STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185249	A. BUILDING _____ B. WING _____	11/16/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN	96 HIGHWAY 3444 ANNVILLE, KY 40402

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** 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, and review of the facility's policy it was determined the facility failed to ensure allegations of abuse were thoroughly investigated, failed to ensure residents were protected from further abuse, and failed to report allegations to state agencies as required, for one (1) of two (2) sampled residents (Resident #2). Facility staff reported to the former Director of Nursing (DON) and the former Assistant DON on [DATE] that Resident #1 was observed to take Resident #2's hand and place it on his/her private part and rub himself/herself. The facility failed to conduct an investigation related to the alleged incident, failed to protect residents from further abuse, and failed to report the alleged incident to state agencies. The facility's failure to ensure allegations of abuse were thoroughly investigated, failure to ensure residents were protected from further abuse, failure to ensure abuse allegations were reported to state agencies, as well as failure to review/revise residents' plans of care when inappropriate sexual behavior was observed, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE], and was determined to exist on [DATE]. The facility submitted an acceptable Allegation of Compliance (AOC) on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the Immediate Jeopardy was removed on [DATE] prior to the SSA initiating the investigation on [DATE]; therefore, it was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy titled Abuse, Neglect and Misappropriation of Property, last reviewed [DATE], revealed that all alleged violations involving abuse would be reported to the administrator and the State Survey Agency in accordance with federal and state law. The policy stated that a reasonable investigation of alleged violations would be conducted. Further review of the policy revealed when a resident exhibited any form of abuse toward another resident the residents were to be removed/separated to ensure their safety. The policy stated the Charge Nurse or DON would ensure the residents had no access to one another until the circumstances of the incident could be determined. 1. Review of the medical record for Resident #1 revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident was interviewable. Interview on [DATE] at 1:20 PM with Resident #1 revealed the resident was unable to recall the incident, which was witnessed by facility staff, involving Resident #2 on [DATE]. 2. Record review revealed the facility admitted Resident #2 on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #2's Quarterly MDS assessment, dated [DATE], revealed the facility assessed the resident to have a BIMS score of 6, which indicated the resident was not interviewable. Interview on [DATE] at 1:40 PM with Resident #2 revealed the resident stated he/she had broken up with his/her significant other and that he/she didn't live here. Resident #2 stated he/she felt safe in the facility. Interview with the Regional Vice President (RVP) on [DATE] at 4:45 PM revealed Resident #1 and Resident #2 became friends around mid-[DATE]. The residents had been observed holding hands, at times, in the front lobby of the facility. The Power of Attorneys (POAs) of Resident #2 were notified that the residents were having physical contact. Resident #2's POAs gave verbal consent related to hand holding/physical contact between Resident #1 and Resident #2. Further interview revealed Resident #1 and Resident #2's previous spouses were deceased ; however, both residents referred to the other as their deceased spouses, and called each other the name of their deceased spouses. The RVP also stated that as the residents' relationship continued the residents were observed kissing (exact dates unknown), and Resident #2's POAs were again notified and no concerns were voiced related to the residents' physical contact. Interview on [DATE] at 3:45 PM with the Assistant Business Office Manager revealed she had witnessed Resident #1 take Resident #2's hand and place it on his/her private part and rub himself/herself on [DATE]. She stated she felt the incident was potential abuse and immediately reported the incident to the former DON and the former ADON. Further interview revealed the former DON stated that the family is aware of it. She stated she did not report the incident to the former Administrator, because she reported it to the former DON and former ADON, like I had been trained to do. The Assistant Business Office Manager stated she never witnessed the former DON or former ADON take any action