STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185122	A. BUILDING _____ B. WING _____	05/13/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWAY MEDICAL CENTER	1155 EASTERN PARKWAY LOUISVILLE, KY 40217

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 0164 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep each resident's personal and medical records private and confidential.** Based on observation, interviews, and review of the facility's policy, Working in Long-Term Care Setting Manual, and the Nurse's Job Description it was determined the facility failed to provide privacy during a wound treatment for one (1) of seven (7) sampled residents chosen for a wound treatment observation out of the total forty-three (43) sampled residents (Resident #17). Certified Medical Technician (CMT) #1 failed to pull the privacy curtains and close the blinds during a wound treatment for Resident #17 leaving the resident exposed. Multiple staff entered the room during the administration of the treatment, but failed to provide the resident privacy. The findings include: Review of the facility's policy for non-sterile dressing changes, not dated, revealed privacy was to be provided to the patient for dignity. The facility provided a page from the Working in Long-Term Care Setting Manual (p.16), not dated, that revealed the manual instructed staff to use privacy curtains or screens during care and procedures and close window coverings. Review of the job description for Staff Nurse/Charge Nurse, dated May 2014, revealed their responsibilities included to ensure all nursing care was provided in privacy. Review of the job description for the Unit Manager, dated June 2014, revealed they were responsible for ensuring all nursing care was provided in privacy and that nursing service personnel knocked before entering the resident's room. Review of the clinical record revealed the facility admitted Resident #17 on 03/10/15 for short term rehabilitation and assessed the resident with a Brief Interview for Mental Status (BIMS) of fifteen (15) of fifteen (15), which indicates the resident was interviewable. Record review revealed Resident #17's care plan specified wound treatments twice daily. Observation during the course of the wound treatment, on 04/01/15 at 9:05 AM, revealed a staff member came into the room and retrieved a mechanical lift from the room. The staff member did not address the resident; the resident's buttocks were exposed at this time. Further observation revealed another staff member came into the room and asked the CMT if she needed any help. Again, the staff member did not address the resident or offer to pull the privacy curtain. A rehabilitation staff came into the room while the resident's buttocks were exposed and asked when the resident would be available for his/her therapy session. Before the treatment was finished, another staff member came into the room and taped an activity calendar at the bottom of the resident's television. The staff member had to walk across the room and could see the resident's exposed buttocks. Interview with Certified Medical Technician (CMT) #1, on 04/01/15 at 9:20 AM, revealed she had forgotten to close the privacy curtain during the wound treatment. During the interview with CMT #1, she stated there were several staff members who entered the room during the wound dressing while the resident's buttocks were exposed. She stated it did not trigger her to pull the privacy curtain because she was nervous and just forgot. She stated she did not realize when staff opened the resident's door, they could see the resident's exposed buttocks. She stated she had never thought about closing the window blinds, but she should have closed them. She stated she had been trained to provide privacy during wound care dressing treatment. Interview with Resident #17, on 04/03/15 at 8:42 AM, revealed he/she was unaware the privacy curtain had not been pulled during the wound treatment because he/she had been positioned towards the wall. The resident stated he\she remembered several people knocked on the door and came into the room during the wound treatment, but he/she did not realize his\her buttocks were exposed at that time. The resident stated he\she would not have wanted this and it upset him\her to know that his/her private parts were exposed. The resident stated privacy was very important to him/her. Interview, on 04/03/15 at 9:20 AM, with Licensed Practical Nurse (LPN) #7 (the nurse who oversees the CMT for wound care) revealed the CMT received training on how to conduct wound treatments that included providing privacy during the procedure. She stated she had observed this CMT perform wound treatments and the CMT had always pulled the privacy curtain during the observed treatments. She stated she performed random audits weekly to ensure staff was knocking on residents' doors and providing privacy during care. She said she had not found any problems during her audits. LPN #7 stated privacy during wound care was very important and the privacy curtain should be pulled, but she had not thought about the windows. She stated she conducted quarterly check-off skills for non-sterile dressing change procedures with the CMTs. However, review of the skill check-off training revealed the last documented observation the nurse conducted for CMT #1 was in November 2014. Interview, on 04/03/15 at 9:00 AM, with the Second Floor Unit Manager, revealed she did walking rounds every two (2) hours to observe for staff knocking on residents' doors and providing privacy when care was provided. She stated skin and wound care rounds were conducted on Mondays and Tuesdays with the Wound Care Nurse while the CMTs performed the actual wound treatment. She stated she did not perform audits on the CMTs during wound dressing changes and she had not been told she should perform these audits. She stated the Wound Care Nurse would be directly responsible for the audits. She stated privacy should be provided during care and that would include closing the window blinds. She stated there were always people walking outside.
F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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 the facility's policy and the facility's investigations, it was determined the facility failed to have an effective system to protect residents from potential abuse after allegations of abuse were reported to staff for three (3) of forty-three (43) sampled residents (Resident #21, Resident #36 and Resident #37). On 04/01/15, the facility received an allegation of abuse involving a Certified Nursing Assistant (CNA) towards Resident #21. The allegation stated the CNA was harsh in speaking to the resident and when the resident requested to be repositioned the CNA stated she had just repositioned the resident fifteen (15) minutes ago; she would not do it again; and, left the room. The resident stated although he/she was hurting badly; he/she did not want to call the CNA again. The resident further alleged if the call light was turned on and the CNA answered, he/she would tell her it was an accident because he/she was afraid of the CNA. The resident was unable to provide staff with the CNA's name; however, the resident provided a description of the alleged perpetrator to the facility. The facility identified the CNA based on the description; however, the facility allowed the alleged perpetrator to continue to work with Resident #21 on 04/01/15 during the night shift. Immediate Jeopardy was identified on 04/03/15 and determined to exist on 04/01/15 related to Resident #21. The facility provided an acceptable Allegation of Compliance (AOC) on 04/09/15, which alleged removal of the Immediate Jeopardy on 04/09/15. However, during an abbreviated survey initiated on 04/28/15 it was determined the IJ had not been removed as alleged, on 04/09/15. Per the facility's AOC, dated 04/09/15, when an allegation of abuse was reported the Administrator/Nursing Administrator would be notified; the alleged perpetrator would be placed on Administrative leave; and, the State Agencies would be notified not to exceed twenty-four (24) hours if no injury occurred. The AOC stated all staff would be trained by 04/08/15 on the facility's Abuse policy and the Clinical and Administrative Director of Nursing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) (DONs) were trained on the policy by the Administrator on 04/03/15. Per the AOC, the Compliance Auditor or the Quality Assurance (QA) Director would audit the revised abuse allegation logs and new abuse allegation checklist weekly and the results of the audits would be brought to the QA committee. It was determined the facility failed to implement these components of the AOC after the facility self reported two more (2) abuse allegations. On 04/19/15, at approximately 9:30 AM, the facility received a second allegation of abuse involving a Certified Nursing Assistant (CNA) towards Resident #36. The allegation stated the CNA was mean and rude and threw the bed covers over the resident's head. The resident identified the alleged perpetrator by name. License Practical Nurse (LPN) #9 pulled the CNA from the resident's care, interviewed her, and then allowed the CNA to return to work caring for other residents on that unit. The alleged perpetrator cared for other residents until 11:00 AM, when the House Supervisor suspended her. On 04/26/15, the facility received a third allegation of abuse involving Outreach Technician (ORT) Restorative Aide #1 that alleged ORT Restorative Aide #1 kissed Resident #37 on the lips. CNA #24 stated he had witnessed this incident at 1:00 PM; however, he did not report what he had witnessed to the nurse. The ORT Restorative Aide continued to provide care for at least forty (40) other residents after the incident with Resident #37. The incident was not reported to the House Supervisor until 4:50 PM by LPN #10; at which time ORT Restorative Aide #1 had already left for the day. In addition, the facility failed to report the alleged sexual abuse to the State Survey Agency until 04/28/15 at 3:10 PM, approximately two (2) days after the incident. The facility's failure to protect residents from potential abuse after an allegation of abuse was reported to staff has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was determined to exist on 04/01/15. The facility provided an acceptable AOC on 05/07/15 which alleged removal of the Immediate Jeopardy on 05/06/15. The SSA verified Immediate Jeopardy was removed on 05/06/15 as alleged, prior to exit on 05/13/15 with the Scope and Severity lowered to a D while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: Review of the facility's policy regarding Abuse Prevention, Intervention and Data Collection, revised April 2015, revealed the facility would protect residents from abuse. The facility would remove any employee who was suspected of abuse immediately and place them on administrative leave during the investigation. The policy stated all employees were required to report immediately any observations, suspicions or information of suspected abuse to the nursing supervisor. After consulting with the Administrator, the supervisor would immediately report the concern to Adult Protective Services (APS) and the Office of Inspector General (OIG). However, the policy did not state who was delegated the authority to place an employee on administrative leave. 1. Review of the clinical record for Resident #21 revealed the facility admitted the resident on 03/10/15, with [DIAGNOSES REDACTED]. The facility completed an initial Minimum Data Set (MDS) on 03/14/15, and assessed the resident using the Brief Interview for Mental Status (BIMS) assessment with a score of fifteen (15) out of fifteen (15), which meant the resident was interviewable. Additionally, the facility assessed Resident #21 as requiring extensive assistance with bed mobility and transfer, which both tasks required two (2) person physical assistance; and, the resident utilized a wheelchair (w/c). Further review revealed the facility completed a Comprehensive Care Plan for Resident #21, on 03/18/15, that stated the goal was to alleviate the resident's distress, and it directed staff to always assess and incorporate non-pharmacological interventions to alleviate bed discomfort and to answer the call light in a timely manner. The Care Plan further instructed staff to reposition the resident every two (2) hours, or per the current turning schedule. In addition, the staff was to maintain the resident's comfort level. Review of Resident #21's clinical record revealed a Nurse's Note, dated 03/11/15 at 10:27 PM, that stated Resident #21 was alert and oriented times three and had left sided paralysis; was assisted with positioning; had an unequal hand grasp ability; and, was able to move the fingers of his/her left hand. However, he/she was unable to reposition the total extremity. Further review revealed a Nurse's Note, dated 03/18/15 at 1:45 PM, which stated the resident continued to receive the maximum assistance with his/her activities of daily living (ADLs) and transfers. Review of Nurse's Notes, dated 03/23/15 at 1:45 AM, revealed Resident #21 was frequently awake on the 11:00 PM to 7:00 AM shift. The resident was beginning to have sensation in his/her left lower extremity. Interview with Licensed Practical Nurse (LPN) #6, Resident #21's routine nurse, on 04/08/15 at 8:36 AM, revealed Resident #21 was awake some nights and was able to use his/her right side more than the left side of his/her body. The nurse stated the resident would moan and say he/she was stiff. Review of the facility's investigation, dated 04/01/15, revealed Unit Manager (UM) #1 spoke with Resident #21 and received an allegation that the resident asked a night shift CNA to reposition him/her. The resident stated the aide refused and he/she was afraid of the aide because she was rough with him/her. At approximately 12:50 PM on 04/01/15, the Clinical Director of Nursing (DON) was made aware of the allegation made by Resident #21 that he/she expressed fear and that the CNA spoke harshly to him/her. Further review of the investigation revealed the resident stated the incident occurred late last week, but he/she could not be specific regarding the date or time. Additionally, the facility's investigation revealed the alleged CNA in question was allowed to continue to work with Resident #21 after the allegation was made to the facility. The investigation further stated at approximately 1:05 PM on 04/01/15, the Clinical DON spoke with Resident #21, who reported that late last week he/she had leg pain and put on his/her call light to request someone to reposition him/her. The resident stated the CNA, who responded to the call light, was harsh in speaking to him/her and said she had just repositioned the resident fifteen (15) minutes ago and left the room. Additionally, the resident stated he/she was hurting badly; however, he/she did not want to call the staff member again as he/she did not know how the CNA would react. Resident #21 stated he/she was afraid of the CNA. Approximately ten (10) minutes later, the Clinical DON and the Assistant Director of Nursing (ADON) spoke with Resident #21 and received a physical description of the CNA that spoke harshly to him/her. UM #1 identified CNA #5 as the alleged perpetrator based on the description given by Resident #21. The Assistant Director of Nursing (ADON) unsuccessfully attempted to call CNA #5 on 04/01/15, at 3:15 PM. There was no documented evidence the facility removed CNA #5 from direct resident care. Further review of the facility's investigation, initiated on 04/01/15, revealed the ADON did not obtain CNA #5's statement until the end of her shift on 04/02/15 at 7:30 AM. Interview with the Clinical DON on 04/02/15 at 11:57 AM, revealed the facility unsubstantiated the allegation of abuse, on 04/06/15 because the resident could not determine when the alleged abuse occurred and with no positive identification, the alleged perpetrator denied the allegation. Per the Clinical DON, additional interviews with the resident revealed the resident was not afraid of the CNA and the CNA had taken care of the resident many times before without any problems. Review of the facility's staffing worksheets and CNA #5's time card, from 03/23/15 through 04/01/15, revealed CNA #5 worked the 11:00 PM to 7:00 AM schedule on the same unit that Resident #21 resided. She worked on 03/23/15, 03/24/15, 03/25/15, 03/26/15, 03/28/15, 03/29/15, 03/30/15, and on 04/01/15. Review of the Daily Assignment Sheets revealed CNA #5 was assigned to care for Resident #21 on 03/24/15, 03/25/15, 03/26/15, and on 04/01/15. Review of the facility's call light log revealed Resident #21's call light was activated between the hours of 11:00 PM and 7:00 AM on 03/24/15, 03/26/15, and on 04/01/15 while CNA #5 was assigned to care for the resident. Interview with Resident #21, on 04/01/15 at 2:45 PM, revealed he/she reported an incident today (04/01/15) that had occurred in the last week with a CNA. The resident stated he/she used the call light due to pain in his/her leg and he/she needed to be repositioned. Resident #21 also stated he/she was unable to get his/her leg comfortable and could not turn himself/herself. The resident stated a CNA came to the room, and stated harshly that she had just repositioned him/her fifteen (15) minutes ago and left the room. The resident further stated he/she felt intimidated and scared of the CNA and would not use the call light the rest of the night. Additionally, the resident stated he/she had seen the CNA since the night of the allegation, and if this particular CNA responded to his/her call light, the resident would say it was an accident. Resident #21 stated he/she was scared to report the incident; however, he/she was concerned the CNA may be treating other residents in the same way. The resident stated he/she reported the incident, on 04/01/15, to the Assistant Unit Manager (UM). Continued interview with Resident #21, on 04/02/15 at 9:02 AM, revealed the CNA had provided care to the resident after the incident was reported to staff the same night, on 04/01/15. The resident stated although he/she had not seen the CNA's badge, he/she knew the CNA's name began with the letter R. The resident then gave a description of the CNA that matched the description reported to UM #1 on 04/01/15. Interview, on 04/02/15 at 9:26 AM, with the Assistant UM revealed he received an allegation from Resident #21 on 04/01/15. He stated the resident reported he/she was in pain last week, used the call light and asked to be repositioned. The Assistant UM stated the resident also reported that the CNA who responded to his/her call light, told him/her that she had just repositioned him/her and she would not do it again. He further stated the resident told him, he/she used the call light again and when the same CNA responded, he/she told the CNA the call light was an accident. He stated Resident #21 gave a description of the CNA. The Assistant UM stated CNA #5 was the only person he was aware of that matched the resident's description of the CNA. The Assistant UM stated CNA #5 worked the night shift on 04/01/15. He further stated he reported Resident #21's allegation to the UM #1 immediately. Interview, on 04/02/15 at 12:20 PM, with Unit Manager (UM) #1 revealed she received a report, on 04/01/15 around 12:50 PM to 1:00 PM

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) from the Assistant UM of the allegation regarding Resident #21. She stated she spoke with Resident #21 at that time and the resident reported that in the last week he/she could not get his/her leg comfortable and asked to be turned. UM #1 stated the resident reported he/she was told by the CNA that she had just turned him/her about fifteen (15) minutes ago and was not going to turn him/her again. The resident stated that he/she felt intimidated and gave a description of the CNA. The UM stated CNA #5 was the only CNA she was aware of who matched the description given by Resident #21. She further stated after she spoke to Resident #21, she reported the allegation to the Clinical DON and provided the Clinical DON the name of CNA #5 as the person she (the UM) was aware of that matched the description provided by Resident #21. UM #1 stated CNA #5 worked the night of 04/01/15, which began at 11:00 PM. Further interview with the UM, on 04/03/15 at 9:08 AM, revealed she did not have the authority to place staff on administrative leave; however, continued interview revealed the DONs, ADON, ADM, and House Supervisor had the authority to place staff on administrative leave. The resident reported the allegation of abuse during the dayshift when the DONs were present in the building. Per interview, the allegation was reported to them appropriately, but the Clinical DON delayed in suspending the CNA because the resident could not determine when the allegation occurred and could not give a name. Review of the Abuse Policy revealed it did not state who had the authority to place an employee on administrative leave. Interview, on 04/01/15 at 2:07 PM, with the Clinical DON, regarding the allegation, revealed the facility received an allegation from Resident #21. She stated the resident reported, on 04/01/15, that he/she had leg pain during the last week and had been using the call light for pain medication and assistance with positioning. The Clinical DON further stated the resident reported the CNA spoke harshly, and told him/her that she had repositioned the resident fifteen (15) minutes ago and walked out of the resident's room. She stated the resident gave a description of the CNA and stated he/she was afraid of that CNA. Continued interview on 04/02/15, at 12:37 PM revealed the Clinical DON and the ADON spoke to the resident again, about ten (10) minutes later for a description of the CNA. She stated CNA #5 matched the description given by the resident, and was the only CNA she was aware of that met that description. However, even with this knowledge, the Clinical DON failed to remove CNA #5 from direct resident care. Continued interview with the Clinical DON on 04/02/15 at 12:37 PM, revealed CNA #5 worked the night of 04/01/15 and was scheduled to work again on 04/02/15. She stated when there was an allegation against a staff member the alleged perpetrator would be placed on administrative leave. However, interview and record review revealed CNA #5 was allowed to continue to work the shift and worked the next scheduled shift before being suspended on 04/02/15. Interview with the Clinical DON, on 04/02/15 at 1:27 PM, revealed the purpose of protecting a resident during an investigation was to keep the incident from happening again. She stated Resident #21 had been protected as the facility was extra vigilant to make sure the resident was okay; however, she would not give an explanation of what vigilant meant. The Clinical DON further stated she did not suspect any staff member had done anything to Resident #21. She stated a staff member would be placed on administrative leave immediately if the facility suspected the individual of abuse. During this interview, she stated that she, the Administrative DON, ADON, Administrator, or Human Resources (HR) could decide if an employee would be placed on administrative leave. The Clinical DON stated CNA #5 had not been placed on administrative leave as the facility did not suspect she had done any harm to Resident #21. She stated the CNA had worked with the resident before the allegation and after the allegation was made and the resident had not voiced any additional complaints about the CNA since the allegation was made on 04/01/15. The Clinical DON further stated Resident #21 had a psychiatric history, and she did not believe the CNA did what Resident #21 alleged. Interview, on 04/02/15 at 2:58 PM, with the Clinical DON revealed CNA #5 was not suspected of abuse. She stated she spoke with the Assistant UM and UM #1 on 04/01/15. She stated when she received the allegation from UM #1, the UM did not say if any staff matched the description the resident had provided and she (the Clinical DON) did not ask. The Clinical DON stated Resident #21 gave a description of the CNA; however, she did not follow-up with the Assistant UM or UM #1 to determine if anyone matched that description. Interview, on 04/02/15 at 12:54 PM, with the ADON revealed she was aware on 04/01/15, during the afternoon, of the allegation related to Resident #21. The ADON further stated she spoke with Resident #21 on 04/01/15, who reported the CNA seemed irritated when he/she used the call light to be repositioned. She stated the ADON gave a description of the CNA and she was aware of only one (1) CNA that worked on that unit that matched the description given by Resident #21; that was CNA #5. However, even with this knowledge, the ADON failed to remove CNA #5 from direct resident care, as per policy, to protect the residents. Continued interview with the ADON on 04/02/15 at 12:54 PM, revealed she spoke with CNA #5, on 04/02/15 at 7:30 AM, after she (CNA #5) worked the night shift on 04/01/15. The ADON further stated when the facility received an allegation of abuse against a staff member, the staff would be placed on administrative leave until the investigation was completed to protect the residents. She stated the purpose of the investigation was to determine if staff should be working in the facility. She stated CNA #5 had not been placed on administrative leave at that time. The ADON stated the Clinical DON was responsible to determine if a staff member should be placed on administrative leave. She further stated the Clinical DON was responsible to conduct the investigation; however, she (the ADON) would assist. Interview with CNA #5, on 04/03/15 at 8:40 AM, revealed she worked the night shift, at 11:00 PM, and always worked with Resident #21. She stated the resident would voice complaints of his/her leg hurting, because the resident's left leg was paralyzed. The CNA stated the resident would say he/she had laid on that side too long. She further stated Resident #21 was turned and repositioned every two (2) hours, and the resident would often ask to be repositioned again. CNA #5 stated she could not recall an incident with Resident #21. She further stated the ADON was at the facility and had waited for her to come to work on the 11:00 PM shift. The ADON did not talk with her until 7:30 AM after the shift was over on 04/02/15. However, she was not placed on administrative leave until around 10:53 PM last night (04/02/15) before the shift started. Review of the staffing sheets revealed CNA #5 was assigned to care for Resident #21 on 04/02/15. Interview, on 04/02/15 at 2:20 PM, with the Administrative DON revealed the Clinical DON was responsible for the investigation, with the ADON's assistance. She stated residents were protected during an investigation as the staff member would not be allowed back to work with the residents and would be placed on administrative leave, pending the outcome of the investigation. Further interview revealed the Administrative DON was not aware CNA #5 was identified as the alleged perpetrator at the time the allegation was reported. She stated the facility could not place everyone on leave when an alleged perpetrator was not identified. She further stated she was not involved in the investigation, and had not spoken to the Assistant UM or UM #1, but she knew they were aware of the allegation. Further interview revealed CNA #5 had worked last night (04/01/15) after the allegation was reported. The Administrative DON stated she was unsure of the reason why CNA #5 had not been placed on administrative leave if staff knew she was the alleged perpetrator. She further stated if a staff member was not placed on administrative leave, the resident would feel intimidation if the same staff member worked with him/her. Interview with the Administrator, on 04/02/15 at 3:35 PM, revealed he knew about the allegation on 04/01/15, but was unaware that the staff knew the name of the alleged perpetrator. Per interview, until the facility determined who the perpetrator was, it was not possible to suspend the entire staff; however, if there was a positive identification of a staff member, that person would be removed immediately. The Administrator stated he assumed the Clinical DON spoke to the Assistant UM and UM #1 on 04/01/15. He further stated he was not aware only one staff member matched the description given by Resident #21 and he was not aware at the time the allegation was made that the Assistant Unit Manager knew the alleged perpetrator was CNA #5. The Administrator stated the purpose of the investigation was to prevent abuse from occurring and prevent a staff member, who had an allegation voiced against them from working with the resident or working in general. He stated if a staff member was not placed on administrative leave, at a minimum, the staff member might be intimidating to a resident. Continued interview with the Administrator, on 04/02/15 at 3:35 PM, revealed he spoke with Resident #21 today (04/02/15) and the resident told him he/she was uncomfortable and in pain and had used the call light several times to be repositioned (referring to the date of the incident). The Administrator stated the resident told him that the CNA said she had just been there fifteen (15) minutes ago. He stated the resident also told him he/she felt afraid and intimidated. He/She did not use the call light any more that night. He also stated the resident told him the aide worked last night (04/01/15). Further interview with the Administrator, on 04/03/15 at 9:30 AM, revealed he had determined the night before on 04/02/15, that the Clinical DON had been informed of a staff member that matched the description given by Resident #21 on 04/01/15. He stated CNA #5 had been suspended the evening of 04/02/15 by the Clinical DON. 2. Review of the clinical record revealed the facility admitted Resident #36 on 06/02/13. The resident's [DIAGNOSES REDACTED]. Review of the most current Minimum Data Set (MDS) assessment, (a quarterly) dated 02/23/15, revealed the facility assessed the resident using the Brief Interview for Mental Status (BIMS) to have a score of ten (10) out of fifteen (15), which meant the resident had some cognition impairment but was still considered to be interviewable. Additionally, the facility assessed Resident #36 as requiring extensive assistance with bed mobility and transfer, requiring two (2) person physical assistance; the resident was non-ambulatory

