavior to the resident's nurse for documentation in the medical record and follow up with the Physician. The nurse will also document in the 24 hour report to share information in the morning meeting. In addition all staff was educated on F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. 30. All resident care plans were reviewed and/or updated by the Regional Case Mix Coordinator on 01/11/14 and 01/12/14 to ensure they were accurate as compared to the Minimum Data Set and physician's orders [REDACTED]. 31. The facility's Administrative staff (ED/Abuse Coordinator and DCS) have been educated by the Corporate Administrative Registered Nurse on 01/12/14 that abuse allegations which are reported to them by employees must be investigated and reported to the appropriate officials in accordance with Federal and State Regulation. 32. The QAPI Committee had an Ad-Hoc QAPI meeting on 01/10/14 to discuss IJ citations and on 01/15/14 to discuss performance improvement opportunities and to review the facility's Abuse policy. The attendees consisted of the Interim Director of Clinical Services, Dietary Manager, Business Office Manager, Director of Admissions, Medical Records, Central Supply, Regional Case Mix Coordinator, Regional Director of Human Resources, Regional Director of Business Services, Regional Director of Clinical Services, Corporate Administrative RN, Director of Rehabilitation Services, Clinical Ambassador, Corporate Director of Education, Regional Vice President of Operations, Vice President of Operations, Vice President of Clinical Services, Vice President of Admissions & Marketing, Corporate Operations Team Member and Executive Director via telephone. 33. The ED and DCS were re-educated by the Corporate Administrative Registered Nurse on 01/12/14, regarding the regulations for F520, the facility's policies for Behaviors, Incidents, Documentation, and Performance Improvement which included the QAPI process, Monitoring of Facility Care Services, Identification of Performance Improvement Opportunities, and the Role of the Performance Team. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 01/21/14-01/22/14 prior to exit as follows: 1. Review of Resident #1's closed medical record and the facility's investigation revealed Resident #1 and SRNA #2 were immediately separated. 2. Review of the facility's investigation revealed the Police were notified of the incident on 12/31/13. 3. Review of the Resident #1 closed medical record revealed the resident was discharged from the facility and sent to the hospital for a psychiatric evaluation on 01/07/14. 4. Review of the facility's investigation revealed the SRNA was immediately suspended and removed from the facility on 12/31/13. 5. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse's notes back to 07/17/13 identified three (3) residents with behaviors requiring increased monitoring through 1:1. Review and observation confirmed 1:1 was occurring and documented. The RDCS revealed Resident #3 was identified as one of these residents. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed Resident #3 was listed as one of the residents assessed. 6. Interview with the Vice President of Clinical Operations (VPCO), on 01/22/14 at 2:48 PM, revealed resident's identified with behaviors from the chart audits, on 01/07/14 through 01/08/14 and staff interviews on 01/11/12 through 01/12/14, had interventions put in place during the care plan review. Observation of Resident #3, on 01/21/14 at 4:12 PM, revealed 1:1 supervision was provided with a SRNA #8. 7. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #3 was listed with identified behaviors, medications, and interventions. 8. Review of Resident #3's Care plan revealed an intervention for 1:1 supervision on 01/13/14. 9. Review of the faxed communication with the SSA from the facility revealed the incident involving Resident #3 and #1, on 11/05/13 was reported on 01/08/14 and a 5 day report was submitted on 01/13/14. 10. Review of the Behavior Meeting notes, on 01/12/14, revealed Resident #2 was reviewed to include a medical record review and care plan review. Interview with the Corporate Administrative Registered Nurse (CARN), on 01/22/14 at 1:27 PM, revealed Resident #2 did not need increased monitoring was not exhibiting behaviors. 11. Review of the faxed communications to the SSA from the Facility revealed the incident on 07/17/13 with Resident #1 and #2 was reported on 01/08/14 and a 5 day follow up was submitted on 01/13/14. 12. Interview with Resident #2, on 01/22/14 at 2:03, revealed he/she did have a conversation with the DCS and SSD regarding the incident on 07/17/13 and 01/06/14. Resident #2 revealed being asked if he/she felt safe and what had occurred. 13. Interview with the Regional Director of Clinical Services (RDCS), on 01/22/14 at 1:08 PM, revealed the audits of resident clinical records which included review of nurse notes back to 07/17/13 identified three (3) residents (#3, #13, and #21) with behaviors requiring increased monitoring. A. Review of the Behavior Management Meeting notes, dated 01/12/14, revealed the three (3) identified were Residents #3, #13, and #21 were included in the meeting. B. Review of the three (3) identified resident's care plan (#3, #13, and #21) revealed interventions to increase supervision using 1:1 was added. C. Review of the Psychiatric ARNP notes, dated 01/15/14, revealed two (2) of the three (3) residents (Residents #13 and #21) had medications and behaviors reviewed. D. Review of the nursing notes and 24 hour report book, revealed the three (3) residents (#3, #13, and #21) were monitored daily with documented behaviors observed. 14. Interview on 01/21/14 with twelve (12) residents, identified as interviewable with a BIMS of 8 or greater, revealed they felt safe at the facility and had been interviewed by the SSD. 15. Review of the facility skin sweeps, dated 01/07/14, 01/08/14, and on 01/15/14, revealed the facility's 89 residents were assessed with [REDACTED]. 16. Interview with sixteen (16) facility staff, Certified Occupational Therapy Assistant (COTA) #1 on 01/20/14 at 2:30 PM; COTA #2 on 01/20/14 at 2:30 PM; LPN #7 on 01/21/14 at 3:25 PM; Maintenance Director on 01/21/14 at 3:30 PM; Dietary Cook on 01/21/14 at 3:35 PM; Dietary Aide on 01/21/14 at 3:37 PM; LPN #8 on 01/21/14 at 3:39 PM; SRNA #10 on 01/21/14 at 4:00 PM; SRNA #8 on 01/21/14 at 4:12 PM; Medical Records on 01/22/14 at 12:58