related to the incident. Interview on [DATE] at 5:10 PM with the former ADON revealed she and the former DON were notified on [DATE] that Resident #1 had placed Resident #2's hand on his/her private part and was observed to rub himself/herself. She stated she did not report the incident immediately to the former Administrator because the Assistant Business Office Manager had stated she was reporting the incident to the former Administrator. However, the former ADON stated she and the former DON followed up with the former Administrator the following day, on [DATE]. She stated the former Administrator just walked out of the room and never acknowledged that we had told him anything. Interview on [DATE] at 10:00 AM with the former DON revealed she and the former ADON were notified on [DATE] that Resident #1 was observed to place Resident #2's hand on his/her private part and rub himself/herself. She stated she did not report it immediately to the former Administrator because the staff that informed her of the incident stated she was reporting the allegation to the former Administrator. However, the former DON stated she and the former ADON discussed the allegation with the former Administrator, who was also the Abuse Coordinator, on [DATE]. The former DON stated the former Administrator never assigned me anything to do and no investigation was done or directed, because he always did that stuff; he was the Abuse Coordinator. The former DON stated it was not her responsibility to report or coordinate investigations in the facility, because the former Administrator usually took care of all of that. Interview was attempted with the former Administrator on [DATE], [DATE], and [DATE] and he was unable to be reached. Interview on [DATE] at 4:30 PM with the Regional Vice President (RVP) revealed the former Administrator and/or former DON should have followed the facility's policy when allegations of abuse were identified. She stated when the allegation was reported to administrative staff they should have protected the residents involved as well as other facility residents, reported the alleged incident to state agencies, and investigated the incident as required. **The facility provided an acceptable Allegation of Compliance (AOC) on [DATE]. The facility implemented the following actions to remove the Immediate Jeopardy.

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) 1) On [DATE], the Regional Vice President (RVP) was made aware of the incident, which was reported to the Administrator and the DON on [DATE]; they were both suspended pending investigation. It was determined that the two (2) residents (Resident #1 and Resident #2) had been more physical with each other and nothing had been done to validate the relationship was appropriate. Staff had repeatedly reported their concerns of physical touching between these two (2) residents to Administration. However, Administration failed to follow the Center's abuse policy and procedures. The facility also failed to update the resident's care plans (Resident #1 and Resident #2). The Administrator and the DON were terminated from the facility. 2) Resident #1 had been on 15-minute checks since [DATE] and had made no attempts to go into Resident #2's room, or any other resident's room in the facility. Resident #1 was evaluated by a psychiatrist on [DATE], and again on [DATE], with medication recommendations, and to monitor the resident every 15 minutes, which were followed through as ordered. Resident #1 has not exhibited any further behaviors. Staff continued to monitor the resident every 15 minutes. A care plan meeting was conducted with Resident #1's Power of Attorney (POA), as well as his/her son on [DATE], and all concerns were discussed and all questions answered at that time. Resident #1 was provided spiritual support by the facility Chaplain on [DATE], and weekly visits will continue for one (1) month. 3) The Medical Director completed a physical examination on Resident #2 (the alleged victim) on [DATE], and no signs or symptoms of sexual abuse were identified. Resident #2 was evaluated by a psychiatrist on [DATE] and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on [DATE] with recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The facility's Chaplain provided spiritual support for the resident on [DATE] and will meet weekly with Resident #2 for the next thirty (30) days. A care plan/family meeting was conducted on [DATE] to discuss any concerns and to answer any questions that Resident #2's POAs may ask. All questions were answered and no concerns were voiced. 4) All residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on [DATE] by the Social Services Worker (SSW), Staff Development Coordinator (SDC), ADON, and the Activity Director related to any concerns related to abuse in the facility. One (1) resident voiced concerns; the concern was reported and investigated as required, with no concerns identified. 