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) utilizing a wheelchair. Further review revealed the facility assessed the resident to be occasionally incontinent of bladder and required the extensive assist from staff with toileting needs. Review of the Comprehensive Care Plan dated 06/14/13, revealed the resident had short/long term memory problems and the goal was for the resident to continue to interact with others and participate in care daily. The care plan instructed staff to approach the resident warmly and positively and in a calm manner. Review of the facility's investigation, initiated on 04/20/15, revealed the Certified Medication Technician (CMT) #2 received an allegation of physical abuse from Resident #36 on 04/19/15. The resident alleged CNA #22 had thrown the bed covers over his/her head and the aide was mean and rude to the resident. The investigation did not specify the definition of mean and rude. The investigation revealed the CMT reported the allegation to LPN #9 and she obtained a written statement from CNA #22. The documented interview with LPN #9 stated CNA #22 switched residents with another aide and was allowed to work with other residents after the abuse allegation was received. The investigation revealed the Clinical DON was notified of the abuse allegation, on 04/19/15 at approximately 10:00 AM. Further review of the abuse investigation revealed Resident #36 was interviewed by the Clinical DON, on 04/20/15 at 3:00 PM. At this time, the resident again reported to staff that the aide threw the bed covers over his/her head and said something the resident didn't like. The Clinical DON interviewed CNA #22 at 3:13 PM via telephone, where she denied the allegation. However, the Clinical DON failed to interview the House Supervisor to determine when the aide was suspended and did not interview further to determine that CNA #22 was allowed to care for other residents. The five (5) day follow up report, dated 04/27/15, revealed the facility found the allegation of mistreatment of [REDACTED]. The report indicated the aide had been placed on administrative leave at the time of the allegation. However, review of the facility's time card report revealed CNA #22 continued to work after the allegation was reported. Review of the facility's staffing worksheets and CNA #22's time card, for 04/19/15, revealed CNA #22 worked 7:00 AM to 11:00 AM on the unit where Resident #36 resided. Resident #36 reported the allegation of abuse at approximately 9:30 AM. Interview with Resident #36, on 04/28/15 at 12:46 PM, revealed he/she could not recall any incident where a facility staff was rough or mean. The resident stated he/she did not recall any incident where staff had pulled the bed covers over his/her head. A family member was present during the interview and stated the resident's memory was not always good but the resident had reported to the family someone had pulled a sheet over his/her head. The resident had told the family member he/she had not seen that aide again. The family member stated the facility had not interviewed her regarding any knowledge of the incident. Further interview with the family member revealed the resident appeared to be more upset since the incident, whereas the resident was calm before; however, she did not think the resident was afraid of anyone. Interview, on 04/28/15 at 3:29 PM, with CMT #2 who received the allegation of abuse from Resident #36, revealed she was passing medications on 04/19/15 sometime between 9:00 AM-10:00 AM. When she took Resident #36's medications into the room, the resident told her CNA #22 was mean and rude and had pulled the bed covers over the resident's head. The resident told her the aide appeared to be angry. The CMT reported the allegation to LPN #9. She returned to the resident's room with LPN #9 and the resident told her the same story; the aide was mean and rude and had pulled the covers over his/her head. Interview with CMT #3, on 04/28/15 at 3:20 PM, revealed she was working the other side of the unit when CMT #2 came to her and reported there was a problem. She stated it was a few hours into the day shift (7 AM-3 PM). She said CMT #2 reported Resident #36 told her CNA #22 had been rude and mean to him/her and threw the covers over the resident's head. CMT #3 did not specify what the resident meant by rude and mean. CMT #2 told her the aides would have to switch teams, but before they could do that, LPN #9 came onto the floor. She went with CMT#2 and LPN #9 to interview Resident #36. When LPN #9 asked the resident what happened, the resident told them CNA #22 had been rude and threw the covers over his/her head. She stated the House Supervisor was notified then came to the floor and told CNA #22 she had to leave. This was before lunch. She thought the House Supervisor started the investigation. A telephone interview with LPN #9, on 04/29/15 at 9:42 AM, revealed she had worked on 04/19/15 as the LPN Supervisor for the sixth and seventh floors. She stated when she came to the seventh floor, CMT #2 reported what the resident had told her during the medication pass. She then went into Resident #36's room with CMT#2 and CMT #3 to interview the resident. The resident told them the same story that CNA #22 was mean and rude and pulled the covers over his/her head. In addition, the resident told them the aide refused to get him/her a tissue. She stated she then went and found CNA #22 in another resident's room providing care. That was between 9:00 AM-10:00 AM. She took the aide to the nurse's station and interviewed her. She obtained a written statement then she told the aide not to go back into Resident #36's room. She said she reassigned Resident #36's care to CNA #23; however, CNA #22 continued to care for all the other residents that were assigned to her that day. She stated she notified the House Supervisor of the incident and when she came onto the floor, she told CNA #22 she had to clock out and go home. She said the aide provided care to other residents until then because she did not have the authority to suspend any staff. Review of the Abuse Policy revealed it did not state who had authority to suspend an employee during an investigation. Telephone interview with CNA #23, on 04/29/15 at 10:58 AM, revealed around 10:00 AM on 04/19/15, she was told by LPN #9 she had to take over the care of Resident #36. She stated LPN #9 told her there had been an allegation against CNA #22 and she could no longer care for that resident. She stated the aide (CNA #22) provided care to other residents assigned to her until the House Supervisor came onto the floor and told her to go home. She stated it was about an hour from when she was told to care for Resident #36 and when the aide was sent home. Telephone interview with the House Supervisor, on 04/29/15 at 11:12 AM, revealed she received a report from LPN #9 that Resident #36 alleged CNA #22 was rude and unprofessional and threw the covers over the resident's head. She said LPN #9 reported the aide denied the allegation. She text the Clinical DON and informed her of the allegation. She said she went to the unit and told the aide she had to go home. She did not watch the aide clock out. She stated LPN #9 had interviewed the aide and obtained a written statement. Therefore, she did not interview the aide again and did not interview the resident. She stated she had not interviewed any staff. She stated she was not aware of any change in assignments and was not aware the aide had cared for other residents after the abuse allegation was received. She stated it was sometime before lunch when she came onto the floor and sent the aide home. She completed the Unusual Occurrence Report and stated it was her responsibility to start the investigation
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 interview, record review, and review of the facility's policy, investigations, and the acceptable Allegation of Compliance (AOC) dated 04/09/15, it was determined the facility failed to have an effective system in place to ensure staff followed its policy for the protection of residents during abuse investigations for three (3) of forty-three (43) sampled residents (Resident #21, Resident #36, and Resident #37). (Refer to F225) On 04/01/15, the facility received an allegation of abuse involving a Certified Nursing Assistant (CNA) towards Resident #21. The allegation stated the CNA was harsh in speaking to the resident and when the resident requested to be repositioned the CNA stated she had just repositioned the resident fifteen (15) minutes ago; she would not do it again; and, left the room. The resident stated although he/she was hurting badly; he/she did not want to call the CNA again. The resident further alleged if the call light was turned on and the CNA answered, he/she would tell her it was an accident because he/she was afraid of the CNA. The resident was unable to provide staff with the CNA's name; however, the resident provided a description of the alleged perpetrator to the facility. The facility identified the CNA based on the description; however, the facility allowed the alleged perpetrator to continue to work with Resident #21 on 04/01/15 during the night shift. Immediate Jeopardy was identified on 04/03/15 and determined to exist on 04/01/15 related to Resident #21. The facility provided an acceptable Allegation of Compliance (AOC) on 04/09/15, which alleged removal of the Immediate Jeopardy on 04/09/15. However, during an abbreviated survey initiated on 04/28/15 it was determined the IJ had not been removed as alleged, on 04/09/15. Per the facility's AOC, dated 04/09/15, when an allegation of abuse was reported the Administrator/Nursing Administrator would be notified; the alleged perpetrator would be placed on Administrative leave; and, the State Agencies would be notified not to exceed twenty-four (24) hours if no injury occurred. The AOC stated all staff would be trained by 04/08/15 on the facility's Abuse policy and the Clinical and Administrative Director of Nursing (DONs) were trained on the policy by the Administrator on 04/03/15. Per the AOC, the Compliance Auditor or the Quality Assurance (QA) Director would audit the revised abuse allegation logs and new abuse allegation checklist weekly and the results of the audits would be brought to the QA committee. It was determined the facility failed to implement these components of the AOC after the facility self reported two more (2) abuse allegations. On 04/19/15, at approximately 9:30 AM, the facility received a second allegation of abuse involving a Certified Nursing Assistant (CNA) towards Resident #36. The allegation stated the CNA was mean and rude and threw the bed covers over the

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	185122	A. BUILDING _____ B. WING _____	05/13/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWAY MEDICAL CENTER	1155 EASTERN PARKWAY LOUISVILLE, KY 40217

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 -** Few	(continued... from page 4) resident's head. The resident identified the alleged perpetrator by name. License Practical Nurse (LPN) #9 pulled the CNA from the resident's care, interviewed her, and then allowed the CNA to return to work caring for other residents on that unit. The alleged perpetrator cared for other residents until 11:00 AM, when the House Supervisor suspended her. On 04/26/15, the facility received a third allegation of abuse involving Outreach Technician (ORT) Restorative Aide #1 that alleged ORT Restorative Aide #1 kissed Resident #37 on the lips. CNA #24 stated he had witnessed this incident at 1:00 PM; however, he did not report what he had witnessed to the nurse. The ORT Restorative Aide continued to provide care for at least forty (40) other residents after the incident with Resident #37. The incident was not reported to the House Supervisor until 4:50 PM by LPN #10; at which time ORT Restorative Aide #1 had already left for the day. In addition, the facility failed to report the alleged sexual abuse to the State Survey Agency until 04/28/15 at 3:10 PM, approximately two (2) days after the incident. The facility's failure to protect residents from potential abuse after an allegation of abuse was reported to staff has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was determined to exist on 04/01/15. The facility provided an acceptable AOC on 05/07/15 which alleged removal of the Immediate Jeopardy on 05/06/15. The SSA verified Immediate Jeopardy was removed on 05/06/15 as alleged, prior to exit on 05/13/15 with the Scope and Severity lowered to a D while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: Review of the facility's policy regarding Abuse Prevention, Intervention and Data Collection, revised April 2015, revealed the facility would protect residents from abuse. The facility would remove any employee who was suspected of abuse immediately and place on administrative leave during the investigation. The policy stated all employees were required to report immediately any observations, suspicions or information of suspected abuse to the nursing supervisor. After consulting with the Administrator, the supervisor would immediately report the concern to Adult Protective Services (APS) and the Office of Inspector General (OIG). However, the policy did not state who was designated with the authority to suspend an employee during an investigation. 1. Review of the facility's investigation, dated 04/01/15, revealed Unit Manager (UM) #1 spoke with Resident #21 and received an allegation that the resident asked a night shift CNA to reposition him/her. The resident stated the aide refused and he/she was afraid of the aide because she was rough with him/her. At approximately 12:50 PM on 04/01/15, the Clinical Director of Nursing (DON) was made aware of the allegation made by Resident #21 (the resident expressed fear of the CNA and that the CNA spoke harshly). The resident stated the incident occurred late last week, but he/she could not be specific regarding the date or time. Additionally, the facility's investigation revealed the alleged CNA in question was allowed to continue to work with Resident #21 after the allegation was made. The investigation further stated at approximately 1:05 PM on 04/01/15, the Clinical DON spoke with Resident #21, who reported that late last week he/she had leg pain and put on his/her call light to request someone to reposition him/her. The resident stated the CNA who responded to the call light was harsh in speaking to him/her and told him/her that she had just repositioned the resident fifteen (15) minutes ago and left the room. Additionally, the resident stated he/she was hurting badly; however, he/she did not want to call the staff member again as he/she did not know how the CNA would react. Resident #21 stated he/she was afraid of the CNA. Approximately ten (10) minutes later, the Clinical DON and the Assistant Director of Nursing (ADON) spoke with Resident #21 and received a physical description of the CNA. UM #1 identified CNA #5, as the alleged perpetrator based on the description given by Resident #21. The Assistant Director of Nursing (ADON) attempted to call CNA #5 on 04/01/15, at 3:15 PM; however, the ADON was not able to speak to CNA #5 to obtain her statement. Review of the investigation revealed no documented evidence the facility removed CNA #5 from direct resident care. Review of the time card report revealed CNA #5 continued to work the shift and worked the next scheduled shift. Although the Abuse policy stated the employee would be suspended immediately. Further review of the facility's investigation, initiated on 04/01/15, revealed the ADON didn't obtain CNA 5's statement until the end of her shift on 04/02/15 at 7:30 AM. Interview with CNA #5, on 04/04/15, revealed Resident #21 apologized when he/she used his/her call light. However, review of the facility's investigation revealed a statement was not obtained from the Assistant UM, who initially received the allegation and there were no other statements obtained from the UM when the allegation was initially reported. The facility unsubstantiated the allegation of abuse, on 04/06/15. Interview with Resident #21, on 04/01/15 at 2:45 PM, revealed he/she reported an incident today (04/01/15) that had occurred in the last week with a CNA. The resident stated the call light was turned on due to pain in his/her leg and the need to be repositioned. The resident stated a CNA came to the room, and stated harshly that she had just repositioned him/her fifteen (15) minutes ago and left the room. The resident further stated he/she felt intimidated and scared of that CNA and would not use the call light the rest of the night. Additionally, the resident stated he/she had seen the CNA since the night of the incident, and if this particular CNA would respond to the call light, he/she (the resident) would say it was an accident. Resident #21 stated he/she was scared to report the incident; however, he/she was concerned the CNA may be treating other residents the same way. The resident reported the allegation on 04/01/15 to the Assistant Unit Manager (UM). Continued interview with Resident #21, on 04/02/15 at 9:02 AM, revealed he/she saw the CNA the previous night, on 04/01/15. Review of CNA #5's time card revealed the CNA worked the 11:00 PM to 7:00 AM shift on 04/01/15. Review of the staffing worksheets and the Daily Assignment Sheets, revealed CNA #5 worked on the same unit Resident #21 resided and was also assigned to care for Resident #21 on 04/01/15 (after the allegation was made). In addition, review of the facility's call light log revealed Resident #21's call light was activated between the hours of 11:00 PM and 7:00 AM on 04/01/15. Interview, on 04/02/15 at 9:26 AM, with the Assistant UM revealed he received a complaint from Resident #21 on 04/01/15 that a CNA would not reposition him/her when he /she was in pain. He stated Resident #21 gave a description of the CNA. Per interview, CNA #5 was the only person he was aware of that matched the description given by Resident #21. The Assistant UM stated he reported Resident #21's allegation to UM #1 immediately. The Assistant UM stated CNA #5 continued to work the night shift on 04/01/15, after the resident had reported the allegation. On 04/02/15 at 12:20 PM, interview with UM #1 revealed she received a report from the Assistant UM, on 04/01/15 around 12:50 PM to 1:00 PM, of an allegation regarding Resident #21. She stated she spoke with Resident #21 and the resident reported the allegation to her. UM #1 stated he/she felt intimidated and gave a description of the CNA. The UM stated CNA #5 was the only CNA she was aware of who matched the description given by Resident #21. She further stated after she spoke to Resident #21, she reported the allegation to the Clinical DON on 04/01/15, and gave the Clinical DON the name of CNA #5 as the person she (the UM) was aware of that matched the description provided by the resident. Per interview, CNA #5 was not placed on administrative leave, per the facility's policy, and worked the night of 04/01/15, which began at 11:00 PM. Interview, on 04/01/15 at 2:07 PM; and, on 04/02/15 at 12:37 PM, with the Clinical DON revealed the facility received an allegation from Resident #21. She spoke to Resident #21 on 04/01/15 around 1:00 PM and the resident reported a CNA was rude and spoke harshly to him/her during the night and felt the CNA did not want to reposition him/her. The Clinical DON stated Resident #21 reported he/she was afraid of the CNA. Further interview with the Clinical DON revealed she and the ADON spoke to the resident again, about ten (10) minutes later for a description of the CNA. She stated CNA #5 matched the description given by the resident, and was the only staff member she was aware of that met that description. She stated when there was an allegation against a staff member the alleged perpetrator would be placed on administrative leave, as per policy. However, per interview and record review, CNA #5 was not removed from resident care per the facility's policy. Further interview with the Clinical DON revealed CNA #5 worked the night of 04/01/15 (11 PM-7 AM) and was also scheduled to work the night of 04/02/15. Interview, on 04/01/15 at 12:54 PM, with the ADON revealed she was made aware on 04/01/15, during the afternoon, of the allegation related to Resident #21. She stated the Clinical DON was responsible to conduct the investigation; however, she (the ADON) was assisting her in the investigation. The ADON further stated she spoke with Resident #21 on 04/01/15, who reported the CNA seemed irritated when she used the call light to be repositioned, and gave a description of the CNA. She stated she was aware of only one (1) CNA that worked on that unit and matched the description given by Resident #21. The ADON further stated when the facility received an allegation of abuse against a staff member, that staff member would be placed on administrative leave until the investigation was completed to protect the resident. The ADON stated the Clinical DON was responsible to determine if a staff member should be placed on administrative leave. She further stated CNA #5 had not been placed on administrative, even though the facility's policy stated the facility would protect residents and/or anyone reporting abuse by placing any employee who was investigated for abuse on administrative leave or be reassigned during the investigation. Continued interview with the Clinical DON, on 04/02/15 at 1:27 PM, revealed she, the Administrative DON, ADON, Administrator, or Human Resources (HR) could decide if an employee would be placed on administrative leave. The Clinical DON stated CNA #5 had not be placed on administrative leave after the allegation was reported because she did not suspect the CNA had done any harm to Resident #21. Per interview, Resident #21 had a psychiatric history, and she did not believe the CNA did what Resident #21 alleged. She further stated if a staff