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	185348	A. BUILDING _____ B. WING _____	**01/22/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	**2141 SYCAMORE AVENUE LOUISVILLE, KY 40206**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 35) PM; Payroll/HR on 01/22/14 at 12:50 PM; Business Office Manager on 01/22/14 at 3:11 PM; LPN #5 on 01/22/14 at 1:01 PM; Housekeeper on 01/22/14 at 12:52 PM; SRNA #12 on 01/22/14 at 4:23 PM; and SRNA #11 on 01/22/14 at 4:05 PM, revealed they were asked to identify any residents who exhibited behaviors, abuse and/or neglect that had not been reported. Review of the Behavior Monitoring tool revealed staff was to document who identified a behavior, which resident, and the behavior identified. 17. Review of the faxed communication and facility investigations revealed the seven (7) identified incidents were reported to the SSA on 01/08/14. The expanded sample included five incidents involving Residents #9 and 10, #11 and 12, #13 and 14, #15 and 16, and #17 and 18. 18. Interview with the RDCS, on 01/22/14 at 1:08 PM, revealed the resident's concerns (grievances) were reviewed for potential allegations and none were identified. 19. Interview with RDCS and DCS, on 01/21/14 at 2:30 PM, revealed personnel files were audited on 01/12/14 for: two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, Criminal Record Checks, and abuse acknowledgment. RDCS and DCS revealed audits compared to current staff roster and the facility had no new hires for review. Review of two (2) SRNAs, the ED and Activities Assistant personnel files revealed they were accurate. 20. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (See #16) on 01/21/14 and 01/22/14, verified abuse education was completed and followed by an abuse post-test. 21. Interview with the Human Resource/Payroll Coordinator, on 01/22/14 at 12:50 PM, revealed she was educated on required screening components for new hires. Components to include Criminal background checks, two (2) reference checks, OIG report, Kentucky Board of Nursing Nurse Aide Abuse Registry, and abuse acknowledgment. 22. Review of training signature sheets, dated 01/11/14 through 01/15/14, revealed both the ED and DCS signatures as attending the training. A separate training, dated 01/12/14, revealed just the ED and DCS were trained on the facility's Abuse and Neglect Policy and the procedures for reporting investigating. The facility's abuse policy contained new employee hire screening components. 23. Interview with the RDCS and the DCS, on 01/21/14 at 2:20 PM, revealed resident interviews regarding potential abuse issues, and mock surveys consisting of care plan review and implementation, behavior documentation, and staff interviews, were completed on all halls on 01/13/14, the F Hall on 01/14/14, E and F Halls on 01/15/13. Mock surveys continued on 01/16/14 for A, C, E, and F Halls, 01/17/14 for E, A, B, F Halls, and A Hall was done again on 01/18/14. 24. Review of the Behavior Management Meeting, dated 01/12/14, revealed twenty-four (24) residents were reviewed. Review of the psychiatric ARNP notes, dated 01/15/14, revealed nine (9) residents were reviewed which included review of medications. 25. Review of the chart audits, dated 01/15/14, revealed care plans were updated according to concerns noted in SSD notes. Review of 24 resident care plans revealed they had been updated. 26. Review of the facility's education, and review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Performance Improvement Committee, Indicators, Performance Improvement Committee, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F226, F250, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation contained 116 staff signatures including the SSD. The SSD was not available for interview. 27. Review of the Morning Minute worksheet provided by the facility as the Social Services oversight revealed concerns identified were addressed. Incident report Investigations were completed by Corporate Social Services. No new incident reports were reported; however, seven (7) incidents identified were reviewed and addressed. 28. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Behavior Management, Behavior Reporting, Abuse Education, Facility Policies and Procedures for Behaviors, Performance Improvement Committee, Indicators, Performance Improvement Committee, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F223, F225, F226, F280, F282, F323, F514, Physical and Sexual behavior, reporting to Charge nurse and DCS/ED, and documentation and care plan interventions contained 116 staff signatures. Interviews with sixteen (16) facility staff members, (see #16) on 01/21/14 and 01/22/14, verified education was completed and followed by a post-test. 29. Review of the staff training signature sheets, dated 01/11/14 through 01/15/14, covering the following topics: Identification of Resident Behaviors, Emotional and Behavioral Support, Management Problems of Resident with Dementia, Behavior Monitoring, Federal Regulations F280, F282, F514, P