5) Skin assessments for 100 percent of residents were conducted on [DATE], for signs and symptoms of abuse with no concerns identified. The assessments were conducted by facility staff nurses, as well as nurse management staff. All assessments were reviewed by the Consulting Nurse on [DATE]. 6) All prior grievances were reviewed by the Administrator/Regional Controller on [DATE] for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) The Administrator/Regional Controller had reviewed all Resident Council Notes from the past six (6) months on [DATE]. The Regional Controller identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) was reported from the November meeting. 8) All reportable incidents for the past twelve (12) months were reviewed on [DATE] to ensure complete and thorough investigations were completed and to ensure compliance with the facility's abuse policy. 9) All residents' charts, which included Progress Notes, were reviewed for the last 60-day timeframe on [DATE] and [DATE]. Resident records were reviewed by the Consulting Nurse, DON, SDC from another facility, and one (1) Nurse Administrator, to ensure no abuse allegations had been documented with no actions taken and to ensure the resident's physician and family had been notified of any changes in condition. 10) All residents were verified to ensure no current residents were on the sex offender registry on [DATE] by Human Resources. No concerns were identified. 11) Facility audits revealed all accidents and incidents were reviewed on [DATE], for the last 30 days, for any unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by Nurse Management, the Interim DON, SDC, and Consulting Nurse. 12) Interviews and review of facility documentation revealed the RVP (Regional Vice President) held a Resident Council Meeting on [DATE] to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. 13) The RVP, Consulting Nurse, and SDC Nurse initiated abuse education on [DATE] with all staff with a post-test of 100 percent to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. The content of training was as follows: abuse policy and procedures, nine (9) types of abuse including use of any video or pictures of residents used in a demeaning way, and all reporting options (Regional team, Signature Caring Line, Ombudsman, Adult Protective Services and the Office of the Inspector General) if a staff member believed possible abuse was ongoing. Certified letters were sent to any employees that had not been re- educated on abuse on [DATE]. The letter informed the employees that they would not be permitted to work until the abuse education was completed. 14) Files for all employees hired in the past six (6) months (25 employees) were reviewed for appropriate credentials and possible abuse allegations. 15) On [DATE] and [DATE], staff was also provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact Situation, Background, Assessment and Recommendation (SBAR) forms and stop and watch form, care plans policy and procedure, to include appropriately updating the resident's care plan to reflect the resident's current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures, with a post-test score of 100 required, effective [DATE]. 16) Daily monitoring of audits will be conducted by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. The audits include the following: five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse; ten (10) random resident chart audits for change in resident condition that have not been followed through with as required to monitor for any unreported allegations of abuse; and, ten (10) random staff abuse tests that require a passing score of 100%. 17) The Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator, will continue to provide daily monitoring by conducting ten (10) random resident interviews (with BIMS score of 8 and above) for any abuse allegations or concerns. The audits will be conducted until IJ is removed, and then for two (2) weeks with weekly QAPI (Quality Assurance Performance Improvement Committee) Audits will be monitored through the QA committee, which will determine the frequency to continue the audits. 18) Clinical meetings five (5) times a week with the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator will be held to review the 24-Hour Report, all accident and incidents, physician orders, and daily charting. The interdisciplinary team will be monitoring for signs and symptoms of abuse or any unreported abuse allegations. 19) The RVP will provide administrative oversight of the Center effective [DATE]. The RVP is the Interim Administrator and will be in place until an administrator has been hired. The Administrator will be provided with abuse training and reporting as part of orientation. 