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) member had abused a resident and was not placed on administrative leave, the resident could be further harmed, or other residents could experience the same abuse. On 04/02/15 at 2:20 PM, interview with the Administrative DON revealed the Administrative team was not made aware the Clinical DON had knowledge of the CNA's name at the time the allegation was reported and she was unsure of the reason the Clinical DON had not been placed CNA #5 on administrative leave, per the facility's policy. Continued interview, on 04/02/15 at 2:58 PM, with the Clinical DON stated she did not suspect CNA #5 of abuse and therefore the CNA was not placed on administrative leave. The Clinical DON stated the facility did not follow its policy to place any employee who was investigated for abuse on administrative leave. The Clinical DON stated if a staff member was not placed on administrative leave, the resident could be harmed. Interview with the Administrator, on 04/02/15 at 3:35 PM, revealed at the time the allegation was reported to him, the facility was not sure who the alleged perpetrator was, and until that was determined it was not possible to suspend the entire staff; however, if there was a positive identification of a staff member, that person would be removed immediately. The Administrator stated he was not aware only one staff member matched the description given by Resident #21 until the day of 04/02/15. The Administrator stated if the alleged perpetrator was identified and not placed on administrative leave, then the facility did not follow it's policy to protect residents during an investigation. Continued interview with the Administrator, on 04/03/15 at 9:30 AM, revealed in the evening hours of 04/02/15, the facility determined the Clinical DON had been informed of the name of a CNA that matched the description given by Resident #21, and CNA #5 had been suspended on 04/02/15. 2. Review of the facility's investigation, initiated on 04/20/15, revealed Certified Medication Tech (CMT) #2 received an allegation of physical abuse from Resident #36 on 04/19/15. The resident alleged CNA #22 had thrown the bed covers over the resident's head and the aide was mean and rude to the resident. The investigation revealed the CMT reported the allegation to LPN #9 and she obtained a written statement from CNA #22. The documented interview with LPN #9 stated CNA #22 was switched where she did not care for Resident #36, but was allowed to work with other residents after the abuse allegation was received. The investigation revealed the Clinical DON was notified of the abuse allegation on 04/19/15 at approximately 10:00 AM. Further review of the abuse investigation revealed Resident #36 was interviewed by the Clinical DON, on 04/20/15 at 3:00 PM, where the resident again reported the aide threw the bed covers over his/her head and said something the resident didn't like. The Clinical DON interviewed CNA #22 at 3:13 PM via telephone where she denied the allegation. However, the Clinical DON failed to interview the House Supervisor to determine when the aide was suspended and did not interview further to determine that CNA#22 was allowed to care for other residents. The five (5) day follow up report, dated 04/27/15, revealed the facility found the allegation of mistreatment to be substantiated. The report stated the aide had been placed on administrative leave at the time of the allegation. Review of the facility's staffing worksheets and CNA #22's time card, for 04/19/15, revealed CNA #22 worked 7:00 AM to 11:00 AM on the unit where Resident #36 resided. Interview with Resident #36, on 04/28/15 at 12:46 PM, revealed she could not recall any incident where a facility staff was rough or mean or an incident where staff had pulled the bed covers over his/her head. A family member was present during the interview and stated the resident's memory was not always good, but the resident had reported to the family that someone had pulled a sheet over his/her head. The resident had told the family member he/she had not seen that aide again. Further interview with the family member revealed the facility had not interviewed her regarding any knowledge of the incident. According to the family member, the resident appeared to be more upset since the incident, whereas the resident was calm before, but she did not think the resident was afraid of anyone. Interview, on 04/28/15 at 3:29 PM, with CMT #2 who received the allegation of abuse from Resident #36, revealed she was passing medications on 04/19/15 sometime between 9:00 AM-10:00 AM. When she took Resident #36's medications into the room, the resident told her CNA#22 was mean and rude and pulled the bed covers over the resident's head. The resident told her the aide appeared to be angry. The CMT reported the allegation to LPN #9. She returned to the resident's room with LPN#9 and the resident told them the same story. Interview with CMT #3, on 04/28/15 at 3:20 PM, revealed she was working the other side of the unit when CMT #2 came to her and reported there was a problem. She stated it was a few hours into the day shift (7 AM-3 PM). She said CMT #2 reported Resident #36 told her CNA #22 had been rude and mean to him/her and threw the covers over the resident's head. CMT #2 told her the aides would have to switch teams, but before they could do that, LPN #9 came onto the floor. She went with CMT #2 and LPN #9 to interview Resident #36. When LPN #9 asked the resident what happened, the resident told them CNA #22 had been rude and threw the covers over his/her head. She stated the House Supervisor was notified and came to the floor and told CNA #22 she had to leave. This was before lunch. She thought the House Supervisor started the investigation. Telephone interview with LPN #9, on 04/29/15 at 9:42 AM, revealed she had worked on 04/19/15 as the LPN Supervisor for the sixth and seventh floors. She stated when she came to the seventh floor, CMT #2 reported what the resident had told her during the medication pass. She then went into Resident #36's room with CMT#2 and CMT #3 to interview the resident. The resident told them the same story related to CNA #22. In addition, the resident told them the aide refused to get him/her a tissue. She stated she then went and found CNA #22 in another resident's room providing care. That was between 9:00 AM-10:00 AM. She took the aide to the nurse's station and interviewed her. She obtained a written statement then she told the aide not to go back into Resident #36's room. She said she reassigned Resident #36's care to CNA #23; however, CNA #22 continued to care for all the other residents that were assigned to her that day. She stated she notified the House Supervisor of the incident and when she came onto the floor, she told CNA #22 she had to clock out and go home. She said the aide provided care to other residents until then, because she did not have the authority to suspend any staff. Telephone interview with CNA #23, on 04/29/15 at 10:58 AM, revealed around 10:00 AM on 04/19/15, she was told by LPN #9 she had to take over the care for Resident #36. She stated LPN #9 told her there had been an allegation against CNA #22 and she could no longer care for that resident. She stated the CNA had provided care to the other residents assigned to her until the House Supervisor came onto the floor and told her to go home. She stated it was about an hour from when she was told to care for Resident #36 and when the aide was sent home. Interview with the House Supervisor, via telephone, on 04/29/15 at 11:12 AM, revealed she received a report from LPN #9 that Resident #36 alleged CNA #22 was rude and unprofessional and threw the covers over the resident's head. She said LPN #9 said the aide denied the allegation. She texted the Clinical DON and informed her of the allegation. She stated she went to the unit and told the aide she had to go home. She did not watch the aide clock out. She stated LPN #9 had interviewed the aide and obtained a written statement. Therefore, she did not interview the aide again and did not interview the resident. She revealed she had not interviewed any staff. She stated she was not aware of any change in assignments and was not aware the aide had cared for other residents after the abuse allegation was received. She stated it was sometime before lunch when she came onto the floor and sent the aide home. She completed the Unusual Occurrence Report. Telephone interview with CNA #22, on 04/28/15 at 5:25 PM, revealed she had been assigned to Resident #36 on 04/19/15. She stated around 9:00 AM, she went in to dress the resident. She was putting the resident's support stockings and shoes on when the resident said he/she had to use the toilet. She told the resident he/she would have to wait until she got someone to help her because the resident was a two-person assist with transfers. She stated the resident starting cursing her, calling her a [***] , and telling her how to do her job. She stated she removed the resident's support stockings and placed them in the resident's wheelchair. She laid the resident back down (the resident was sitting on the side of the bed) and placed the bed covers over the resident up to the neck. She stated she wanted to let the resident calm down and then she was going to return with help. CNA #22 stated at approximately 9:30 AM, LPN #9 came and informed her of the allegation and requested her to provide a written statement, which she did. After she had written the statement, she continued to care for her other assigned residents. She said she went back into Resident #36's room and took the roommate to the bathroom; this occurred after she had been informed of the allegation. She states she did not provide care for Resident #36, but she did provide care for his/her roommate. She stated LPN #9 assisted her with taking the roommate to the bathroom; however, LPN #9 denied this allegation. She stated around 11:00 AM the House Supervisor came onto the floor and told her to clock out and go home. Interview with the Clinical DON, on 04/29/15 at 4:05 PM, revealed the allegation was reported to her via text from the House Supervisor at 10:11 AM on 04/19/15. She stated she told the House Supervisor to suspend the aide immediately. She stated it was the facility's practice to suspend staff during an abuse investigation. She stated the House Supervisor was the only staff that had the authority to suspend someone during the weekends and they had to call the DONs. She stated supervisors and staff nurses could not suspend staff. Further interview with the Clinical DON revealed she conducted the abuse investigation. She stated she did know that CNA #22 had not been removed from patient care immediately and that she had been allowed to care for other residents after the abuse allegation was reported. She reviewed her text messages and stated that she had texted the House Supervisor at 10:16 AM to suspend the aide. She stated her expectations would be the aide should have been held at the nurse's station until the House Supervisor came onto the floor. However, she stated she had not asked about this during her investigation and she had no reason to review CNA #22's time card. Review of the

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	185122	A. BUILDING _____ B. WING _____	05/13/2015

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PARKWAY MEDICAL CENTER	1155 EASTERN PARKWAY LOUISVILLE, KY 40217

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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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) Activity of Daily Living (ADL) care tracker information for 04/19/15 revealed CNA #22 documented cared for other residents until 10:52 AM, several hours after the allegation was reported. 3. Review of the clinical record for Resident #37 revealed the resident had resided at the facility since January 2011. Review of the most current [DIAGNOSES REDACTED]. Review of the MDS assessment, dated 03/17/15, revealed the facility assessed the resident to have a BIMS score of eleven (11) out of possible fifteen (15) which meant the resident was interviewable. No behaviors were noted and the facility assessed the resident to need limited assist of one-person for transfers and ambulation. Interview with Resident #37, on 04/29/15 at 12:38 PM, revealed when the resident was asked if any staff had been inappropriate with him/her, the resident replied, Yes, and named the ORT by name. The resident said the ORT had kissed him/her on the mouth and pointed to the lips. The resident stated the kiss occurred in the resident's room when the resident was getting ready to walk with the ORT. The resident said a nurse had seen the ORT kissing him/her. Further interview with the resident revealed the ORT had not kissed him/her before and the resident was surprised. Interview with ORT Restorative Aide #1, on 04/29/15 at 1:00 PM, revealed he denied the allegation. He stated he went to walk the resident and found the resident sitting on the side of the bed. He placed the gait belt around the resident and noticed the resident's pants were loose around the resident's waist. He assisted the resident to a standing position and pulled the resident's pants up at the same time. He walked the resident from the room, to the elevator, and to the end of the hallway. After he ambulated the resident, they returned to the resident's room and he sat the resident on the side of the bed to perform active range of motion exercises. He stated the resident did not say anything during the session. Further interview with the ORT revealed after completion of the range of motion exercises, he told the resident he would see him/her tomorrow and left the room. He could not recall if the resident said anything. He stated the resident didn't appear to be any different from other days. He stated he recalled seeing CNA #24 in the hallway with a blue linen bag. The ORT said he was close to the resident's face, but denied he kissed or touched the resident's face. He said he had never kissed any resident. He stated he did not go back into Resident #37's room, but cared for other residents to the end of his work shift. Review of ORT Restorative Aide #1's time card for 04/26/15 revealed the ORT worked from 7:00 AM to 3:15 PM. Telephone interview with CNA #24, on 04/29/15 at 3:07 PM, revealed he witnessed ORT Restorative Aide #1 kiss Resident #37 on the lips. He said he was passing by the resident's room to take dirty linen to the dirty utility room, which was directly across from the resident's room. He stated the resident had a gait belt around his/her waist and the ORT was assisting the resident from a sitting position from the bed. He stated the resident was rising and the ORT gently kissed the resident on the lips. He stated he couldn't believe what he saw. He thought it could be a culture thing or the kiss could have been a reward. He stated he witnessed the kiss around 1:00-1:30 PM, but he did not report it at this time. He stated he thought about it then reported what he saw to the nurse, but by that time, the ORT had already left for the day. He stated he was trained to report abuse immediately, but he was shocked and didn't want to get the ORT in trouble. Telephone interview with LPN #10, on 04/30/15 at 2:23 PM, revealed CNA #24 had reported what he witnessed to CNA #25 and #26 then they reported to her at approximately 4:15 PM on 04/26/15. She stated she went to look for CNA #24 to ask him about the allegation, but he was off the floor. When he came back on the floor, she interviewed the aide and he told her he had witnessed the ORT kissing the resident on the lips. She asked the aide why he didn't report what he witnessed at that time and he told her he was afraid the ORT aide would know who had reported it. She said she told the aide he should have reported what he saw right away and the aide told her he was afraid of losing his job. She said she then went to find the House Supervisor on the first floor. She reported what was told to her. She said she had interviewed the resident before reporting to the House Supervisor and the resident told her the ORT had kissed him/her on the lips. She asked the resident if the kiss made him/her uncomfortable and the resident said, Yes. Telephone interview with CNA #26, on 04/30/15 at 3:17 PM, revealed she did not witness the incident, but was told by CNA #24. She stated the aide pulled her and CNA #25 aside and told them he was walking past Resident #37's room and saw the ORT kiss Resident #37 on the lips. She stated CNA #24 told them he didn't know what to do. She told him he should have told the nurse. She stated she and CNA #25 went into Resident #37's room and asked the resident if anyone had kissed him/her on the lips and the resident said, Yes. After that she reported what the resident had told her to LPN #10. Interview with CNA #25, on 04/30/15 at 3:28 PM, revealed CNA #24 told him he had witnessed ORT Restorative Aide #1 kiss Resident #37. He said CNA #24 told him the ORT had leaned in and kissed the resident on the mouth. He said he told CNA #24 he needed to tell somebody. He stated CNA #26 requested for him to go with her to question the resident. They went into Resident #37's room and asked the resident if it was true, if someone had kissed him/her. The resident looked at him and shook his/her head, Yes. He asked the resident if that made him/her feel uncomfortable, and the resident shook his/her head, Yes. He stated the resident's eyes got really big, but he/she didn't say a name. He said he had worked with this resident for years and found his/her answers to be appropriate and correct. He stated he reported what the resident said to LPN #10. Interview with the Administrative DON, on 04/29/15 at 2:24 PM, revealed she had not concluded the investigation. She stated she had identified CNA #24 had delayed in reporting the abuse allegation. She stated the ORT had already left for the day when the allegation was reported and had not worked since and was on administrative leave pending the investigation. She stated CNA #24 was also suspended for not reporting according to the facility's abuse policy. She stated the incident occurred on Sunday, April 26, 2015 around 1:00 PM and the House Supervisor was not notified until 4:50 PM. Review of the facility's investigation revealed, the facility did not follow its policy, as they did not report the alleged sexual abuse to the Office of Inspector General (OIG) until 04/28/15 at 3:10 PM. Interview with the Administrative DON, on 04/29/15 at 2:24 PM, revea
F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure residents identified as needing one on one (1:1) activities were provided one on one activities and those identified as needing assistance to attend group activities of preference received assistance for three (3) of forty-three (43) sampled residents (Residents #1, #5 and #11). The findings include: Review of the facility's policy titled Resident Activities, not dated, revealed the Activities' Program would be designed to meet the physical, social and psychosocial needs of the individual resident. Activities would be planned with each resident according to the resident's needs and interests unless written contraindications were specified by the resident's physician. The facility would provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. Activities could occur at any time and were not limited to formal activities being provided by activity staff. Review of Resident #1's, #5's and #11's Activity calendars, dated February and March 2015, and the facility's Activity Calendar used for all residents, dated February and March 2015 (which was provided to the survey team upon entrance on 03/30/15) revealed the daily activities listed on each calendar were the same. Residents #1, #5 and #11's activity calendars had a key in the upper left corner of the form that revealed the color codes. An item highlighted in pink meant an activity took place with the resident. If highlighted in orange staff had conversed with the resident; yellow highlight indicated the resident refused the activity; and, if highlighted in blue the resident participated in the activity passively. 1. Review of Resident #1's clinical record revealed the facility readmitted the resident on 06/19/14 after an acute hospital stay. The resident's [DIAGNOSES REDACTED]. Review of Resident #1's Admission Minimum Data Set (MDS) activity assessment, completed on 07/23/12, revealed the facility assessed the resident's activity preferences to include: books; newspapers; magazines; listening to music and, group activities. The assessment also stated the resident found it very important to go outside and somewhat important to attend religious services. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 03/20/15, revealed the facility assessed the resident as needing extensive assistance with dressing, eating, bathing and hygiene. During the MDS assessment, a Brief Interview for Mental Status (BIMS) was not conducted due to Resident #1 was rarely/never understood. Review of Resident #1's Activities' Assessment, dated 06/24/14, revealed Resident #1's family member provided the answers to the assessment questions. The Activities Assessment form had twenty-two (22) resident activity preferences listed and next to each preference was a blank for a check mark to be placed if the resident found them of interest. No items were checked to indicate they were of interest to Resident #1. Review of the eight (8) activity preference questions listed for Resident #1, revealed music, reading, news, pets and groups, were not important to the resident. There were two (2) questions answered as somewhat important to the resident and they were related to doing things outside and participating in religious services. Review of the Comprehensive Care Plan for Resident #1 revealed the facility developed an Activity Care Plan, on 04/17/14 with a goal that did not have a target date. The Care Plan stated the resident would allow one on one visits from activity staff. The approaches on the care plan did not include the resident's activity preferences noted in the MDS assessment or checked on the Activities Assessment. However, it stated the Activity staff was to introduce themselves to the resident before each