20) The Quality Assurance Performance Improvement (QAPI) committee (Interim Administrator and DON, SSW, SDC, Dietary Manager, Activity Director, Consulting Nurse and Medical Director by phone) meetings were conducted on [DATE] and [DATE], to review this plan and all audits for needed revisions, compliance, and/or further education. The QAPI committee will then determine the need for reduction of audits monthly, based on audit outcomes and compliance. 21) Determining Decision-Making Capacity, Sexual Consent Capacity will be used as a guide or reference for the care plan team, physician, psychologists and families to help generate the correct conversations and decisions effective [DATE]. ***The State Survey Agency verified the removal of the jeopardy through the following actions on [DATE]. 1) Interview with the Regional Vice President of Operations (RVP) on [DATE] revealed the Administrator and DON were terminated from employment on [DATE]. 2) Review of Resident #1's record revealed documentation of 15-minute checks and an evaluation by a psychiatrist on [DATE] and [DATE]. Further review of the record revealed documentation that the care plan meeting was conducted and the resident's care plan was revised. Review of the facility's documentation revealed the resident received visits from the Chaplain on [DATE] and [DATE]. 3) Review of Resident #2's medical record revealed the Medical Director completed a physical examination of Resident #2 (the alleged victim) on [DATE], and no signs or symptoms of sexual abuse were identified. The record further revealed that

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Resident #2 was evaluated by a psychiatrist on [DATE] and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on [DATE] with a recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The record further revealed the Chaplain had provided spiritual support for the resident on [DATE] and again on [DATE]. The record revealed a care plan/family meeting was conducted on [DATE]. 4) Review of the facility's audits on [DATE] revealed all residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on [DATE] by the SSW, SDC, ADON, and the Activity Director related to any concerns related to abuse in the facility. Review of an investigation dated [DATE] revealed one (1) resident voiced a concern; the concern was reported and investigated as required, with no problems identified. Interview with the SSW on [DATE] at 3:20 PM, the SDC on [DATE] at 4:00 PM, and the ADON on [DATE] at 5:10 PM, revealed all residents with a BIMS score of eight (8) to fifteen (15) were interviewed on [DATE]. 5) Review of the facility's audits on [DATE] revealed skin assessments for 100% of residents were conducted on [DATE], for signs and symptoms of abuse, with no concerns identified. Interview with the SDC on [DATE] at 4:00 PM, ADON on [DATE] at 3:40 PM, and Registered Nurse (RN) #1 on [DATE] at 3:20 PM confirmed skin assessments had been conducted on 100% of facility residents on [DATE]. 6) Review of the facility audits revealed all prior grievances were reviewed by the Administrator/Regional Controller on [DATE] for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) Further review of audits conducted by the facility revealed the Administrator/Regional Controller had reviewed all resident council notes from the past six (6) months on [DATE]. Interview with the Regional Controller on [DATE] at 5:00 PM revealed he had identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) reported from November's meeting. All concerns were addressed and corrected by the Regional Controller. 8) Review of the facility's audits on [DATE], conducted by the Regional Controller, revealed the Regional Consulting Nurse had reviewed all reportable incidents for the last 12 months on [DATE]. The Consulting Nurse had reviewed the allegations to ensure the facility's policy had been followed and that complete and thorough investigations had been conducted. Further review of the audits revealed the Consulting Nurse reviewed all reportable incidents, at least monthly when she visits the Center. Interview with the RVP on [DATE] at 4:30 PM revealed since [DATE] she had been involved as the Interim Administrator, and had remained on-site since [DATE]. The RVP stated she had been involved in all reportable incidents to ensure they had been reported and that a thorough and complete investigation had been conducted. 9) Interviews with the Regional Consulting Nurse and the RVP on [DATE] at 4:15 PM and 4:30 PM, as well as review of the facility's audits revealed all residents' charts which included progress notes had been reviewed for the last 60-day timeframe on [DATE] and [DATE] to ensure no abuse allegations had been documented with no actions taken, and no concerns were identified, and that the resident's physician and family had been notified of any changes in condition, and no concerns were identified. 10) Review of facility's documentation revealed 100% of the residents were verified to ensure no current residents were on the sex offender registry on [DATE] by Human Resources, and no concerns were identified. Interview with the RVP on [DATE] at 4:30 PM revealed she had validated that Human Resources had ensured that none of the residents were listed on the sex offender registry. 11) Review of facility's audits revealed all accidents and incidents from the last 30 days were reviewed on [DATE] for any unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by nurse management, the interim DON, SDC, and consulting nurse. Interviews with the SDC on [DATE] at 4:00 PM, the ADON on [DATE] at 5:10 PM, and the Regional Consulting Nurse verified they assisted with the audits. 12) Interview with the RVP on [DATE] at 4:30 PM and review of facility documentation revealed the she had held a Resident Council Meeting on [DATE] to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. Interviews with Residents A and B on [DATE] at 12:55 PM and 1:00 PM confirmed they had been educated, during a Resident Council Meeting, related to abuse and relationships in the facility. 13) Review of facility documentation related to staff training revealed the RVP, Consulting Nurse, and SDC nurse had initiated abuse education on [DATE] with all staff with validation of training with post-test requiring a score of 100% to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. Review of post tests revealed staff competency was acquired. Review of personnel records revealed certified letters were sent to staff informing them they would not be permitted to work until retrained. 14) Review of facility documentation of audits conducted revealed the Administrator/Regional Controller reviewed files of all new employees on [DATE], that had been hired in the past 6 months (25 employee files), for appropriate credentials and possible abuse allegations; and no concerns were identified. 15) Review of facility documentation revealed that on [DATE] and [DATE] staff was provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact SBAR and Stop and Watch form, care plans policy and procedure, to include appropriately updating the residents' care plans to reflect the residents' current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures with post-test score of 100 required, effective [DATE]. Interview with the Consulting Nurse on [DATE] at 4:15 PM revealed the training was conducted with on [DATE] and [DATE]. 16) Review of facility documentation revealed daily monitoring audits had been conducted from [DATE] through [DATE] by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator that included five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse, ten (10) random resident chart audits for change in resident condition that had not been followed through with as required, and ten (10) random staff abuse tests. Interviews with the interim DON on [DATE] at 3:40 PM and the Consulting Nurse on [DATE] at 4:15 PM revealed the audits were conducted. 17) Review of the facility's documentation and interview with the RVP on [DATE] at 4:30 PM revealed she, as well as the Consulting Nurse, Interim DON, SDC, and SSW conducted ten (10) random resident interviews (with BIMS scores of 8 and above) for any abuse allegations or concerns. 18) Review of facility documentation revealed on [DATE] staff initiated ongoing monitoring through clinical meetings five (5) times a week, which consisted of the following staff members in attendance: Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. Interviews with the Consulting Nurse on [DATE] at 4:15 PM and the RVP on [DATE] at 4:30 PM, revealed staff reviewed the 24-hour report, all accident and incidents, physician orders, and daily charting for sign and symptoms of abuse or any unreported abuse allegations. 19) Interview with the RVP on [DATE] at 4:30 PM confirmed she had provided administrative oversight of the facility since [DATE]. 20) Review of facility documentation and interviews with the Consulting Nurse on [DATE] at 4:15 PM and the RVP on [DATE] at 4:30 PM revealed the QAPI committee met on [DATE] and [DATE] to review the plan and all audits for needed revisions, compliance, and or further education. 21) Review of facility documentation and interviews with the Consulting Nurse on [DATE] at 4:15 PM and the RVP on [DATE] at 4:30 PM confirmed the Determining Decision-Making Capacity, Sexual Consent Capacity would be used as a guide or reference for the care plan team, physician, psychologists, and families to help generate the correct conversations and decisions effective [DATE].