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F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) interaction; schedule activities to allow for limited energy; respect the resident's desire to be alone on occasion; invite the resident's family/friends to attend selected activities with the resident; and, respect the resident's choice in regards to limited/no activities. At the end of the pre-printed list of approaches was a hand written notation of family visits. Hand written notations were made to the right side of the document that stated staff reviewed the care plan and no changes were made during reviews conducted in April 2014, July 2014, October 2014 and December 2014. Continued review of Resident #1's care plan revealed it did not contain approaches for staff to provide activities of interest as stated in the resident's Activity Assessment such as; participating in outdoor activities, religious services or activity preferences that included reading books, newspapers, magazines, or listening to music, and attending group activities. Review of the Certified Nursing Assistant Care Plan for Resident #1, dated 03/19/15, revealed the Plan did not contain information that informed nursing assistants of the resident's activity preferences. Review of Resident #1's Activity Department Notes, dated 12/22/14, revealed Activity staff visited one on one with Resident #1 in order to provide socialization and stimulation such as playing music, reading a book, conversing, applying lotion, or watching television. Review of an undated Activity Note for Resident #1, provided to the Surveyor by the Director of Activities, on 04/02/15, revealed the resident was invited to group activities such as special events and parties when up in wheelchair but often declined. The resident was visited one on one for socialization/stimulation and enjoyed watching television at times. Further review of the Note revealed during visits staff conversed with the resident and encouraged the resident to verbally respond and use various sensory stimulation tactics such as applying lotion to hands and arms, playing music, reading short stories or the daily work and other tactics; will follow care plan. Review of Resident #1's February, March and April 2015 Activity Calendars revealed the resident did not receive the sensory stimulation documented in the Activity Notes such as; applying lotion, playing music or the reading of short stories. Review of Resident #1's activity calendar for February 2015, revealed the calendar did not indicate the facility assisted the resident to attend, passively attend, or that the resident refused to attend the group activities listed such as: Music Listening, Bible Study, Special Event of Movie Day Party, Piano Music with Misha, Eastern Parkway Church, Sunday Worship each Sunday, On Unit Video or Sit and Fit, Ground Hog Leap, Abe Lincoln on Unit, On Unit Popcorn and Music, Music with Dave, Parachute Movement on Unit, and Birthday Party. Review of Resident #1's Activity Calendar for March 2015, revealed the calendar did not indicate the facility assisted the resident to attend, passively attend, or that the resident refused to attend the group activities listed such as: Music Listening, Bible Study, Special Event of Movie Day Party, Music with Earl, On Unit Activity, Eastern Parkway Church, Birthday Party, Wacky Wednesday events, St. Patrick's Day Party, Sunday Worship each Sunday, On Unit Video or Sit and Fit. Review of Resident #1's Activity Calendar for April 2015, revealed the calendar did not indicate the facility assisted the resident to attend, passively attend, or that the resident refused to attend the group activities listed such as: Wacky Wednesday, Bible Study, or Bingo Music. Observations of Resident #1 revealed one on one activities by facility staff did not occur during these observations. On 03/30/15 at 5:30 PM, the family was pushing Resident #1 in his/her wheelchair into his/her room from the hallway; on 03/31/15 at 8:15 AM, the resident was in bed on his/her back with his/her eyes closed; at 9:30 AM the resident was in bed with his/her eyes open and positioned on his/her left side; at 11:20 AM the resident was in bed with his/her eyes open and positioned on the right side; at 2:05 PM the resident was in bed on his/her back with his/her eyes closed; on 04/01/15 at 7:46 AM the resident was in bed on his/ her right side with eyes closed; from 10:02 AM until 10:45 AM, revealed the resident was in bed receiving a bed bath. 2. Review of Resident #5's clinical record revealed the facility admitted the resident on 10/17/14 with [DIAGNOSES REDACTED]. Review of Resident #5's Significant Change Minimum Data Set (MDS) assessment, completed on 02/09/15, revealed the facility assessed the resident as needing extensive assistance with dressing, eating, bathing and hygiene. Review of the Brief Interview for Mental Status (BIMS), conducted during the assessment, revealed the resident scored seven (7) out of fifteen (15) indicating severe cognitive impairment; the resident was not interviewable. Review of the resident's Comprehensive Care Plan revealed the facility developed an Activity Care Plan on 01/28/15, with a goal that did not have a target date that stated the resident would receive in room visit stimulation and would respond to the visits by opening his/her eyes and verbally respond yes on questions. The approaches on the care plan stated the activity staff would offer a schedule of activities for the resident to select choice(s), and would polish the resident's nails as needed. The resident would receive visits from a deacon or priest and would receive communion if able. Activity staff would hold the resident's hand during visits for comforting. Resident #5's care plan approaches stated the family was supportive and came to visit often. Also, that during visits activity staff would ensure health related equipment such as the oxygen tank worked properly. Another approach listed stated the activity staff would play soothing music for (length of time and frequency). However, the Care Plan did not indicate a length of time or frequency. Review of the Certified Nursing Assistant Care Plan for Resident #5, dated 11/07/14, revealed the plan did not contain information that informed nursing assistants of the resident's activity preferences. Review of Resident #5's Initial Activities Assessment, dated 02/09/15, revealed several areas on the form were not completed. Review of a hand written note in the comment section revealed the resident was unable to provide information for this assessment. The family was able to provide information and the resident was end of life care. Further review of the Assessment revealed check marks were placed next to music and spiritual events indicating these were Resident #5's likes. Review of the Activity Note, dated 02/22/15, revealed Resident #5 had a change in status due to the switch to palliative care. Further review revealed the resident was alert to self; preferred to stay in bed; the family was supportive and came to visit often; the resident enjoyed snacks; and, the resident had no interest in activities at this time. Past interest included bingo parties, music programs, special events and some religious related programs. The resident was of the Catholic religion and received deacon visits and communion weekly. The resident was visited one on one for socialization. During visit converse on various topics of choice. The resident enjoyed having nails polished, offer to polish nails. Will follow plan of care. Review of Resident #5's Activity Calendar for March 2015 and April 2015, revealed the resident did not receive in room visits that consisted of listening to music or spiritual events as listed as likes in the Activities Assessment. The resident's Activity Calendar did not indicate the facility provided the resident with visits from a priest, ensured nails were polished or hand holding occurred as listed in the resident's care plan. Observations of Resident #5 revealed one on one activity by facility staff did not occur during these observations. On 03/30/15 at 5:25 PM, the resident was in bed with his/her eyes open visiting with roommate; on 03/31/15 at 8:05 AM the resident was in bed on his/her back with eyes closed; at 9:10 AM the resident was in bed on his/her back with eyes closed; at 10:35 AM the resident was in bed on his/her back with eyes closed; at 2:05 PM, the resident was in bed on his/her right side with eyes closed; on 04/01/15 at 9:45 AM, the resident was in bed on his/her back with eyes closed; and, on 04/02/15 at 8:00 AM, the resident was in bed on his/her right side with eyes closed. 3. Review of Resident #11's clinical record revealed the facility admitted the resident on 08/14/06 with [DIAGNOSES REDACTED]. Review of Resident #11's Quarterly Minimum Data Set (MDS) assessment, completed on 02/18/15, revealed the facility assessed the resident as needing extensive assistance with dressing, eating, bathing and hygiene. During the MDS assessment a Brief Interview for Mental Status (BIMS) was not conducted due to Resident #11 was rarely/never understood. Review of Resident #11's Initial Activities Assessment, dated 11/18/14, revealed several areas on the form were not completed. Activity preferences marked as very important' to the resident were to have books, newspapers, magazines, listening to music and participating in religious activities. Activity preferences marked as somewhat important stated the resident liked to be around pets. Review of the Comprehensive Care Plan for Resident #11 revealed the facility developed an Activity Care Plan on 11/18/14 and the Problem/Need stated the resident's social participation during programs may be limited secondary to the resident being non-verbal. Resident #11 needed to be assisted to and from activities. The goal did not have a target date and stated the resident would be assisted to activities of interest when up in a wheel chair and visited one on one weekly by the next review date. The approaches listed on the care plan stated to invite and assist the resident to group programs of interest such as parties, music programs and church. When asking resident direct questions, phrase questions for simple yes-no responses by nodding his/her head. Allow the resident ample time to respond. Allow resident to hug you while interacting for stimulation. The resident liked to sit out in the hallway for stimulation. Provide resident with magazines to look at. Continued review of the Care Plan revealed hand written notations were made to the right side of the document that stated staff reviewed the Care Plan and no changes were made on 02/18/15 and 02/22/15. Review of the Certified Nursing Assistant Care Plan for Resident #11, dated 11/11/14, revealed the plan did not contain information that informed nursing assistants of the resident's activity preferences. Review of Resident #11's Activity Calendar documentation for February 2015 revealed the facility did not provide weekly one on one activity's to Resident #11, according to the resident's preferences or facility assessment findings, during the period of 02/15/15 through 02/22/15. The facility did not ensure the resident was offered the opportunity to attend Sunday worship, which was one of

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F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) the resident's preference. Continued review of the February calendar revealed pink highlighted hand written notations of Greet and Hug was documented as an activity provided on 02/06/15, 02/09/15, 02/12/15, 02/23/15, and 02/26/15. On 02/01/15, the Activity of Calendar Delivery was highlighted pink; and, on 02/02/15 the act of delivering the facility's Newsletter was also highlighted pink. On 02/13/15 and 02/14/15, the pink highlighted and hand written activity was Hug and Dance. Review of Resident #11's Activity Calendar documentation for March 2015, revealed the facility did not provide the resident with magazines to look at as per the care plan during the month of March. Continued review of the Activity Calendar revealed the activity staff Cleaned Nails as an activity on 03/04/15 and 03/30/15. The highlighted in pink and handwritten activity of Greet and Hug was documented as done on 03/08/15, 03/10/15, 03/16/15, 03/18/15, 03/19/15, and 03/30/15. The highlighted in pink and handwritten notation of Hallway on unit in Chair was documented as an activity on 03/20/15 and 03/27/15. Further review of Resident #1's activity calendar for March 2015, revealed the calendar did not indicate the facility assisted the resident to attend, or passively attend, or that the resident refused to attend the group activities listed: On Unit Music In Dayroom, Music Listening, Movie Day party, Music with Dave, Sunday Worship on 03/01/15, 03/15/15, 03/22/15, and 03/29/15, or On Unit Activity. Observation of Resident #11, on 03/30/15 at 5:15 PM, revealed the resident was in bed with his/her eyes open. One on one activity by facility staff did not occur during this observation. Observation of Resident #11, on 03/31/15 at 8:00 AM, revealed the resident was in a wheel chair in hallway outside his/her room. One on one activity by facility staff did not occur during this observation. Observation of Resident #11, on 04/01/15 at 7:45 AM and 8:50 AM, revealed the resident was up in his/her wheel chair sitting in the hallway outside of his/her room with a tube feeding pump connected to the resident and plugged into an electrical wall outlet. Observation on, 04/01/15 at 10:44 AM, revealed Activity Staff in the common area by the nursing station conducting the Wacky Wednesday group activity of playing music and dancing. Observation revealed seven (7) residents were in the area where the Wacky Wednesday activity was conducted. Continued observation during the activity revealed Residents #1, #5, and #11 were all in their rooms and in bed and were not among the seven (7) residents in the common area participating in the activity. After Activity Staff completed the activity of playing music and dancing they left the unit. Observation of Resident #11 on, 04/01/15 at 10:45 AM, revealed Resident #11 was in his/her room sitting up in bed with his/her eyes open while the Wacky Wednesday activity took place in the common area of the unit. Interview with Certified Medication Technician #1, on 04/01/15 at 3:20 PM, revealed she was not sure what activities were scheduled each day. She stated bathing and getting residents up was based on their therapy schedule and not on the activity schedule. She stated the residents that were able to do most of their own activities of daily living and attended activities off the unit did not need the staffs' help. She stated she would ask those that needed help getting out of bed when they wanted to get up. Interview with Certified Nursing Assistant (CNA) #1, on 04/07/15 at 1:00 PM, revealed the facility activities usually began around 3:00 PM. She stated most activities occurred on the first floor and some activities were provided on the unit. She stated she was not provided with a document that informed her which activities residents preferred to attend. She stated she would ask residents that got out of bed, if they wanted assistance in getting up, but it was not related to activities attendance. She stated most residents were already up when activities were provided such as Wacky Wednesday. Further interview revealed CNA #1 stated activity staff assisted residents with transportation to activities off the unit. Interview with the 300 Assistant Unit Manager, on 04/07/15 at 12:50 PM, revealed he did not know each resident's activities of preference on his unit. He stated the Unit had an Activity Calendar on the wall that staff used as a reference. He also stated the CNAs had a Nursing Assistant Care Plan that directed them in the care they provided to residents. He stated he and the Unit Manager were responsible for documenting the information located in the activity section of the plan. He stated he would have to defer to the Activity personnel for that information since the plan did not contain information indicating the activity preferences for Residents #1, #5, and #11. Interview with 300 Unit Manager #1, on 04/07/15 at 1:10 PM, revealed she referred to the activity calendar on the big board at the end of the hall to know when activities were provided. She stated staff assisted residents to activities upon request. She stated she did not know which residents on her unit received one on one activity or if they had received them. She would have to call the Activity Department to find out. Interview with Activity Partners #1 and #2, on 04/07/15 at 2:00 PM, revealed the activity person for the third floor resigned a couple of weeks ago and they stepped in to help provide activities for residents on the third floor unit. Activity Partner #1 stated she had provided activities on the unit for about a week. She stated she provided activities to one side of the unit and another Activity Partner provided activities to the other side of the unit. She stated she was also responsible for activities on another floor. She said she provided activities to residents the morning of 04/07/15, but could not provide one on one activities to each resident on the list because she had to complete one on one activities for residents on her other floor. She stated she could not get to every resident on both units so she would get to as many as she could. Continued interview with Activity Partner #2 revealed she developed resident activity care plans and believed the approach of introduce yourself, to resident before each interactionwas a specific activity of interest and not a part of normal customer service delivery. She also stated the activity staff would go to the store and buy items for residents and this was considered an activity of interest. She stated they had purchased hot sauce, reading glasses and lottery tickets for residents upon request. Activity Partner #2 stated she documented family visits as an activity even though the Activity Department did not plan the visit. She stated Resident #1's daughter came every day and was considered an activity provided to the resident. She stated Resident #5's family came every day and was considered an activity provided to the resident. She stated she would also reposition Resident #5 in bed, along with ensuring the oxygen was on and the tubing in place, and considered these actions as activities provided. She stated Resident #11 liked to be hugged and this was documented as an activity provided to the resident. She stated each month the activity calendar and newsletter was delivered to each resident's room and this was considered an activity for each resident. Interview with the Activity Director, on 04/02/15 at 2:30 PM, revealed Residents #1, #5, and #11 were to receive one on one activities due to their assessed need. She stated in March she determined resident activity care plans were not individualized. However, she had not determined Residents #1, #5, and #11 were not consistently receiving the assessed and care planned one on one activity preferences or that Resident #1 and #11 had not received staff assistance to attend activities of interest until review of the activity calendar documentation with the Surveyor on 04/02/15. The Activity Director stated the Activities Department had three (3) staff recently leave for various reasons in March. She stated activity staff assigned to other floors stepped up to help out on the third floor and with other activity related responsibilities. She stated she allowed her staff autonomy and did not oversee their work or calendar documentation. She stated she delegated the responsibility of care plan development to Activity Partner #2 and determined that she needed additional training in this process during the audit completed in March. She stated the care plan goals and approaches were not measurable as written. Further interview revealed the Quarterly Narrative documentation did not show an effective evaluation of the activities provided to each resident. She stated the activity staff did not know how to write measurable goals and approaches in order to evaluate each resident's response to the activities provided. She stated going forward she would have to learn how to develop an Activity care plan again and review staff documentation of activities provided to ensure the program met the requirements and residents were receiving the planned activities of choice.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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, review of the facility's policy, and the facility's investigation, it was determined the facility failed to provide care and services according to the care plans for five (5) of forty-three (43) sampled residents (Residents #1, #2, #5, #11 and #21). Certified Nursing Assistant (CNA) #5 failed to reposition Resident #21 when the resident requested to be turned for comfort reasons. CNA #5 stated she would not turn the resident and left the room even though the care plan directed staff to maintain the resident's comfort level and to alleviate distress by providing non-pharmacological resident interventions. Resident #21 activated the call light for assistance with repositioning his/her leg because of pain on 04/01/15. A Certified Nursing Assistant came to the room, and spoke harshly to the resident, telling the resident that she had just repositioned him/her fifteen (15) minutes ago and left the room without assisting the resident. The resident stated he/she felt intimidated and scared of that CNA and would not use the call light the rest of the night. After the facility was made aware of the allegation, they allowed the CNA to continue to work and provide resident care. (Refer to F225) Immediate Jeopardy (IJ) was identified on 04/03/15 and was determined to exist on 04/01/15. However, during an abbreviated survey initiated on 04/28/15 (investigating complaints KY and KY) it was determined the IJ had not been removed as alleged, on 04/09/15, due to the facility's failure to ensure all components of the AOC were implemented. Additionally, staff failed to administer a tube feeding at the correct rate as care planned for

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) Resident #2 on 03/31/15; and staff failed to provide activities according to the resident's interests noted on their plans of care for Residents #1, #5, and #11. The facility's failure to follow the care plan for the residents has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was determined to exist on 04/01/15. The facility provided an acceptable AOC on 05/07/15 which alleged removal of the Immediate Jeopardy on 05/06/15. The SSA verified Immediate Jeopardy was removed on 05/06/15 as alleged, prior to exit on 05/13/15 with the Scope and Severity lowered to a D while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: Interview with the Administrative Director of Nurses, on 04/07/15 at 1:52 PM, revealed the facility did not have a policy on implementing care plans; however, they used the Center for Medicare/Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 Manual as their policy. Review of the facility's CMS RAI Version 3.0 Manual for Care Planning, dated May 2013, revealed the comprehensive care plan must describe the services that were needed for the resident to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. A resident's care plan would provide information on how issues could be addressed to provide for the resident's highest practicable level of well-being. In addition, the manual stated the facility must provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes and with accepted professional standards and principles that apply to professionals providing services in such a facility. 1. Review of the clinical record for Resident #21 revealed the facility admitted the resident on 03/10/15 with [DIAGNOSES REDACTED]. Review of a Nurse's Note, dated 03/11/15 at 10:27 PM, revealed Resident #21 was alert and oriented times three and had left sided paralysis; was assisted with positioning; had an unequal hand grasp ability; and, was able to move his/her fingers of the left hand; however, he/she was unable to reposition the total extremity. Record review revealed the facility completed an Initial Minimum Data Set (MDS) on 03/14/15, and assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated the resident was interviewable. Additionally, the facility assessed Resident #21 as requiring extensive assistance with bed mobility and transfer, requiring two (2) person physical assistance; and, utilized a wheelchair (w/c). Review of Resident #21's Comprehensive Care Plan, completed on 03/18/15, revealed the facility initiated a care plan related to the use of [MEDICAL CONDITION] medications. The care plan included an intervention to always assess and incorporate non-pharmacological interventions to alleviate chair or bed discomfort and to answer the resident's call light in a timely manner. Further review revealed the care plan further instructed staff to reposition the resident every two (2) hours, or per the current turning schedule. In addition, the staff was to maintain the resident's comfort level. Review of the clinical record revealed a Nurse's Note, dated 03/18/15 at 1:45 PM, which stated the resident continued to receive the maximum assistance with his/her activities of daily living (ADLs) and transfers. Review of a Nurse's Note, dated 03/23/15 at 1:45 AM, revealed Resident #21 was frequently awake on the 11:00 PM to 7:00 AM shift; and, the resident was beginning to have sensation in his/her left lower extremity. Interview with Resident #21, on 04/01/15 at 2:45 PM, revealed he/she used the call light due to pain in his/her leg and the need to be repositioned. Resident #21 stated he/she was unable to get his/her leg comfortable and could not turn himself/herself. Continued interview revealed the resident stated CNA #5 came to the room, and harshly stated that she had repositioned the resident fifteen (15) minutes ago, and would not turn him/her again and left the room. The resident further stated he/she felt intimidated and scared of CNA #5 and would not use the call light the rest of the night. Additionally, the resident stated he/she had seen CNA #5 since the night of the incident, and if CNA #5 responded to his/her call light, he/she (the resident) would say it was an accident. Interview with the Clinical Director of Nursing (DON), on 04/01/15 at 2:07 PM, revealed the resident reported, that he/she had leg pain within the last week and had put on the call light for assistance. The resident reported CNA #5 answered the call light. When CNA #5 came into the room, she spoke harshly to the resident and told him/her that she (CNA #5) had repositioned him/her fifteen (15) minutes ago and walked out of the resident's room. The DON stated the resident was afraid of CNA #5. Review of the facility's investigation, dated 04/01/15, revealed Resident #21 reported to the Assistant Unit Manager, Unit Manager (UM) #1, the Clinical Director of Nursing (DON), and the Assistant Director of Nursing (ADON), that he/she had asked a night shift CNA (CNA #5) to reposition him/her. The resident stated CNA #5 refused to assist him/her and he/she was afraid of CNA #5 because she was rough with him/her. The resident continued to express fear of CNA #5 because she spoke harshly. Resident #21 reported that late last week he/she had leg pain and put on his/her call light to request someone to reposition him/her. The resident stated CNA #5 who responded to the call light was harsh when speaking to him/her and the aide told him/her that she had just repositioned the resident fifteen (15) minutes ago and left the room. Additionally, the resident reported he/she was hurting badly; however, he/she did not want to call CNA #5 again as he/she did not know how CNA #5 would react. Interview, on 04/02/15 at 9:26 AM, with the Assistant UM revealed the resident reported he/she was in pain last week, used the call light, and asked to be repositioned. The Assistant UM stated the resident also reported CNA #5, who responded, said she had just repositioned the resident and would not do it again. He further stated the resident told him they had used the call light again and when the same staff responded (CNA #5), the resident would tell the aide he/she accidentally activated the call light by mistake and did not request assistance. Interview with the UM, on 04/02/15 at 12:20 PM, revealed the resident reported that in the last week he/she was uncomfortable and asked to be turned. The resident stated he/she was told by CNA #5 that she had just turned him/her about fifteen (15) minutes ago and was not going to turn him/her again. The resident stated he/she felt intimidated by CNA #5. Interview with the Clinical DON, on 04/02/15 at 12:37 PM, revealed the resident felt CNA #5 did not want to reposition him/her. Resident #21 reported he/she was afraid of the CNA. Interview, on 04/01/15 at 12:54 PM, with the ADON revealed Resident #21 reported CNA #5 seemed irritated when he/she used the call light to be repositioned. Interview with the Administrator, on 04/02/15 at 3:35 PM, revealed the resident said he/she was uncomfortable and in pain and had used the call light several times to be repositioned. The resident reported CNA #5 said she was just there fifteen (15) minutes ago. The resident reported he/she felt afraid and intimidated, and did not use the call light any more that night. Interview with CNA #5, on 04/03/15 at 8:40 AM, revealed she worked the night shift, starting at 11:00 PM, and always worked with Resident #21. She stated the resident would voice complaints of his/her leg hurting, stating he/she had been on that side to long. CNA #5 stated the resident's left leg was paralyzed and he/she could not turn him/herself. She further stated Resident #21 was turned and repositioned every two (2) hours, and the resident would often ask to be repositioned again. Interview, on 04/07/15 at 12:41 PM, with CNA #7 revealed she had worked with Resident #21 and was his/her CNA that day. The CNA stated she had been in the resident's room more frequently than every two (2) hours that day and had repositioned the resident every time she entered the resident's room as the resident would state his/her left side was hurting. Interview with Licensed Practical Nurse (LPN) #5, on 04/07/15 at 12:50 PM, revealed she worked with Resident #21 and if the resident was in pain, she could give the resident medication, or turn and reposition him/her. The Nurse stated Resident #21 was scheduled for repositioning every two (2) hours; however, he/she should also be repositioned when he/she requested to be repositioned. She further stated repositioning the resident could alleviate the resident's discomfort. Interview with the Assistant UM, on 04/07/15 at 1:09 PM, revealed Resident #21 should be turned and repositioned every two (2) hours, and when he/she voiced pain. He further stated Resident #21 reported to him that he/she had a lot of pain the night of the incident. The Assistant UM stated if the resident was not repositioned when in pain, then the resident's pain would not be alleviated. Interview with the Staff Development Nurse, on 04/07/15 at 2:30 PM, revealed if a resident was in pain and requested to be repositioned, staff was aware they could immediately reposition the resident to make the resident more comfortable. She stated if a resident wanted to be in a different position, then he/she had that right. The Staff Development Nurse further stated if staff did not reposition a resident when he/she requested, then it could be abuse or neglect. Interview, on 04/07/15 at 3:41 PM, with Night Supervisor #2 revealed if a resident requested to be repositioned for comfort staff should turn the resident and try to make the resident comfortable, per the resident's plan of care. Interview with Night Shift Supervisor #1, on 04/07/15 at 4:12 PM, revealed if a resident requested to be repositioned staff was expected to reposition the resident. The Supervisor stated if a resident was not repositioned when he/she asked, the resident could have an increase in discomfort. Interview with the Clinical DON, on 04/08/15 at 12:38 PM, revealed the purpose of the resident care plan was a guide on how to provide that resident's care. She stated she expected staff to follow the interventions on the resident's care plans. She further stated staff could reposition a resident to alleviate discomfort and that was basic nursing. The Clinical DON stated the resident's statement that the CNA refused to reposition him/her would imply the CNA did not follow the care plan. Additionally, she stated when the CNA refused to reposition the resident when requested also did not follow the RAI manual for care planning and did not meet the resident's highest practicable well being. The Clinical DON stated if the resident's care plan was not followed, the resident could have a negative outcome. She stated if a resident was not repositioned and was in pain, the resident would continue to be in pain.

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) She further stated the resident determined what his/her level of pain was and should be treated accordingly. The Clinical DON stated if a resident requested to be repositioned, the staff member would be expected to reposition the resident. She further stated she monitored resident care through the daily team huddle with the Unit Managers. Interview with the Administrator, on 04/08/15 at 1:51 PM, revealed he monitored that resident care met resident needs through speaking with the DONs daily, Quality Assurance (QA) meetings, and morning huddles. He stated the Clinical DON or Administrative DON was responsible to oversee that resident care plan interventions were followed and implemented. He stated Resident #21's care plan was not followed when the resident stated he/she was not repositioned by the aide when asked to be repositioned. The Administrator further stated the resident's allegation would not have met the RAI care plan policy and therefore, would not meet the resident's highest practicable well being. He stated if the resident was not repositioned as requested, and was in pain, the resident would remain in pain. 2. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 11/03/09 with [DIAGNOSES REDACTED]. The facility completed a Significant Change Minimum Data Set (MDS) assessment, on 12/23/14, and stated the resident was comatose and had a Gastrostomy tube ([DEVICE]) in place for nutrition. Review of the Comprehensive Care Plan, dated 12/24/14, revealed a Diet Plan of Care that stated the resident was to receive nothing by mouth, supplements and flushes were in place; and, the resident was at risk for dehydration, weight loss, and aspiration. The care plan interventions stated for staff to provide tube feeding supplements as ordered. Review of a care plan for Skin Failure, dated 12/26/14, revealed the resident was at further risk for skin breakdown secondary to his/her Gastrostomy status and the staff was to provide nutrition and fluids via the [DEVICE] per current orders. Review of the physician's orders [REDACTED]. Additionally, the order stated the tube feeding should be held one (1) hour before and one hour after the administration of [MEDICATION NAME]. The physician's orders [REDACTED]. Review of the physician's orders [REDACTED]. Review of the Enteral Feeding Progress Note NAR review, dated 03/16/15 at 10:34 AM, revealed Glucerna was to run at 60cc per hour for 20 hours due to the order to hold tube feeding for [MEDICATION NAME], one hour before and one hour after. Review of a Dietary Note, dated 02/17/15, revealed the resident had a weight loss in February of 5.6 pounds from 146 to 140.4 and 4.6 pounds for the last three (3) months. The resident had a Stage IV (4) sacral wound that had improved and the tube feeding should be increased from Glucerna at 55 cc per hour to 60 cc per hour. Review of a Dietary Note, dated 03/16/15, revealed the resident's Glucerna was increased last month due to weight loss of one (1) pound. The 03/25/15 Note, stated the resident had lost five (5) pounds since January from 146 to 141 pounds and the Dietary Note, dated 03/31/15, stated the resident had lost six (6) pounds in the last three (3) months from 147.2 to 141 pounds and his/her tube feeding had been increased. Review of the Treatment Administration Record (TAR), dated March 2015, revealed on 03/31/15, the total amount of tube feeding administered to Resident #2 was 333 cc on the 7:00 AM to 3:00 PM shift. However, the resident's order was for Glucerna at 60 cc per hour for six hours, which would total 480 cc. Observation of Resident #2, on 03/31/15 at 8:34 AM, 10:40 AM, 11:30 AM, 11:56 AM, 12:10 PM, and 3:22 PM, of Resident #2 revealed the tube feeding rate was infusing at 50 cc per hour, not at the 60 cc per hour rate. Interview, on 04/02/15 at 2:22 PM, with Licensed Practical Nurse (LPN) #4 revealed she had provided care for Resident #2 on 03/31/15 during the day shift. She stated when she came on duty the pump (tube feeding) had been held, from 6:00 AM to 7:00 AM due to the [MEDICATION NAME] medication. The nurse stated she started the tube feeding at 7:00 AM at the rate that was already programmed in the pump. The LPN further stated she could not remember if she checked the pump for the correct rate. She stated she was unaware if the tube feeding was held during the shift and there were no problems with the tube feeding infusion that day. The nurse stated she checked how much tube feeding the resident had received around 2:00 PM, and the resident had received 333 cc on her shift. Post survey interview via telephone with LPN #11, on 04/15/15 at 3:56 PM, revealed nurses should check a resident's tube feeding when it was changed; at the beginning of the shift; during medication administration; and, at the end of the shift. She stated the nurse would sign the MAR that the tube feeding was given, including the type of tube feeding and the rate. The nurse further stated Resident #2's tube feeding was turned off for certain medications and would then be re-started after the medication had been given. She stated the tube feeding would be discussed during nursing report only if there was a change in the type or the rate. The nurse stated the resident's care plan included an approach for tube feeding per the current orders and the resident was NPO. The LPN further stated the purpose of the care plan was to ensure a resident received proper care that met the needs of the resident. The LPN stated the resident did have a pressure ulcer area on his/her bottom and the rate of the tube feeding may have been increased due to the weight loss. She stated if the care plan was not implemented or followed, the resident was at risk for developing any problems listed in the care plan the facility was trying to address. Post survey interview via telephone, on 04/15/15 at 4:04 PM, with UM #8 revealed nurses should check the resident's tube feeding at the beginning of the shift; when connecting a new bottle; when giving medications; and, at the end of the shift. She stated the tube feeding would be turned off for a while when the resident received [MEDICATION NAME] and the nurse should check the tube feeding when she turned it back on after the medication was given. The UM stated the tube feeding rate was also on the MAR. She further stated she was unsure how or when it was discovered the tube feeding was at the wrong rate as she had been off from work for several days since 03/30/15. The UM stated the purpose of the care plan was to identify the resident's problems and needs, potential risks, and how to care for the resident. She further stated she monitored that the care plan interventions were followed by reviewing records and talking with the staff. She stated her concern regarding Resident #2 was his/her chronic wound on his/her bottom. The UM further stated if the resident's care plan was not followed, the resident could have weight loss, slow wound healing, or not get the nutrition the resident needed. 3. Review of Resident #1's clinical record revealed the facility readmitted the resident on 06/19/14 after an acute hospital stay, with the [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 03/20/15, revealed the facility assessed the resident as needing extensive assistance with dressing, eating, bathing and hygiene. During the MDS assessment a Brief Interview for Mental Status (BIMS) was not conducted due to Resident #1 was rarely/never understood. Review of the Activities' Assessment for Resident #1, dated 12/22/14, revealed the resident was alert and oriented with periods of confusion. The resident was up when tolerated in a cardiac chair. The family visited almost daily and was supportive. Activities visited the resident for one on one visits to provide socialization and stimulation such as playing music, reading a book, conversing, applying lotion, or watching television. Review of the Comprehensive Care Plan for Resident #1 revealed the facility developed an Activity care plan, on 04/17/14, with a goal that did not have a target date, and stated the resident would allow one on one visits from activity staff. The Approaches on the care plan stated the Activity staff was to introduce themselves to the resident before each interaction; schedule activities to allow for limited energy; respect the resident's desire to be alone on occasion; invite resident's family/friends to attend selected activities with resident and respect the resident's choice in regard to limited or no activities. At the end of the pre-printed list of approaches was a hand written notation that family visited. Hand written notations were made to the right side of the document that stated staff reviewed the care plan and no changes were made during reviews conducted in April 2014, July 2014, October 2014 and December 2014. Observation of Resident #1, on 04/01/15 from 10:02 AM until 10:45 AM, revealed the resident was in bed receiving a bed bath, during the time the Wacky Wednesday activity occurred in the common area of the unit. The staff did not invite or provide a choice to attend the activity. Interview with Certified Medication Technician #1, on 04/01/15 at 3:20 PM, revealed she was not sure what activities were scheduled each day. She stated bathing and getting residents up was based on their therapy schedule and not on the activity schedule. She stated the residents that were able to do most of their own activities of daily living and attended activities off the unit did not need the staffs' help. She stated she would ask those that needed help getting out of bed when they wanted to get up. Review of the Certified Nursing Assistant Care Plan for Resident #1, dated 03/19/15, revealed the plan did not contain information that informed nursing assistants of resident's activity preferences. Review of the Activity Calendar (utilized to document a resident's participation in a scheduled activity) for Resident #1 and dated February 2015, revealed the calendar did not indicate the facility assisted the resident to attend, passively attend, or that the resident refused to attend the group activities listed in his/her care plan. Review of Resident #1's Activity Calendar for March 2015, revealed the calendar did not indicate the facility assisted the resident to attend, passively attend, or that the resident refused to attend the group activities listed such as: Music Listening, Bible Study, Special Event of Movie Day Party, Music with Earl, On Unit Activity, Eastern Parkway Church, Birthday Party, Wacky Wednesday events, St. Patrick's Day Party, Sunday Worship each Sunday, On Unit Video or Sit and Fit. Review of Resident #1's activity calendar for April 2015, revealed the calendar did not indicate the facility assisted the resident to attend, passively attend, or that the resident refused to attend the group activities listed such as: Wacky Wednesday, Bible Study, or Bingo Music. One on one activity by facility staff did not occur during the following observations of Resident #1: on 3/30/15 at

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) 5:30 PM, a family member was pushing Resident #1 in their wheelchair in to the resident's room from the hallway; on 03/31/15 at 8:15 AM, the resident was in bed on their back with eyes closed; at 9:30 AM the resident was in bed with their eyes open and positioned on the left side; at 11:20 AM the resident was in bed with their eyes open and positioned on the right side; at 2:05 PM the resident was in bed on their back with eyes closed; on 04/01/15 at 7:46 AM, the resident was in bed on their right side with eyes closed. Continued review of the Comprehensive Care Plan for Resident #1, dated 07/01/14, revealed a problem area of multiple Stage II and Stage III pressure ulcers. The resident was at risk for worsening of these areas and additional skin failure; with goals of open areas will remain clean and discomfort will be managed until next review. Interventions revealed the staff was to provide treatments as ordered; low air loss mattress; reposition every two (2) hours; and provide incontinent care as needed. The care plan did not address the resident's heel boots to be worn at all times or the Kerlix to the skin tear. Review of the CNA care plan, dated 03/19/15, revealed the staff was to place bilateral heel Medix to the resident's feet and notify the nurse if the dressing needed to be changed, as well as, mesh panties to be applied daily and when soiled to hold dressing in place. Observation of Resident #1, on 03/31/15 at 9:30 AM, revealed the resident was lying on the left side on the bed. Resident #1 was raising the bed sheet and revealed the resident did not have a brief on and no abdominal pads were in place to the buttock/sacral area. Observation of Resident #1's skin assessment performed by the 300 Assistant Unit Manager, on 03/31/15 at 11:25 AM, revealed no abdominal pads were in place to the buttock/sacral area. Observation of Resident #1, on 04/01/15 at 10:02 AM, during the bed bath, revealed no abdominal pads were in place to the buttock/sacral area. Interview with Licensed Practical Nurse (LPN) #1, on 04/01/15 at 3:30 PM, revealed she expected the nursing assistants to inform her when the dressing became soiled or needed replacement. Interview with the 300 Assistant Unit Manager, on 04/01/15 at 3:30 PM, revealed he did not know how to keep Resident #1's dressing in place without tape as ordered by the physician and he would have to refer to the wound care nurse for direction. He stated he expected the nursing assistants to notify the nurse assigned to the resident if the dressing needed to be re-applied due to not being in place or soiled. Interview with Clinical Director of Nursing, on 04/01/15 at 3:30 PM, revealed she expected the nursing assistants to notify the nurse assigned to the resident if the dressing needed to be re-applied due to not being in place or soiled. Observation of Resident #1, on 03/31/15 at 11:20 AM, revealed the resident had a bleeding area on the left forearm. The resident used the sheet to blot the bleeding area on the forearm. Observation of Resident #1's skin assessment performed by the 300 Assistant Unit Manager, on 03/31/15 at 11:25 AM, revealed the Assistant Manager noted the new skin tear to Resident #1's left forearm. Review of Resident #1's Physician Verbal Telephone Order, dated 03/31/15 and timed at 11:45 AM, revealed the physician's orders [REDACTED]. Observation of Resident #1, on 03/31/15 at 2:05 PM, revealed the resident did not have a Kerlix on the left arm as ordered by the physician. Observation of Resident #1, on 04/01/15 at 7:46 AM, revealed the resident did not have a Kerlix on the left arm as ordered by the physician. Interview with the 300 Assistant Unit Manager, on 04/01/15 at 3:30 PM, revealed the physician's orders [REDACTED].#1's left arm should have been implemented within one hour after receiving the order. Continued review of the physician's orders [REDACTED].#1 also had an order for [REDACTED]. Observations of Resident #1, on 03/31/15 at 11:20 AM, 11:25 AM and 11:35 AM revealed Resident #1 was lying down on the bed without the ordered bilateral heel Medix boots in place. Interview with Certified Nursing Assistant (CNA) #9, on 03/31/15 at 11:35 AM, revealed she had not been in Resident #1's room since her shift started at 7:00 AM and she had not removed the bilateral heel boots. She stated the facility had a CNA care plan for each resident in their rooms for the CNAs to reference and she would have to reference that form to determine if the resident needed the boots on at all times while in bed. Interview with the 300 Assistant Unit Manager, on 03/31/15 at 11:25 AM, revealed Resident #1 had an order for [REDACTED]. He stated nursing staff were responsible for ensuring boots remained on while in bed. Post survey interview via telephone with CNA #10, on 04/23/15 at 2:40 PM, revealed the resident was to wear bilateral boots at all times while in bed. She stated although the CNA care plan did not state at all times, the staff knew this. However, the resident would kick them off and the CNAs would have to go back and check and replace the boots. Post survey interview via telephone with the 300 Unit UM, on 04/23/15 at 3:10 PM, revealed she ensured the resident's care plan was being followed by checking to see if the nurses had signed the treatment records for completion and she checked the residents against the CNA care plan to ensure the care plan was being followed. However, she stated this was done daily. She further stated the CNAs received report from the nurses and made rounds with oncoming shift for resident needs. 4. Review of Resident #5's clinical record revealed the facility admitted the resident on 10/17/14 with [DIAGNOSES REDACTED]. Review of Resident #5's Initial Activities Assessment, dated 02/09/15, revealed several areas on the form were not completed. A hand written note in the comment section stated the resident was unable to provide information for this assessment. The family provided the information, as the resident was end of life care. Further review of the assessment revealed check marks were placed next to music and spiritual events indicating these were Resident #5's likes. Review of Resident #5's Significant Change Minimum Data Set (MDS) assessment, completed on 02/09/15, revealed the facility assessed the resident as needing extensive assistance with dressing, eating, bathing and hygiene. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored a seven (7) out of fifteen (15) indicating severe cognitive impairment and not interviewable. Review of the Comprehensive Care Plan for Resident #5 revealed the facility developed an Activity Care Plan on 01/28/15 with a goal that did not have a target date that stated the resident would receive in room visit stimulation and would respond to the visits by opening his/her eyes and verbally respond to yes or no questions. The approaches on the care plan stated the activity staff would offer a schedule of activities for the resident to select choice(s), and would polish the resident's nails as needed. The resident would receive visits from a Deacon or Priest and would receive communion if able. Activity staff would hold the resident's hand during visits for comforting. Resident #5's care plan approaches stated the family was supportive and came to visit
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and review of the facility's policy, it was determined the facility staff failed to provide treatments for pressure wounds according to the care plan and physician orders [REDACTED].#1). The nursing staff failed to ensure abdominal pads remained in place to cover a staged pressure wound; failed to apply Kerlix wrap to a skin tear; and, failed to apply heel boots to the bilateral heels of Resident #1. The findings include: Review of the facility's policy titled, Physician Services, not dated, revealed a planned regimen of medical care for each resident which covers medications, treatments, restorative services, diet, special procedures recommended for the health and safety of the resident, activities, plans for continuing care and discharge are prescribed by the attending physician. However, the policy did not provide direction to staff regarding the time-frame for the implementation of verbal orders once received or how the facility would ensure orders remained in effect for each resident on an ongoing basis. Review of Resident #1's clinical record revealed the facility readmitted the resident on 06/19/14, after an acute hospital stay, with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 03/20/15, revealed the facility assessed the resident as needing extensive assistance with dressing, eating, bathing and hygiene. During the MDS assessment a Brief Interview for Mental Status (BIMS) was not conducted due to Resident #1 was rarely/never understood. Review of the Comprehensive Care Plan for Resident #1, dated 07/01/14, revealed a problem area of multiple Stage II and Stage III pressure ulcers. The facility assessed the resident to be at risk for worsening of these areas and additional skin failure. The goals included, the open areas will remain clean and discomfort will be managed until next review. Interventions revealed the staff was to provide treatments as ordered; low air loss mattress; reposition every two (2) hours; and provide incontinent care as needed. The Care Plan did not address the resident's heel boots to be worn at all times or the Kerlix to the skin tear. Review of Resident #1's Physician Orders, dated March 2015, revealed an order for [REDACTED]. Observation of Resident #1, on 03/31/15 at 9:30 AM, revealed the resident was lying on his/her left side on the bed. Resident #1 was raising the bed sheet which revealed the resident did not have a brief on and no abdominal pads were in place to the buttock/sacral area. Observation of Resident #1's skin assessment performed by the 300 Assistant Unit Manager, on 03/31/15 at 11:25 AM, revealed no abdominal pads were in place to the buttock/sacral area. Observation of Resident #1, on 04/01/15 at 10:02 AM, prior to the start of and during the bed bath, revealed no abdominal pads were in place to the buttock/sacral area. Interview with Licensed Practical Nurse (LPN) #1, on 04/01/15 at 3:30 PM, revealed Resident #1 had a treatment and dressing to the sacral area completed two (2) times a day as ordered by the physician. She stated she expected the nursing assistants to inform her when the dressing became soiled or needed replacement. Interview with the 300 Unit Assistant Manager, on 04/01/15 at 3:30 PM, revealed he did not know how to keep Resident #1's dressing in place without tape as ordered by the physician and would have to refer to the wound care nurse for direction. He stated he expected the nursing assistants to notify the nurse assigned to the resident if the dressing needed to be re-applied due to