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 it was determined the facility failed to ensure policies and procedures were implemented when allegations of abuse were reported for one (1) of two (2) sampled residents (Resident #2). Facility staff reported to the former Director of Nursing (DON) and the former Assistant DON on 10/26/16

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) that Resident #1 was observed to take Resident #2's hand and place it on his/her private part and rub him/herself. The facility failed to follow their policy and procedures as they did not conduct an investigation related to the alleged incident, failed to protect residents from further abuse, and failed to report the alleged incident to state agencies as outlined in the facility policy. The facility's failure to ensure its policies and procedures were followed and its failure to ensure allegations of abuse were thoroughly investigated, failure to ensure residents were protected from further abuse, failure to ensure abuse allegations were reported to state agencies, as well as failure to review/revise residents' plans of care when inappropriate caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/10/16, and was determined to exist on 10/26/16. The facility submitted an acceptable Allegation of Compliance (AOC) on 11/16/16 alleging the Immediate Jeopardy was removed on 11/05/16. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the Immediate Jeopardy was removed on 11/05/16 prior to the SSA initiating the investigation on 11/09/16; therefore, it was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy titled Abuse, Neglect and Misappropriation of Property, last reviewed 08/30/16, directed the facility to ensure all alleged violations involving abuse were reported to the administrator, and the state survey agency in accordance with federal and state law. Staff was required to conduct a reasonable investigation of all alleged violations that occurred in the facility. The policy stated when a resident exhibited any form of abuse toward another resident the residents were to be removed/separated to ensure their safety. The Charge Nurse or DON was directed to ensure the residents had no access to one another until the circumstances of the incident were determined. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 05/20/16 with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 08/27/16, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident was interviewable. Interview on 11/09/16 at 1:20 PM with Resident #1 revealed the resident was unable to recall the incident involving Resident #2 on 10/26/16, which was witnessed by facility staff. 2. Resident #2's medical record revealed the facility admitted the resident on 05/28/15, with [DIAGNOSES REDACTED]. Resident #2's Quarterly MDS assessment, dated 09/13/16, revealed the facility assessed the resident to have a BIMS score of 6, which indicated the resident was not interviewable. Interview on 11/09/16 at 1:40 PM with Resident #2 revealed the resident stated he/she had broken up with his/her significant other and that he/she didn't live here. Resident #2 stated he/she felt safe in the facility. Interview on 11/09/16 at 3:45 PM with the Assistant Business Office Manager revealed she had observed Resident #1 take Resident #2's hand and place it on his/her private part and rub himself/herself on 10/26/16. She stated she felt she had witnessed potential abuse and immediately reported the incident to the former DON and the former ADON. She stated the former DON told her that the family was aware of it. The Assistant Business Office Manager stated she never witnessed the former DON or former ADON take any action related to the reported incident. Interview on 11/10/16 at 5:10 PM with the former ADON confirmed that she and the former DON were notified on 10/26/16 that Resident #1 had placed Resident #2's hand on his/her private part and was observed to rub him/herself. The former ADON stated she did not report the incident immediately to the former Administrator, because the Assistant Business Office Manager had stated she was reporting the incident to the former Administrator. However, the former ADON stated she and the former DON followed up with the former Administrator the following day, 10/27/16, and the former Administrator just walked out of the room and never acknowledged that we had told him anything. Interview on 11/14/16 at 10:00 AM with the former DON revealed she and the former ADON were notified on 10/26/16 that Resident #1 was observed to place Resident #2's hand on his/her private part and rub himself/herself. She stated she did not report it immediately to the former Administrator because the staff that informed her of the incident stated she was reporting the allegation to the former Administrator. However, the former DON stated she and the former ADON discussed the allegation with the former Administrator, who was also the abuse coordinator, on 10/27/16. The former DON stated the former Administrator never assigned me anything to do and no investigation was done or directed, because he always did that stuff; he was the Abuse Coordinator. She stated it was not her responsibility to report or coordinate investigations in the facility because the former Administrator usually took care of all of that. Interview was attempted with the former Administrator on 11/10/16, 11/14/16, and 11/16/16 and he was unable to be reached. Interview on 11/16/16 at 4:30 PM with the Regional Vice President (RVP) revealed the former Administrator and/or former DON should have followed the facility's policy when allegations of abuse were reported in the facility. According to the facility's policy, staff was required to conduct a reasonable investigation of all alleged violations that occurred. The policy stated when a resident exhibited any form of abuse toward another resident the residents were to be removed/separated to ensure their safety. The RVP stated when the allegation was reported to administrative staff they should have protected the residents involved as well as other facility residents, reported the alleged incident to state agencies, and investigated the incident as outlined in the facility policy. **The facility provided an acceptable Allegation of Compliance (AOC) on 11/16/16. The facility implemented the following actions to remove the Immediate Jeopardy. 