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F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 12) not being in place or soiled. He stated he did not audit/monitor nursing staff dressing applications to determine if orders were implemented or being followed accordingly. Interview with Clinical Director of Nursing, on 04/01/15 at 3:30 PM, revealed she expected the nursing assistants to notify the nurse assigned to the resident if the dressing needed to be re-applied due to not being in place or soiled. Observation of Resident #1, on 03/31/15 at 11:20 AM, revealed the resident had a bleeding area on the left forearm. The resident used the sheet to blot the bleeding area on the forearm. Observation of Resident #1's skin assessment performed by the 300 Assistant Unit Manager, on 03/31/15 at 11:25 AM, revealed the Assistant Unit Manager noted the new skin tear to Resident #1's left forearm. Review of Resident #1's Physician Verbal Telephone Order, dated 03/31/15, and timed at 11:45 AM, revealed the physician's orders [REDACTED]. Observation of Resident #1, on 03/31/15 at 2:05 PM; and on 04/01/15, revealed the resident did not have a Kerlix dressing on the left arm as ordered by the physician. Interview with the 300 Unit Assistant Manager, on 04/01/15 at 3:30 PM, revealed the physician order [REDACTED]. Continued review of the Physician Orders, dated March 2015, revealed Resident #1 also had an order for [REDACTED]. Observations of Resident #1, on 03/31/15 at 11:20 AM, 11:25 AM and 11:35 AM revealed Resident #1 was lying down on the bed without the ordered bilateral heel Medix boots in place. Interview with Certified Nursing Assistant (CNA) #9, on 03/31/15 at 11:35 AM, revealed she had not been in Resident #1's room since her shift started at 7:00 AM and she had not removed the resident's bilateral heel boots. She stated the facility had a CNA care plan for each resident in their room so the CNAs could reference to determine the resident's needs. Interview with the 300 Unit Assistant Manager, on 03/31/15 at 11:25 AM, revealed Resident #1 had an order for [REDACTED].
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **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 staff administered tube feedings at the correct rate of infusion for one (1) of forty-three (43) sampled residents (Resident #2). Licensed Practical Nurse (LPN) #4 failed to ensure the tube feeding rate was set to infuse at 60 cc per hour for the 7:00 AM to 3:00 PM shift. The tube feeding rate was set at 50 cubic centimeters (cc) per hour thus infusing 333 cc of tube feeding instead of 480 cc. The findings include: Review of the clinical record for Resident #2 revealed the facility admitted the resident on 11/03/09 with [DIAGNOSES REDACTED]. The facility completed, on 12/23/14, a Significant Change Minimum Data Set (MDS) assessment which assessed the resident to be comatose and he/she had a Gastrostomy tube (feeding tube) in place for nutrition. Review of the March 2015 physician's orders [REDACTED]. Additionally, the order stated the tube feeding should be held one (1) hour before and one (1) hour after the resident received [MEDICATION NAME] [MEDICATION]). Review of the physician's orders [REDACTED]. The physician's orders [REDACTED]. Review of a Dietary Note, dated 02/17/15, revealed the resident had a weight loss in February of 5.6 pounds from 146 to 140.4; and, 4.6 pounds for the last three (3) months. The resident had a Stage IV (4) sacral wound that had improved and the tube feeding should be increased from Glucerna at 55 cc per hour to 60 cc per hour. Observation of a skin assessment for Resident #2, on 04/01/15 at 10:30 AM, revealed the resident had an open area on his/her sacrum. Review of the Wound Care Center's documentation revealed on 03/20/15 the Stage IV Sacral wound measured 1.4 x 0.7 cm with 100% granulation with no foul odor noted. There was fragile scar tissue and to continue current wound treatment. On 03/6/15 the wound measured 2.4 x 1.8 cm with 100% granulation tissue. The Wound Care Center documented the wound looked good. On 02/13/15 the sacrum wound measured 2 .5 cm x 0.2 cm with granulation, palliative care. On 01/23/15 the sacrum wound measured 1.4 x 2 cm with granulation but the wound had macerated edges, continue with same treatment. On 01/09/15 , the wound measured 1.5 x 2 cm. Further review of a Dietary Note, dated 03/16/15, revealed the resident's Glucerna was increased last month due to weight loss of one (1) pound. The 03/25/15 Note, stated the resident had lost five (5) pounds since January from 146 to 141 pounds and the Dietary Note, dated 03/31/15, stated the resident had lost six (6) pounds in the last three (3) months from 147.2 to 141 pounds and his/her tube feeding had been increased. Observation of Resident #2, on 03/30/15 at 5:15 PM, revealed the resident did not respond when spoken to and only moved his/her eyes around the room. Observations, on 03/31/15 at 8:34 AM, 10:40 AM, 11:30 AM, 11:56 AM, 12:10 PM, and 3:22 PM, revealed the tube feeding rate was set at 50 cc per hour rather than the physician ordered 60 cc per hour. Review of the Treatment Administration Record (TAR), dated March 2015, revealed on 03/31/15, staff documented Resident #2 received 333 cc on the 7:00 AM to 3:00 PM shift with Glucerna infusing at 60 cc per hour; rather than the observed rate provided at 50 cc's per hour. The 7:00 AM to 3:00 PM shift included the hold time of one hour before to one hour after the administration of [MEDICATION NAME]. Interview, on 04/02/15 at 2:22 PM, with Licensed Practical Nurse (LPN) #4 revealed she provided care for Resident #2 on 03/31/15 during the day shift. She stated when she came on duty the feeding had been held, due to the [MEDICATION NAME] medication from 6:00 AM to 7:00 AM. The nurse stated she started the tube feeding at 7:00 AM at the rate that was already programmed in the pump. The LPN further stated she could not remember if she checked the pump for the correct rate. She stated she did not recall if the tube feeding was held during the shift and there were no problems with the tube feeding infusion that day. The nurse stated she checked how much tube feeding the resident received, around 2:00 PM, and the resident had received 333 cc on the day shift. Post survey interview, on 04/15/15 at 3:56 PM, with LPN #11 revealed a resident's tube feeding should be checked when it was changed; at the beginning of the shift; during medication administration; and, at the end of the shift. She stated the nurse should sign the Medication Administration Record (MAR) that the tube feeding was given. The nurse further stated Resident #2's tube feeding was turned off for certain medications and would then be re-started after the time the medication had been given. She stated the tube feeding would be discussed during nursing report only if there was a change in the type of feeding or the rate. The nurse stated the resident was NPO (received nothing by mouth). The LPN further stated the resident did have an area on his/her bottom and the rate of the tube feeding may have been increased due to the weight loss. She stated if the tube feeding rate was less than what was ordered, the resident's blood sugars could run low or the resident could have weight loss or develop skin issues. Post survey interview with Unit Manager (UM) #8, on 04/15/15 at 4:04 PM, revealed the resident's tube feeding and rate were listed on the MAR. She stated the nurses should check the resident's tube feeding at the beginning of the shift; when connecting a new bottle; when giving medications; and, at the end of the shift. She stated the tube feeding would be turned off for a while when the resident received [MEDICATION NAME] and the nurse should check the tube feeding when they turned it back on after the medication was given. She stated the resident's tube feeding rate was changed to 60 cc per hour due to weight loss and the resident was nutritionally at risk. The UM further stated she monitored residents with tube feedings through rounding during the shift. She stated if the resident received a tube feeding rate less than ordered, the resident could have weight loss, have slow wound healing, or not get the nutrition the resident needed.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on interview, record review, and review of the facility's policies, Administrator's job description, and the facility's Allegation of Compliance (AOC) dated 04/09/15, it was determined the facility failed to have an effective system in place to ensure the Administrator provided oversight of the corrective actions in the AOC and to ensure all aspects of the AOC and Abuse Policy were implemented and followed by staff to ensure residents were free from abuse for two (2) of forty-three (43) sampled residents (Residents #36 and #37). (Refer to F225, F226 and F520) Immediate Jeopardy (IJ) was identified on 04/03/15 and was determined to exist on 04/01/15 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) at a Scope and Severity of a J; and, at 42 CFR 483.20 Resident Assessment (F282) at a Scope and Severity of a J. The facility's AOC, dated 04/09/15, alleged the IJ was removed on 04/09/15. However, during an abbreviated survey initiated on 04/28/15 (investigating complaints KY and KY) it was determined the IJ at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) had not been removed as alleged, on 04/09/15. Per the facility's AOC, when an allegation of abuse was reported, the Administrator/Nursing Administrator would be notified; the alleged perpetrator would be placed on Administrative leave; and, the State Agencies would be notified not to exceed twenty-four (24) hours if no injury occurred. Per the AOC, the Compliance Auditor or the Quality Assurance (QA) Director would audit weekly the revised abuse allegation logs and new abuse allegation checklist (tools developed to assist with the facility's investigations) and the results of the audits would be brought to the QA committee. Interview and record review determined the facility failed to implement these components of the AOC after the facility self-reported two (2) abuse allegations. On 04/19/15, ten (10)

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) days after the facility had alleged the removal of IJ, Resident #36 alleged Certified Nurse Aide (CNA) #22 was mean and rude and threw the bed covers over the resident's head. CNA #22 was allowed to care for other residents after the abuse allegation was received. The facility did not reported the allegation to the SSA until 4:09 PM on 04/20/15, greater than twenty-four (24) hours after the incident occurred. On 04/26/15, seventeen (17) days after the facility had alleged the removal of IJ, CNA #24 failed to follow the facility's abuse policy for reporting incidents of abuse immediately to the nurse. CNA #24 alleged he saw Outreach Technician (ORT) Restorative Aide #1 kiss Resident #37 on the lips. However, he did not report what he had witnessed until hours later after the alleged perpetrator had left for the day. The ORT Restorative Aide #1 had provided care to approximately forty (40) other residents before the end of his shift. In addition, the facility failed to report the abuse allegation to the State Survey Agency until two (2) days after the alleged abuse occurred. The facility's failure to ensure the Administrator administered in a manner to ensure corrective actions of the AOC were implemented and monitored to protect residents from abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was determined to exist on 04/01/15. The facility provided an acceptable (AOC) on 05/07/15, which alleged removal of the Immediate Jeopardy on 05/06/15. The State Survey Agency verified Immediate Jeopardy was removed as alleged prior to exit on 05/13/15. The Scope and Severity was lowered to a D while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: Review of the facility's policy regarding Abuse Prevention, Intervention and Data Collection, revised April 2015, revealed the facility would protect residents from abuse. The facility would remove any employee who was suspected of abuse immediately and place on administrative leave during the investigation. The policy stated all employees were required to report immediately any observations, suspicions or information of suspected abuse to the nursing supervisor. After consulting with the Administrator, the supervisor will immediately report the concern to the State Agencies. Review of the Administrator's job description, dated 10/03/2005, revealed the Administrator's primary function was to manage operations in accordance with current applicable federal, state, and local standards, guidelines, and regulations to assure that the organization is operating effectively and efficiently. The individual would strive to provide to all those entrusted to his/her care the highest quality of appropriate services possible in light of resources or other constraints. Practice administration in accordance with capabilities and proficiencies and strive, in all matters relating to their professional functions, to maintain a professional posture that places paramount the interests of the facility and its residents. Interview with the Administrator, on 04/30/15 at 3:45 PM, revealed he provided oversight over the DONs who conducted the abuse investigations. He stated the abuse investigations were discussed with him. He stated he was not aware CNA #22 was allowed to work after the abuse allegation was received from Resident #36 because the Clinical DON did not know. He was told the aide had been placed on administrative leave. He said he thought the checklist were working. When he saw the checks he assumed the two DONs had reviewed it. Both have to sign off on the abuse log indicating that the investigation was complete. They were to look at each area checked. The Administrator stated the Compliance Auditor's responsibility was to ensure each step was done on the checklist, not just check for marks. He stated he assumed that all steps had been done. He was unaware residents were not protected during an abuse investigation and allegations were not reported according to facility policy. The Administrator stated monitoring and audits were tools used to ensure the AOC was implemented. He revealed he had questioned the Compliance Auditor about the audits, but only spoke of ensuring they were done, not of content. No issues with the audits had been reported to him. Review of the acceptable AOC, dated 04/09/15, revealed the abuse allegation checklist and abuse allegation log would be audited by the Compliance Auditor and the results would be brought to the QA committee. However, interview with the Compliance Auditor, on 04/30/15 at 1:15 PM revealed this was not done. Continued interview with the Administrator, on 04/30/15 at 3:45 PM, revealed the QA conducted on 04/27/15 was a quarterly QA where the committee discussed issues from January, February, and March 2015. He said they did not talk about the AOC and did not bring the AOC to review during that QA meeting. He added the DONs did not discuss any abuse investigations. He stated the results of the audits conducted by the Compliance Auditor were not discussed and there was limited talk about deficiencies and corrective actions. He said it was his responsibility and there needed to be closer monitoring. The Administrator stated the AOC had not been implemented and he could not say that enough oversight had been provided. He stated he was not sure where the breakdown occurred; however, a lot of assumptions were made. He further stated he did not ask the Medical Director for input. 1. Review of the facility's investigation, initiated on 04/20/15, revealed the Certified Medication Technician (CMT) #2 received an allegation of physical abuse from Resident #36 on 04/19/15. The resident alleged CNA #22 had thrown the bed covers over the resident's head and the aide was mean and rude to the resident. The investigation revealed the CMT reported the allegation to LPN #9 and she obtained a written statement from CNA #22; however the aide was allowed to work with other residents after the abuse allegation was received. Further review of the abuse investigation revealed the Clinical DON failed to determine when the aide was suspended and did not know CNA#22 was allowed to care for other residents. The five (5) day follow up report, dated 04/27/15, revealed the facility found the allegation of mistreatment to be substantiated. Interview with CNA #22, on 04/28/15 at 5:25 PM, LPN #9, on 04/29/15 at 9:42 AM, and CNA #23, on 04/29/15 at 10:58 AM, revealed CNA #22 was allowed to care for other residents after the abuse allegation was received. Review of CNA #22's time card, for 04/19/15, revealed CNA #22 worked until 11:00 AM, several hours after the abuse allegation was received at 9:30 AM. Interview with the Clinical DON, on 04/29/15 at 4:05 PM, revealed the investigation had not identified CNA #22 had not been removed from patient care immediately and had been allowed to care for other residents after the abuse allegation was reported. She She had not asked during her investigation and stated she had no reason to review CNA #22's time card 2. Interview with the Administrative DON, on 04/29/15 at 2:24 PM, revealed she had not concluded the investigation of alleged abuse for Resident #37. She stated her investigation had identified CNA #24 did not report the alleged abuse right away on 04/26/15. She stated the ORT Restorative Aide had already left for the day when the allegation was reported and had not worked since. He was placed on administrative leave pending the investigation. She stated the incident occurred on Sunday, April 26, 2015 around 1:00 PM and the House Supervisor was not notified until 4:50 PM. In addition, the Administrative DON revealed she had not reported the alleged abuse to the State Survey Agency until two days after the alleged abuse was reported (04/28/15 at 3:10 PM). She stated the facility's fax machine was not working on 04/27/15 and she did not call and report the abuse allegation. Telephone interview with CNA #24, on 04/29/15 at 3:07 PM, CNA #25, on 04/30/15 at 3:28 PM, and CNA #26, on 04/30/15 at 3:17 PM, revealed they failed to report the alleged abuse according to the facility's abuse policy. Review of the House Supervisor's written statement revealed on 04/26/15 at approximately 4:45 PM, LPN #10 reported ORT Restorative Aide #1 was observed by CNA #24 kissing Resident #37 on the lips. She texted the Administrative DON at 4:51 PM notifying her of the event. Review of ORT Restorative Aide #1's time card for 04/26/15 revealed the ORT worked from 7:00 AM to 3:15 PM. Review of the Restorative Care Participation documentation for 04/26/15 revealed the ORT Restorative Aide documented at 1:27 PM he had worked with Resident #37 for thirty (30) minutes. In addition, the aide documented he provided restorative care to forty (40) residents after Resident #37's session. The State Survey Agency validated the removal of Immediate Jeopardy on 04/09/15 prior to exit as follows: 1. Interview, on 04/09/15 at 4:48 PM, with the Clinical DON revealed she notified Resident #21's physician and family, DCBS and OIG the day the allegation was made, on 04/01/15. Review of the facility's investigation revealed the notifications were made on 04/01/15. 2. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she interviewed and assessed Resident #21 on 04/01/15 for behavioral and psychosocial concerns. The resident was not tearful and did not express any anxiety. Review of the facility's investigation revealed the Clinical DON interviewed the resident on 04/01/15. 3. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she interviewed Resident #21 on 04/02/15. 4. Interview, on 04/09/15 at 5:03 PM, with the Administrative DON revealed the alleged CNA was placed on administrative leave on 04/02/15. Interview with CNA #5, on 04/03/15 at 8:40 AM, revealed the facility suspended her on 04/02/15. 5. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, the Administrative DON, on 04/09/15 at 5:03 PM, and the Administrator, on 04/09/15 at 5:14 PM, revealed the Administrator trained the Clinical DON and Administrative DON, on 04/03/15, on the abuse policy and collecting statements jointly, with verbalized understanding. Review of the training records revealed, on 04/03/15, the Administrator trained the Clinical DON and Administrative DON on the abuse policy and collecting statements jointly. 6. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she developed the investigation checklist, on 04/03/15, to ensure every step had been taken during an investigation. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she had been trained by the Administrative DON on the use of the investigation checklist and completed by either DON. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed he approved the new Investigation Checklist. Review of the Investigation Checklist revealed an effective date of April 2015. 7. Interview, on 04/09/15 at 4:48 PM, with the Clinical DON and, on 04/09/15 at 5:03 PM, with the Administrative DON revealed the