1) On 11/02/16, the Regional Vice President (RVP) was made aware of the incident, which was reported to the Administrator and the DON on 10/26/16; they were both suspended pending investigation. It was determined that the two (2) residents (Resident #1 and Resident #2) had been more physical with each other and nothing had been done to validate the relationship was appropriate. Staff had repeatedly reported their concerns of physical touching between these two (2) residents to Administration. However, Administration failed to follow the Center's abuse policy and procedures. The facility also failed to update the resident's care plans (Resident #1 and Resident #2). The Administrator and the DON were terminated from the facility. 2) Resident #1 had been on 15-minute checks since 10/27/16 and had made no attempts to go into Resident #2's room, or any other resident's room in the facility. Resident #1 was evaluated by a psychiatrist on 11/03/16, and again on 11/10/16, with medication recommendations, and to monitor the resident every 15 minutes, which were followed through as ordered. Resident #1 has not exhibited any further behaviors. Staff continued to monitor the resident every 15 minutes. A care plan meeting was conducted with Resident #1's Power of Attorney (POA), as well as his/her son on 11/04/16, and all concerns were discussed and all questions answered at that time. Resident #1 was provided spiritual support by the facility Chaplain on 11/04/16, and weekly visits will continue for one (1) month. 3) The Medical Director completed a physical examination on Resident #2 (the alleged victim) on 11/03/16, and no signs or symptoms of sexual abuse were identified. Resident #2 was evaluated by a psychiatrist on 11/03/16 and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on 11/10/16 with recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The facility's Chaplain provided spiritual support for the resident on 11/04/16 and will meet weekly with Resident #2 for the next thirty (30) days. A care plan/family meeting was conducted on 11/02/16 to discuss any concerns and to answer any questions that Resident #2's POAs may ask. All questions were answered and no concerns were voiced. 4) All residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on 11/02/16 by the Social Services Worker (SSW), Staff Development Coordinator (SDC), ADON, and the Activity Director related to any concerns related to abuse in the facility. One (1) resident voiced concerns; the concern was reported and investigated as required, with no concerns identified. 5) Skin assessments for 100 percent of residents were conducted on 11/02/16, for signs and symptoms of abuse with no concerns identified. The assessments were conducted by facility staff nurses, as well as nurse management staff. All assessments were reviewed by the Consulting Nurse on 11/02/16. 6) All prior grievances were reviewed by the Administrator/Regional Controller on 11/03/16 for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) The Administrator/Regional Controller had reviewed all Resident Council Notes from the past six (6) months on 11/03/16. The Regional Controller identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) was reported from the November meeting. 8) All reportable incidents for the past twelve (12) months were reviewed on 11/03/16 to ensure complete and thorough investigations were completed and to ensure compliance with the facility's abuse policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185249	A. BUILDING _____ B. WING _____	11/16/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN	96 HIGHWAY 3444 ANNVILLE, KY 40402

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) 9) All residents' charts, which included Progress Notes, were reviewed for the last 60-day timeframe on 11/03/16 and 11/04/16. Resident records were reviewed by the Consulting Nurse, DON, SDC from another facility, and one (1) Nurse Administrator, to ensure no abuse allegations had been documented with no actions taken and to ensure the resident's physician and family had been notified of any changes in condition. 10) All residents were verified to ensure no current residents were on the sex offender registry on 11/04/16 by Human Resources. No concerns were identified. 11) Facility audits revealed all accidents and incidents were reviewed on 11/04/16, for the last 30 days, for any unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by Nurse Management, the Interim DON, SDC, and Consulting Nurse. 12) Interviews and review of facility documentation revealed the RVP (Regional Vice President) held a Resident Council Meeting on 11/03/16 to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. 