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) Administrative DON revised the Allegation Log to include two (2) sets of signatures for review by nursing administration. The Administrative DON trained the Clinical DON how to use the log. Interview, on 04/09/15 at 5:14 PM, with the Administrator revealed he approved the revised Allegation Log which required both DONs to initial they had reviewed the allegations. Review of the Allegation Log revealed it contained Nursing Administration review and was revised April 2015, and was reviewed by the Clinical DON, Administrative DON, the Clinical Support Services, and Administrative Nursing Assistant. Review of the revised allegation log revealed a place for two (2) signatures were added on 04/03/15. 8. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she interviewed other interviewable residents regarding possible issues with care and abuse. Review of the Resident Interviews for Resident #21's investigation, dated 04/08/15, revealed, on 04/07/15, the Administrative DON interviewed fourteen (14) interviewable residents if there were any issues or concerns with staff. No concerns were noted. Interview, on 04/09/15 at 4:25 PM, with the Treatment Nurse revealed she completed skin assessments of eight (8) non-interviewable residents, on 04/08/15, on the 3rd floor. She stated she completed one side of the unit and the Outreach Technician (ORT) nurse completed the other side of the unit with no concerns noted. Review of six (6) skin assessments and two (2) wound assessments revealed skin assessments were completed on 04/08/15. Interview with Resident #4, on 04/01/15 at 10:25 AM; Resident #12, on 03/31/15 at 8:46 AM; Resident #13, on 03/31/15 at 7:47 AM; Resident #15, on 04/01/15 at 10:20 AM; and, Resident #16, on 03/31/15 at 9:30 AM, revealed no concerns with staff interactions with the residents. 9. Interview, on 04/09/15 at 5:03 PM, with the Administrative DON revealed she reviewed facility allegations for the last year, for a total of twenty-five (25) investigations with no concerns noted. Review of a statement by the Administrative DON, dated 04/07/15, revealed twenty-five (25) investigations were reviewed in the last twelve (12) months by the Administrative DON, with no concerns noted. Review of four (4) investigations revealed no regulatory violations for Residents #31, #32, #33 and #34. 10. Interviews on 04/09/15 with a total of fifty (50) employees revealed: seventeen (17) CNAs (CNA #13 at 1:56 PM, CNA #3 at 1:57 PM, CNA #22 at 2:00 PM, CNA #21 at 2:06 PM, CNA #8 at 2:12 PM, CNA #9 at 2:20 PM, CNA #17 at 2:21 PM, CNA #15 at 2:52 PM, CNA #14 at 2:46 PM, CNA #16 at 3:05 PM, CNA #19 at 3:05 PM, CNA #10 at 3:09 PM, CNA #18 at 3:12 PM, CNA #20 at 3:15 PM, CNA #11 at 3:17 PM, CNA #23 at 3:20 PM, CNA #12 at 3:31 PM), six (6) LPNs (LPN #1 at 3:07 PM, LPN #5 at 2:47 PM, LPN #3 at 2:45 PM, LPN #9 at 3:07 PM, LPN #10 at 3:30 PM, LPN #8 at 2:18 PM, RN #4 at 2:09 PM, five (5) Unit Managers (UM/RN #2 at 2:00 PM, UM/RN #3 at 2:27 PM, UM/RN #6 at 3:00 PM, UM #1 at 3:00 PM, UM/RN #7 at 3:35 PM), three (3) housekeepers (Housekeeper #2 at 2:09 PM, Housekeeper #3 at 2:15 PM, Housekeeper #4 at 2:15 PM), a CSR at 2:27 PM, a Dietary Aide at 2:31 PM, Central Supply at 2:51 PM, Rehabilitation Secretary at 2:40 PM, Rehabilitation Director at 2:42 PM, the Nutrition Services Director at 1:58 PM, the Social Services Director at 2:11 PM, the Activities Director at 2:24 PM, RAI Coordinator at 2:34 PM, HR Director at 2:43 PM, Receptionist at 3:02 PM, Compliance Auditor at 3:31 PM, QA Director at 3:45 PM, Rehab Manager at 3:55 PM, Treatment Nurse at 4:25 PM, House Supervisor at 4:33 PM, Clinical DON at 4:48 PM, and the Administrative DON at 5:03 PM revealed they had all received abuse training within the last week; they were aware of the types of abuse; when to report abuse; and, to who to report alleged abuse. Review of the training records revealed three hundred and eleven (311) staff had completed post tests between 04/02/15 and 04/08/15. Interview with the HR Director, on 04/09/15 at 2:43 PM, revealed all staff had been trained on abuse except those staff on vacation or leave. The HR Director stated a sign was posted at the time clock and a letter was mailed to those staff not yet trained, that they must receive training prior to working. Observation, on 04/09/15 at 4:04 PM, of the time clock revealed a sign posted with thirteen (13) staff names to obtain abuse training prior to going to their unit. Review of the letter sent to staff revealed it was dated 04/08/15 from the HR Director that stated staff must receive the abuse training and answer the questionnaire before they started work. Review of the facility's staff roster revealed the letter was mailed to ten (10) employees, who were either sick, on vacation, or leave of absence. 11. Interview with the Compliance Auditor, on 04/09/15 at 3:31 PM, and the QA Director, on 04/09/15 at 3:45 PM, revealed they would review the Allegation Log for completion and signatures weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter. They stated the audits would go to the QA meetings for review. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed the Compliance Auditor would conduct audits of the Allegation Log and report the findings to the QA Committee. 12. Interview, on 04/09/15 at 3:31 PM, with the Compliance Auditor and, on 04/09/15 at 3:45 PM, with the QA Director revealed either would audit the Investigation Checklist weekly for four (4) weeks, monthly for three (3) months, then quarterly for a year with results to QA the Committee. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed the Compliance Auditor would audit the Investigation Checklist and report to the QA Committee. Review of the Investigation Checklist revealed an inception date of 04/03/15. 13. Review of the third floor care plan updates revealed, on 04/03/15, the care plan for Resident #21 was updated by the RAI Coordinator. 14. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she reviewed resident behavior and antipsychotic care plans on 04/08/15, and then all residents, checking if the care plan had been updated, initiated, and implemented, with no concerns noted. Review of care plan audits for all six (6) floors, dated 04/07/15 revealed all care plans were reviewed for residents on each floor of the facility with 119 care plans revised. 15. Interview with the Social Services Director, on 04/09/15 at 2:11 PM, the RAI Coordinator, on 04/09/15 at 2:43 PM, with the UM on the 2nd floor (RN #2 on 04/09/15 at 2:00 PM and RN #3 on 04/09/15 at 2:27 PM), the UM on the 3rd floor, on 04/09/15 at 3:00 PM, and the Administrative DON, on 04/09/15 at 5:03 PM, revealed they received care plan training this week and was conducted by the Administrative DON, that included who initiated and updated the care plan, and how to implement the care plan, with verbal competency. Review of the care plan training records revealed care plan training included who initiated and updated the care plan, when the care plan should be revised, and who was responsible to implement the care plan. 16. Interview, on 04/09/15 at 2:00 PM, with UM/RN #2; on 04/09/15 at 2:27 PM, with UM/RN #3; and, on 04/09/15 at 3:00 PM, with UM #1 revealed walking rounds were conducted throughout the shift, but they did not document those rounds. The UMs stated they were observing direct staff to ensure care was provided according to the resident's care plan. Review of care plans revealed Resident #4's care plan was revised on 04/07/15, based on the UM rounds, to reflect the current placement in isolation. 17. Interview with the RAI Coordinator, on 04/09/15 at 2:34 PM, revealed she held a Program of Care meeting on 04/08/15 to review and ensure resident care plans were appropriate. Meetings would be held weekly, with discussion of certain residents each week, with all residents discussed quarterly. Interview with the Nutrition Services Director, on 04/09/15 at 1:58 PM; the Social Services Director, on 04/09/15 at 2:11 PM; the Activities Director, on 04/09/15 at 2:24 PM, revealed their assistants would attend the Program of Care meetings; however, the Directors would attend in the assistants place when needed, and would discuss resident care plan interventions. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed the Program of Care meetings would review that resident care plans were up to date, make any needed changes, and interventions were implemented. 18. Interview, on 04/09/15 at 3:31 PM, with the Compliance Auditor revealed she would audit the Program of Care meetings three (3) times a week for four (4) weeks, three (3) times a month for one (1) quarter, then quarterly and give the results to the DON for the QA Committee. 19. Interview with the Compliance Auditor, on 04/09/15 at 3:31 PM, revealed she would conduct ten (10) chart audits each month for three (3) months, then quarterly to ensure care plans were updated and interventions performed, with discrepancies corrected by the UM. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed the Compliance Auditor would complete ten (10) chart audits and ensure the residents' care plans interventions were implemented; the UM would correct any issues immediately. She stated results would be taken to the QA Committee. Review of the Care Plan Monitoring Tool, dated April 2015, revealed it included review of the resident care plan, if the care plan had been updated, observations, concerns, if the care plan was followed, and Assistant UM or UM aware of result. 20. Interview with the Nutrition Services Director, on 04/09/15 at 1:58 PM, the Social Services Director, on 04/09/15 at 2:11 PM, the Activities Director, on 04/09/15 at 2:24 PM, the HR Director, on 04/09/15 at 2:43 PM, the Compliance Auditor, on 04/09/15 at 3:31 PM, the QA Director, on 04/09/15 at 3:45 PM, the Rehab Manager, on 04/09/15 at 3:55 PM, the Medical Director, on 04/09/15 at 4:07 PM, the Treatment Nurse, on 04/09/15 at 4:25 PM, the Clinical DON, on 04/09/15 at 4:48 PM, the Administrative DON, on 04/09/15 at 5:03 PM, and the Administrator, on 04/09/15 at 5:14 PM, revealed they attended QA meetings, with three (3) held, and discussed the Immediate Jeopardy (IJ), corrective actions, care plans, new checklists, and training. Review of sign in sheets that included review of the IJ and corrective actions revealed QA meetings were held on 04/03/15, 04/06/15, and 04/08/15. An abbreviated survey conducted 04/28/15 investigating KY and KY determined the facility failed to implement the corrective actions of the AOC dated 04/09/15. Review of the acceptable AOC, dated 04/09/15, revealed the abuse allegation checklist and abuse allegation log would be audited by the Compliance Auditor and the results would be brought to the QA committee. Review of the newly developed checklist to be utilized by the facility to ensure abuse investigations were completed, (which was an intervention on the AOC) revealed no date when it was completed and only checks on the forms without any additional information provided. Interview with the Compliance Auditor, on

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	185122	A. BUILDING _____ B. WING _____	05/13/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWAY MEDICAL CENTER	1155 EASTERN PARKWAY LOUISVILLE, KY 40217

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** - Few	(continued... from page 15) 04/30/15 at 1:15 PM, revealed when she reviewed the newly developed checklist she only looked for the check marks and did not review the content of the investigation. In addition, she stated the audits of the abuse investigation checklist were not taken to the Quality Assurance (QA) meeting on 04/27/15. Interview with the Administrator, on 04/30/15 at 3:45 PM, validated the audits of the checklist and the abuse logs were not discussed at the 04/27/15 QA meeting. Immediate Jeopardy was determined not to be removed on 04/09/15 as alleged. The facility was notified of this finding on 04/30/15. The facility took the following actions to remove the Immediate Jeopardy on 05/06/15 as follows: 1. The Clinical DON made notification on 04/20/15 of the allegation (KY) to Resident #36's family, physician, OIG and DCBS. The Administrative DON made notification of the allegation of abuse (KY) to Resident #37's family and Physician on 04/27/15. Notification to the OIG and DCBS was made on 04/28/15. 2. On 04/21/15, a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor with no injuries consistent with abuse noted. Fifty-six (56) skin assessments were completed on non-interviewable residents by Unit Managers, Assistant Managers, and Staff Development Nurse as of 05/04/15. No issues were found. 3. 05/04/15, one hundred thirty (130) residents were interviewed by Social Services, and the RAI Coordinators to ensure there were no unresolved or uninvestigated allegations of abuse. No issues were identified. 4. The abuse allegation checklist was revised on 04/28/15 by the Clinical DON to reflect name, date, and time of actions, with a space for narrative documentation to record all actions taken during the abuse investigation. 5. On 05/01/15, the facility obtained the services of a consultant company to provide assistance with training, policy revision, QA and ongoing oversight and consultation. These consultant employees included Nurses, therapists, and Administrators. The facility's Administrative DONs, Human Resources Director, and Assistant Director of Nurses met with the consultants and revised the abuse policy to reflect procedures for immediate protection of residents by removal of the alleged perpetrator from patient care and reporting immediately allegations of any abuse to the state agencies. All staff would receive training on the new Abuse policy revisions and no staff would work past 05/05/15 without receiving the training. This would include agency staff. 6. On 05/05/15, education was provided by the contracted consultant on requirements for abuse allegation reporting and investigation with competency. No staff would be allowed to work past 05/05/15 without receiving the training. This would include agency staff. As of 05/05/15, two hundred ninety-seven (297) employees had been trained. 7. On 05/04/15, the facility implemented a new Nurses' Abuse Allegation Investigation Protocol. The protocol was a step by step reference for nurses and House Supervisors to be used when a resident alleged abuse. The protocol was posted in visible locations on all nursing units and included in all staff education. (Attachment B) 8. On 05/04/15, a QA meeting was held to review the alleged deficient practice and plans of actions established to correct the practices. The consultant observed the QA meeting. Members present included the Administrator, Consultant, Social Services, Medical Director, DONs and other Department Directors. The Administrator established a weekly QA meeting that included review of the deficiencies cited. 9. On 05/04/15, the Elder Justice Act reporting notification requirements was added to the admission packet. The revised Abuse policy and Elder Justice Act information was placed in a binder at the receptionist desk. 10. On 05/05/15, five (5) random staff and resident interviews would be conducted weekly by Social Services and Nursing Administration to ensure there were no unresolved/investigated abuse allegations and staff understanding of reporting requirements. 11. On 05/04/15, the contracted consultant educated the Administrator and made observations at the facility to ensure the Administrator was administering the facility in accordance with professional standards and per his job description included ensuring a system was in place to protect residents from abuse and neglect. 12. Beginning 05/01/15, a consultant would conduct weekly visits for four weeks then monthly visits to ensure the Administrator followed professional standards and job description ensuring systems remained in place for reporting and investigation of allegations of abuse and neglect per established plan of correction. The Administrator established weekly administrative consultative visits with the consultants. 13. The contract consultant re-educated the Administrator, on 05/04/15, on the requirements of a functional QA process to include delegation of action items for identified concerns including oversight of entire AOC and implementation of systems and follow-up to ensure corrections were made and reviewed with the Interdisciplinary Team (IDT). 14. Beginning 05/04/15 the Human Resources Director would update the Administrator daily of the status of staff training on abuse. 15. On 05/05/15, the Administrator amended the agenda for the daily quality meeting with the IDT, to address deficiencies cited. This included reviewing audits, education, and ongoing monitoring to determined effectiveness of current actions. 16. Weekly QA meetings that began on 05/04/15, was held to review identified concerns regarding any issues with the Plan of Correction and follow-up to ensure corrections were sustained. The meeting would consist of at a minimum the Administrator, Director of Nursing, Social Services, Assistant Director of Nursing, and other Department Directors. The contract consultant would observe the QA process monthly, including audit tools (attachment E) for at least three (3) months to ensure Quality Assurance Performance Improvement Committee was functional and meeting the identified needs of the facility. The QA committee would consist of the Administrator, DONs, ADON, Social Services, and the Medical Director attending at least quarterly. When the Medical Director was present, they would review a sample of residents' abuse allegations for effectiveness in the revised processes. The QA meeting would review audits (and take action if needed) related to the deficiencies. Theses audits would include resident interviews and skin audits conducted on 05/04/15 and abuse audits which began on 04/08/15 and are ongoing. The reports would be presented by the Compliance Auditor. The State Survey Agency validated the removal of Immediate Jeopardy on 05/13/15 prior to exit as follows: 1. Review of the clinical record and facility investigation validated the Clinical DON notified Resident #36's family, physician, OIG, and DCBS on 04/20/15. Review of the fax verification revealed the OIG was notified on 04/20/15 at 4:09 PM. Review of the clinical record and facility investigation revealed the Administrative DON notified Resident #37's family and physician on 04/27/15. Review of the faxed verification sheet revealed notification to the OIG on 04/28/15 at 3:11 PM. Review of the Department of Community Based Services (DCBS) intake summary revealed the notification was received on 04/29/15. Interview with the Administrative DON, on 04/29/15 at 2:24 PM, revealed the facility's fax machine was broken on Monday, April 27, 2015 and she failed to provide notification via telephone. 2. Review of facility's investigation revealed a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor on 04/21/15, with no injuries consistent with abuse. Review of the skin assessments conducted by the Unit Managers, Assistant Managers, and Staff Development Nurse through 05/04/15, revealed fifty-three (53) skin assessments were conducted for residents with a BIMS score less than eight (8). 3. Review of the resident interview forms revealed Social Services, and the RAI Coordinators conducted one hundred t
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on interview and review of the facility's policy and Acceptable Allegation of Compliance (AOC) dated 04/09/15, it was determined the facility failed to maintain a Quality Assurance (QA) program implemented and monitored the plans of actions as stated the Allegation of Compliance to correct quality deficiencies as evidenced by the facility's failure to ensure the Abuse Policy was implemented to protect residents from abuse for two (2) of forty-three (43) sampled residents (Resident #36 and #37). (Refer to F225, F226 and F490) Immediate Jeopardy (IJ) was identified on 04/03/15 and was determined to exist on 04/01/15 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) at a Scope and Severity of a J; and, at 42 CFR 483.20 Resident Assessment (F282) at a Scope and Severity of a J. The facility's AOC, dated 04/09/15, alleged the IJ was removed on 04/09/15. However, during an abbreviated survey initiated on 04/28/15 (investigating complaints KY and KY) it was determined the IJ at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) had not been removed as alleged, on 04/09/15. Per the facility's AOC, when an allegation of abuse was reported, the Administrator/Nursing Administrator would be notified; the alleged perpetrator would be placed on Administrative leave; and, the State Agencies would be notified not to exceed twenty-four (24) hours if no injury occurred. Further review of the revealed the Compliance Auditor or the Quality Assurance (QA) Director would audit weekly the revised abuse allegation logs and new abuse allegation checklist (tools developed to assist with the facility's investigations) and the results of the audits would be brought to the QA committee. However, interview with the Compliance Auditor, on 04/30/15 at 1:15 PM, revealed she only audited the checklist forms to ensure the check marks were made. She did not review any abuse investigation to ensure they were completed, or that they followed the facility's abuse policy. The audits conducted were not taken to the 04/27/15 QA meeting as stated in the AOC. Interview and record review determined the facility failed to implement these components of the AOC after the facility self-reported two (2) abuse allegations. On 04/19/15, ten (10) days after the facility had alleged the removal of IJ, Resident #36 alleged Certified Nurse Aide (CNA) #22 was mean and rude and threw the bed covers

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 16) over the resident's head. CNA #22 was allowed to care for other residents after the abuse allegation was received. The facility did not reported the allegation to the SSA until 4:09 PM on 04/20/15, greater than twenty-four (24) hours after the incident occurred. On 04/26/15, seventeen (17) days after the facility had alleged the removal of IJ, CNA #24 failed to follow the facility's abuse policy for reporting incidents of abuse immediately to the nurse. CNA #24 alleged he saw Outreach Technician (ORT) Restorative Aide #1 kiss Resident #37 on the lips. However, he did not report what he had witnessed until hours later after the alleged perpetrator had left for the day. The ORT Restorative Aide #1 had provided care to approximately forty (40) other residents before the end of his shift. In addition, the facility failed to report the abuse allegation to the State Survey Agency until two (2) days after the alleged abuse occurred. The facility's failure to have an effective system in place to ensure the QA committee functioned to identify quality deficiencies, develop plans of action, and implement the plans of action has caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 04/01/15. The facility provided a new acceptable (AOC) on 05/07/15 which alleged removal of the Immediate Jeopardy on 05/06/15. The State Survey Agency verified Immediate Jeopardy was removed as alleged prior to exit on 05/13/15. The Scope and Severity was lowered to a D while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: The facility did not provide a policy regarding a Quality Assurance Program. Review of the facility's policy regarding Abuse Prevention, Intervention and Data Collection, revised April 2015, revealed the facility would protect residents from abuse by removing any employee who was suspected of abuse immediately and place on administrative leave during the investigation. The policy stated all employees were required to report immediately any observations, suspicions or information of suspected abuse to the nursing supervisor. After consulting with the Administrator, the supervisor would immediately report the concern to the State Agencies. The Compliance Auditor audited the checklist forms to ensure only the check marks were made. She did not review any abuse investigation to ensure they were completed, or that they followed the facility's abuse policy. The audits conducted were not taken to the 04/27/15 QA meeting as stated in the AOC. Review of the AOC, dated 04/09/15, revealed the abuse allegation checklist and abuse allegation log would be audited by the Compliance Auditor or Quality Assurance Director weekly times four (4) weeks, then monthly, then quarterly. Results of the audits would be brought to the QA Committee. Review of the QA Sign-in Sheets revealed a QA meeting was held on 04/27/15. Interview with the Compliance Auditor, on 04/30/15 at 1:15 PM, revealed she only audited to ensure the checklist was completed. She stated she only looked to ensure each area was checked; however, she did not go back and see if the investigation had been completed. She stated she was just checking for the check marks. Further interview revealed she conducted the audits on the abuse investigation log in the same manner. She was only looking to see if there were two (2) signatures present on the abuse log . She did not check for content. She stated she took the audits to the Quality Assurance (QA) meeting conducted on 04/27/15, but they were not discussed, per the AOC the audits were to be discussed in QA. She revealed this was a quarterly QA meeting and only issues from January, February, and March were discussed. The QA Committee decided to review the audits in the July QA meeting. Further interview revealed she had not identified an problems, as she was only looking for the check marks. Interview with the Administrator, on 04/30/15 at 3:45 PM, revealed he provided oversight over the Director of Nurses (DONs), who conducted the abuse investigations. He stated the abuse investigations were discussed and it was an ongoing process. He said he thought the checklists were working. When he saw the checks he assumed the two (2) DONs had reviewed it, as the both have to sign off on the abuse log that the investigation was complete. He stated the Compliance Auditor's responsibility was to ensure each step was done on the checklist, not just check for marks. He stated he assumed that all steps had been completed. He was unaware residents were not protected during an abuse investigation and allegations were not reported according to facility policy. The Administrator stated monitoring and audits were tools used to ensure the AOC was implemented. He stated he had questioned the Compliance Auditor about the audits, but they only spoke of ensuring they were done, not of their content. No issues with the audits had been reported to him and he was told they were being implemented. Continued interview with the Administrator revealed the QA conducted on 04/27/15 was a quarterly QA where the committee discussed issues from January, February, and March 2015. Per interview, the committee did not talk about or review the AOC and the DONs did not discuss any abuse investigations during this meeting. In addition, he stated the Compliance Auditor did not discuss the results of the audits conducted and there was limited talk about deficiencies and corrective actions. He said there needed to be closer monitoring. The State Survey Agency validated the removal of Immediate Jeopardy on 04/09/15 prior to exit as follows: 1. Interview, on 04/09/15 at 4:48 PM, with the Clinical DON revealed she notified Resident #21's physician and family, DCBS and OIG the day the allegation was made, on 04/01/15. Review of the facility's investigation revealed the notifications were made on 04/01/15. 2. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she interviewed and assessed Resident #21 on 04/01/15 for behavioral and psychosocial concerns. The resident was not tearful and did not express any anxiety. Review of the facility's investigation revealed the Clinical DON interviewed the resident on 04/01/15. 3. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she interviewed Resident #21 on 04/02/15. 4. Interview, on 04/09/15 at 5:03 PM, with the Administrative DON revealed the alleged CNA was placed on administrative leave on 04/02/15. Interview with CNA #5, on 04/03/15 at 8:40 AM, revealed the facility suspended her on 04/02/15. 5. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, the Administrative DON, on 04/09/15 at 5:03 PM, and the Administrator, on 04/09/15 at 5:14 PM, revealed the Administrator trained the Clinical DON and Administrative DON, on 04/03/15, on the abuse policy and collecting statements jointly, with verbalized understanding. Review of the training records revealed, on 04/03/15, the Administrator trained the Clinical DON and Administrative DON on the abuse policy and collecting statements jointly. 6. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she developed the investigation checklist, on 04/03/15, to ensure every step had been taken during an investigation. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she had been trained by the Administrative DON on the use of the investigation checklist and completed by either DON. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed he approved the new Investigation Checklist. Review of the Investigation Checklist revealed an effective date of April 2015. 7. Interview, on 04/09/15 at 4:48 PM, with the Clinical DON and, on 04/09/15 at 5:03 PM, with the Administrative DON revealed the Administrative DON revised the Allegation Log to include two (2) sets of signatures for review by nursing administration. The Administrative DON trained the Clinical DON how to use the log. Interview, on 04/09/15 at 5:14 PM, with the Administrator revealed he approved the revised Allegation Log which required both DONs to initial they had reviewed the allegations. Review of the Allegation Log revealed it contained Nursing Administration review and was revised April 2015, and was reviewed by the Clinical DON, Administrative DON, the Clinical Support Services, and Administrative Nursing Assistant. Review of the revised allegation log revealed a place for two (2) signatures were added on 04/03/15. 8. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed she interviewed other interviewable residents regarding possible issues with care and abuse. Review of the Resident Interviews for Resident #21's investigation, dated 04/08/15, revealed, on 04/07/15, the Administrative DON interviewed fourteen (14) interviewable residents if there were any issues or concerns with staff. No concerns were noted. Interview, on 04/09/15 at 4:25 PM, with the Treatment Nurse revealed she completed skin assessments of eight (8) non-interviewable residents, on 04/08/15, on the 3rd floor. She stated she completed one side of the unit and the Outreach Technician (ORT) nurse completed the other side of the unit with no concerns noted. Review of six (6) skin assessments and two (2) wound assessments revealed skin assessments were completed on 04/08/15. Interview with Resident #4, on 04/01/15 at 10:25 AM; Resident #12, on 03/31/15 at 8:46 AM; Resident #13, on 03/31/15 at 7:47 AM; Resident #15, on 04/01/15 at 10:20 AM; and, Resident #16, on 03/31/15 at 9:30 AM, revealed no concerns with staff interactions with the residents. 9. Interview, on 04/09/15 at 5:03 PM, with the Administrative DON revealed she reviewed facility allegations for the last year, for a total of twenty-five (25) investigations with no concerns noted. Review of a statement by the Administrative DON, dated 04/07/15, revealed twenty-five (25) investigations were reviewed in the last twelve (12) months by the Administrative DON, with no concerns noted. Review of four (4) investigations revealed no regulatory violations for Residents #31, #32, #33 and #34. 10. Interviews on 04/09/15 with a total of fifty (50) employees revealed: seventeen (17) CNAs (CNA #13 at 1:56 PM, CNA #3 at 1:57 PM, CNA #22 at 2:00 PM, CNA #21 at 2:06 PM, CNA #8 at 2:12 PM, CNA #9 at 2:20 PM, CNA #17 at 2:21 PM, CNA #15 at 2:52 PM, CNA #14 at 2:46 PM, CNA #16 at 3:05 PM, CNA #19 at 3:05 PM, CNA #10 at 3:09 PM, CNA #18 at 3:12 PM, CNA #20 at 3:15 PM, CNA #11 at 3:17 PM, CNA #23 at 3:20 PM, CNA #12 at 3:31 PM), six (6) LPNs (LPN #1 at 3:07 PM, LPN #5 at 2:47 PM, LPN #3 at 2:45 PM, LPN #9 at 3:07 PM, LPN #10 at 3:30 PM, LPN #8 at 2:18 PM, RN #4 at 2:09 PM, five (5) Unit Managers (UM/RN #2 at 2:00 PM, UM/RN #3 at 2:27 PM, UM/RN #6 at 3:00 PM, UM #1 at 3:00 PM, UM/RN #7 at 3:35 PM), three (3) housekeepers (Housekeeper #2 at 2:09 PM, Housekeeper #3 at 2:15 PM, Housekeeper #4 at 2:15 PM), a CSR at 2:27 PM, a Dietary Aide at 2:31 PM, Central Supply at 2:51 PM, Rehabilitation Secretary at 2:40 PM, Rehabilitation Director at 2:42 PM, the Nutrition

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	185122	A. BUILDING _____ B. WING _____	05/13/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWAY MEDICAL CENTER	1155 EASTERN PARKWAY LOUISVILLE, KY 40217

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 -** Few	(continued... from page 17) Services Director at 1:58 PM, the Social Services Director at 2:11 PM, the Activities Director at 2:24 PM, RAI Coordinator at 2:34 PM, HR Director at 2:43 PM, Receptionist at 3:02 PM, Compliance Auditor at 3:31 PM, QA Director at 3:45 PM, Rehab Manager at 3:55 PM, Treatment Nurse at 4:25 PM, House Supervisor at 4:33 PM, Clinical DON at 4:48 PM, and the Administrative DON at 5:03 PM revealed they had all received abuse training within the last week; they were aware of the types of abuse; when to report abuse; and, to who to report alleged abuse. Review of the training records revealed three hundred and eleven (311) staff had completed post tests between 04/02/15 and 04/08/15. Interview with the HR Director, on 04/09/15 at 2:43 PM, revealed all staff had been trained on abuse except those staff on vacation or leave. The HR Director stated a sign was posted at the time clock and a letter was mailed to those staff not yet trained, that they must receive training prior to working. Observation, on 04/09/15 at 4:04 PM, of the time clock revealed a sign posted with thirteen (13) staff names to obtain abuse training prior to going to their unit. Review of the letter sent to staff revealed it was dated 04/08/15 from the HR Director that stated staff must receive the abuse training and answer the questionnaire before they started work. Review of the facility's staff roster revealed the letter was mailed to ten (10) employees, who were either sick, on vacation, or leave of absence. 11. Interview with the Compliance Auditor, on 04/09/15 at 3:31 PM, and the QA Director, on 04/09/15 at 3:45 PM, revealed they would review the Allegation Log for completion and signatures weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter. They stated the audits would go to the QA meetings for review. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed the Compliance Auditor would conduct audits of the Allegation Log and report the findings to the QA Committee. 12. Interview, on 04/09/15 at 3:31 PM, with the Compliance Auditor and, on 04/09/15 at 3:45 PM, with the QA Director revealed either would audit the Investigation Checklist weekly for four (4) weeks, monthly for three (3) months, then quarterly for a year with results to QA the Committee. Interview with the Administrator, on 04/09/15 at 5:14 PM, revealed the Compliance Auditor would audit the Investigation Checklist and report to the QA Committee. Review of the Investigation Checklist revealed an inception date of 04/03/15. 13. Review of the third floor care plan updates revealed, on 04/03/15, the care plan for Resident #21 was updated by the RAI Coordinator. 14. Interview with the Clinical DON, on 04/09/15 at 4:48 PM, revealed she reviewed resident behavior and antipsychotic care plans on 04/08/15, and then all residents, checking if the care plan had been updated, initiated, and implemented, with no concerns noted. Review of care plan audits for all six (6) floors, dated 04/07/15 revealed all care plans were reviewed for residents on each floor of the facility with 119 care plans revised. 15. Interview with the Social Services Director, on 04/09/15 at 2:11 PM, the RAI Coordinator, on 04/09/15 at 2:43 PM, with the UM on the 2nd floor (RN #2 on 04/09/15 at 2:00 PM and RN #3 on 04/09/15 at 2:27 PM), the UM on the 3rd floor, on 04/09/15 at 3:00 PM, and the Administrative DON, on 04/09/15 at 5:03 PM, revealed they received care plan training this week and was conducted by the Administrative DON, that included who initiated and updated the care plan, and how to implement the care plan, with verbal competency. Review of the care plan training records revealed care plan training included who initiated and updated the care plan, when the care plan should be revised, and who was responsible to implement the care plan. 16. Interview, on 04/09/15 at 2:00 PM, with UM/RN #2; on 04/09/15 at 2:27 PM, with UM/RN #3; and, on 04/09/15 at 3:00 PM, with UM #1 revealed walking rounds were conducted throughout the shift, but they did not document those rounds. The UMs stated they were observing direct staff to ensure care was provided according to the resident's care plan. Review of care plans revealed Resident #4's care plan was revised on 04/07/15, based on the UM rounds, to reflect the current placement in isolation. 17. Interview with the RAI Coordinator, on 04/09/15 at 2:34 PM, revealed she held a Program of Care meeting on 04/08/15 to review and ensure resident care plans were appropriate. Meetings would be held weekly, with discussion of certain residents each week, with all residents discussed quarterly. Interview with the Nutrition Services Director, on 04/09/15 at 1:58 PM; the Social Services Director, on 04/09/15 at 2:11 PM; the Activities Director, on 04/09/15 at 2:24 PM, revealed their assistants would attend the Program of Care meetings; however, the Directors would attend in the assistants place when needed, and would discuss resident care plan interventions. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed the Program of Care meetings would review that resident care plans were up to date, make any needed changes, and interventions were implemented. 18. Interview, on 04/09/15 at 3:31 PM, with the Compliance Auditor revealed she would audit the Program of Care meetings three (3) times a week for four (4) weeks, three (3) times a month for one (1) quarter, then quarterly and give the results to the DON for the QA Committee. 19. Interview with the Compliance Auditor, on 04/09/15 at 3:31 PM, revealed she would conduct ten (10) chart audits each month for three (3) months, then quarterly to ensure care plans were updated and interventions performed, with discrepancies corrected by the UM. Interview with the Administrative DON, on 04/09/15 at 5:03 PM, revealed the Compliance Auditor would complete ten (10) chart audits and ensure the residents' care plans interventions were implemented; the UM would correct any issues immediately. She stated results would be taken to the QA Committee. Review of the Care Plan Monitoring Tool, dated April 2015, revealed it included review of the resident care plan, if the care plan had been updated, observations, concerns, if the care plan was followed, and Assistant UM or UM aware of result. 20. Interview with the Nutrition Services Director, on 04/09/15 at 1:58 PM, the Social Services Director, on 04/09/15 at 2:11 PM, the Activities Director, on 04/09/15 at 2:24 PM, the HR Director, on 04/09/15 at 2:43 PM, the Compliance Auditor, on 04/09/15 at 3:31 PM, the QA Director, on 04/09/15 at 3:45 PM, the Rehab Manager, on 04/09/15 at 3:55 PM, the Medical Director, on 04/09/15 at 4:07 PM, the Treatment Nurse, on 04/09/15 at 4:25 PM, the Clinical DON, on 04/09/15 at 4:48 PM, the Administrative DON, on 04/09/15 at 5:03 PM, and the Administrator, on 04/09/15 at 5:14 PM, revealed they attended QA meetings, with three (3) held, and discussed the Immediate Jeopardy (IJ), corrective actions, care plans, new checklists, and training. Review of sign in sheets that included review of the IJ and corrective actions revealed QA meetings were held on 04/03/15, 04/06/15, and 04/08/15. An abbreviated survey conducted 04/28/15 investigating KY and KY determined the facility failed to implement the corrective actions of the AOC dated 04/09/15. Review of the acceptable AOC, dated 04/09/15, revealed the abuse allegation checklist and abuse allegation log would be audited by the Compliance Auditor and the results would be brought to the QA committee. Review of the newly developed checklist to be utilized by the facility to ensure abuse investigations were completed, (which was an intervention on the AOC) revealed no date when it was completed and only checks on the forms without any additional information provided. Interview with the Compliance Auditor, on 04/30/15 at 1:15 PM, revealed when she reviewed the newly developed checklist she only looked for the check marks and did not review the content of the investigation. In addition, she stated the audits of the abuse investigation checklist were not taken to the Quality Assurance (QA) meeting on 04/27/15. Interview with the Administrator, on 04/30/15 at 3:45 PM, validated the audits of the checklist and the abuse logs were not discussed at the 04/27/15 QA meeting. Immediate Jeopardy was determined not to be removed on 04/09/15 as alleged. The facility was notified of this finding on 04/30/15. The facility took the following actions to remove the Immediate Jeopardy on 05/06/15 as follows: 1. The Clinical DON made notification on 04/20/15 of the allegation (KY) to Resident #36's family, physician, OIG and DCBS. The Administrative DON made notification of the allegation of abuse (KY) to Resident #37's family and Physician on 04/27/15. Notification to the OIG and DCBS was made on 04/28/15. 2. On 04/21/15, a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor with no injuries consistent with abuse noted. Fifty-six (56) skin assessments were completed on non-interviewable residents by Unit Managers, Assistant Managers, and Staff Development Nurse as of 05/04/15. No issues were found. 3. 05/04/15, one hundred thirty (130) residents were interviewed by Social Services, and the RAI Coordinators to ensure there were no unresolved or uninvestigated allegations of abuse. No issues were identified. 4. The abuse allegation checklist was revised on 04/28/15 by the Clinical DON to reflect name, date, and time of actions, with a space for narrative documentation to record all actions taken during the abuse investigation. 5. On 05/01/15, the facility obtained the services of a consultant company to provide assistance with training, policy revision, QA and ongoing oversight and consultation. These consultant employees included Nurses, therapists, and Administrators. The facility's Administrative DONs, Human Resources Director, and Assistant Director of Nurses met with the consultants and revised the abuse policy to reflect procedures for immediate protection of residents by removal of the alleged perpetrator from patient care and reporting immediately allegations of any abuse to the state agencies. All staff would receive training on the new Abuse policy revisions and no staff would work past 05/05/15 without receiving the training. This would include agency staff. 6. On 05/05/15, education was provided by the contracted consultant on requirements for abuse allegation reporting and investigation with competency. No staff would be allowed to work past 05/05/15 without receiving the training. This would include agency staff. As of 05/05/15, two hundred ninety-seven (297) employees had been trained. 7. On 05/04/15, the facility implemented a new Nurses' Abuse Allegation Investigation Protocol. The protocol was a step by step reference for nurses and House Supervisors to be used when a resident alleged abuse. The protocol was posted in visible locations on all nursing units and included in all staff education. (Attachment B) 8. On 05/04/15, a QA meeting was held to review the alleged deficient practice and plans of actions established to correct the practices. The consultant

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 18) observed the QA meeting. Members present included the Administrator, Consultant, Social Services, Medical Director, DONs and other Department Directors. The Administrator established a weekly QA meeting that included review of the deficiencies cited. 9. On 05/04/15, the Elder Justice Act reporting notification requirements was added to the admission packet. The revised Abuse policy and Elder Justice Act information was placed in a binder at the receptionist desk. 10. On 05/05/15, five (5) random staff and resident interviews would be conducted weekly by Social Services and Nursing Administration to ensure there were no unresolved/investigated abuse allegations and staff understanding of reporting requirements. 11. On 05/04/15, the contracted consultant educated the Administrator and made observations at the facility to ensure the Administrator was administering the facility in accordance with professional standards and per his job description included ensuring a system was in place to protect residents from abuse and neglect. 12. Beginning 05/01/15, a consultant would conduct weekly visits for four weeks then monthly visits to ensure the Administrator followed professional standards and job description ensuring systems remained in place for reporting and investigation of allegations of abuse and neglect per established plan of correction. The Administrator established weekly administrative consultative visits with the consultants. 13. The contract consultant re-educated the Administrator, on 05/04/15, on the requirements of a functional QA process to include delegation of action items for identified concerns including oversight of entire AOC and implementation of systems and follow-up to ensure corrections were made and reviewed with the Interdisciplinary Team (IDT). 14. Beginning 05/04/15 the Human Resources Director would update the Administrator daily of the status of staff training on abuse. 15. On 05/05/15, the Administrator amended the agenda for the daily quality meeting with the IDT, to address deficiencies cited. This included reviewing audits, education, and ongoing monitoring to determined effectiveness of current actions. 16. Weekly QA meetings that began on 05/04/15, was held to review identified concerns regarding any issues with the Plan of Correction and follow-up to ensure corrections were sustained. The meeting would consist of at a minimum the Administrator, Director of Nursing, Social Services, Assistant Director of Nursing, and other Department Directors. The contract consultant would observe the QA process monthly, including audit tools (attachment E) for at least three (3) months to ensure Quality Assurance Performance Improvement Committee was functional and meeting the identified needs of the facility. The QA committee would consist of the Administrator, DONs, ADON, Social Services, and the Medical Director attending at least quarterly. When the Medical Director was present, they would review a sample of residents' abuse allegations for effectiveness in the revised processes. The QA meeting would review audits (and take action if needed) related to the deficiencies. Theses audits would include resident interviews and skin audits conducted on 05/04/15 and abuse audits which began on 04/08/15 and are ongoing. The reports would be presented by the Compliance Auditor. The State Survey Agency validated the removal of Immediate Jeopardy on 05/13/15 prior to exit as follows: 1. Review of the clinical record and facility investigation validated the Clinical DON notified Resident #36's family, physician, OIG, and DCBS on 04/20/15. Review of the fax verification revealed the OIG was notified on 04/20/15 at 4:09 PM. Review of the clinical record and facility investigation revealed the Administrative DON notified Resident #37's family and physician on 04/27/15. Review of the faxed verification sheet revealed notification to the OIG on 04/28/15 at 3:11 PM. Review of the Department of Community Based Services (DCBS) intake summary revealed the notification was received on 04/29/15. Interview with the Administrative DON, on 04/29/15 at 2:24 PM, revealed the facility's fax machine was broken on Monday, April 27, 2015 and she failed to provide notification via telephone. 2. Review of facility's investigation revealed a skin assessment was performed on Resident #36, by the Unit Manager of the Seventh Floor on 04/21/15, with no injuries consistent with abuse. Review of the skin assessments conducted by the Unit Managers, Assistant Managers, and Staff Development Nurse through 05/04/15, revealed fifty-three (53) skin assessments were conducted for residents with a BIMS score less than eight (8). 3. Review of the resident interview forms revealed Social Services, and the RAI Coordinators conducted one hundred thirty-three (133) resident interviews by 05/04/15. No resident alleged abuse. The interview form included a questionnaire for staff to determine if the resident had any mood or behavioral changes. None was noted. 4. Interview with the Clinical DON, on 05/13/15 at 4:20 PM, revealed the abuse checklist was revised to give more details to ensure the investigation was conducted and timely. In addition, the Compliance Auditor would be able to determine if the investigation was completed timely and according to the facility's Abuse policy. Review of the checklist for the abuse investigation for Residents #37, 38, 39, 40, 41, 42, and #43 revealed the abuse checklist was completed with details of notification (including the state agencies), protection of the resident, resident and staff interviews, meeting with DONs and Administrator, and when copy of the checklist was sent to the QA committee. Residents #38, 39, 40, 41, 42, and 43 was completed after the facility was notified of the Immediate Jeopardy. 5. Interview with the Administrator, on 05/13/15 at 6:20 PM, revealed a consultant services was obtained on 05/01/15. The consultants had been at the facility providing abuse education to staff and assistance with development of the AOC, and QA guidance. The consultants were at the facility on 05/01/15, 05/04/15, 05/12/15 and 05/13/15. They are scheduled to be at the facility on 05/21/15 and 05/26/15. He stated the Abuse policy was revised on 05/04/15 with input from the consultant services. Review on 05/13/15, of the revised Abuse policy, revealed language changes in how the residents would be protected included the employee suspected of abuse would be removed from the unit and patient care immediately. The House Supervisor or Nursing Administration would assure the employee clocked out and left the facility. Employees who witnessed potential abuse are instructed to immediately intervene to protect the resident, the alleged perpetrator should not be left alone with the resident. All employees were required to immediately report any observations, suspicion, or information of suspected or actual abuse, neglect, or misappropriation of property to the House Supervisor. House Supervisor or Nursing Administration would report all allegations of abuse or neglect to DCBS, Police, and OIG immediately. Four (4) abuse investigations were reviewed on 05/13/15 for Residents #40, 41, 42 and #43 and validated the facility used the abuse investigation checklist and the QA investigation tool. Based on residents' interviews, record review, and review of the facility's investigation, no problems were found with these abuse investigations. Review of the training records revealed all working staff had been trained on the new abuse policy. Observations on 05/13/15 of the second, third, fourth, fi