13) The RVP, Consulting Nurse, and SDC Nurse initiated abuse education on 11/02/16 with all staff with a post-test of 100 percent to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. The content of training was as follows: abuse policy and procedures, nine (9) types of abuse including use of any video or pictures of residents used in a demeaning way, and all reporting options (Regional team, Signature Caring Line, Ombudsman, Adult Protective Services and the Office of the Inspector General) if a staff member believed possible abuse was ongoing. Certified letters were sent to any employees that had not been re- educated on abuse on 11/03/16. The letter informed the employees that they would not be permitted to work until the abuse education was completed. 14) Files for all employees hired in the past six (6) months (25 employees) were reviewed for appropriate credentials and possible abuse allegations. 15) On 11/03/16 and 11/04/16, staff was also provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact Situation, Background, Assessment and Recommendation (SBAR) forms and stop and watch form, care plans policy and procedure, to include appropriately updating the resident's care plan to reflect the resident's current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures, with a post-test score of 100 required, effective 11/04/16. 16) Daily monitoring of audits will be conducted by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. The audits include the following: five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse; ten (10) random resident chart audits for change in resident condition that have not been followed through with as required to monitor for any unreported allegations of abuse; and, ten (10) random staff abuse tests that require a passing score of 100%. 17) The Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator, will continue to provide daily monitoring by conducting ten (10) random resident interviews (with BIMS score of 8 and above) for any abuse allegations or concerns. The audits will be conducted until IJ is removed, and then for two (2) weeks with weekly QAPI (Quality Assurance Performance Improvement Committee) Audits will be monitored through the QA committee, which will determine the frequency to continue the audits. 18) Clinical meetings five (5) times a week with the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator will be held to review the 24-Hour Report, all accident and incidents, physician orders, and daily charting. The interdisciplinary team will be monitoring for signs and symptoms of abuse or any unreported abuse allegations. 19) The RVP will provide administrative oversight of the Center effective 11/02/16. The RVP is the Interim Administrator and will be in place until an administrator has been hired. The Administrator will be provided with abuse training and reporting as part of orientation. 20) The Quality Assurance Performance Improvement (QAPI) committee (Interim Administrator and DON, SSW, SDC, Dietary Manager, Activity Director, Consulting Nurse and Medical Director by phone) meetings were conducted on 11/02/16 and 11/09/16, to review this plan and all audits for needed revisions, compliance, and/or further education. The QAPI committee will then determine the need for reduction of audits monthly, based on audit outcomes and compliance. 21) Determining Decision-Making Capacity, Sexual Consent Capacity will be used as a guide or reference for the care plan team, physician, psychologists and families to help generate the correct conversations and decisions effective 11/04/16. ***The State Survey Agency verified the removal of the jeopardy through the following actions on 11/16/16. 1) Interview with the Regional Vice President of Operations (RVP) on 11/09/16 revealed the Administrator and DON were terminated from employment on 11/04/16. 2) Review of Resident #1's record revealed documentation of 15-minute checks and an evaluation by a psychiatrist on 11/03/16 and 11/10/16. Further review of the record revealed documentation that the care plan meeting was conducted and the resident's care plan was revised. Review of the facility's documentation revealed the resident received visits from the Chaplain on 11/04/16 and 11/11/16. 3) Review of Resident #2's medical record revealed the Medical Director completed a physical examination of Resident #2 (the alleged victim) on 11/03/16, and no signs or symptoms of sexual abuse were identified. The record further revealed that Resident #2 was evaluated by a psychiatrist on 11/03/16 and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on 11/10/16 with a recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The record further revealed the Chaplain had provided spiritual support for the resident on 11/04/16 and again on 11/11/16. The record revealed a care plan/family meeting was conducted on 11/02/16. 4) Review of the facility's audits on 11/16/16 revealed all residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on 11/02/16 by the SSW, SDC, ADON, and the Activity Director related to any concerns related to abuse in the facility. Review of an investigation dated 11/02/16 revealed one (1) resident voiced a concern; the concern was reported and investigated as required, with no problems identified. Interview with the SSW on 11/10/16 at 3:20 PM, the SDC on 11/16/16 at 4:00 PM, and the ADON on 11/10/16 at 5:10 PM, revealed all residents with a BIMS score of eight (8) to fifteen (15) were interviewed on 11/02/16. 5) Review of the facility's audits on 11/16/16 revealed skin assessments for 100% of residents were conducted on 11/02/16, for signs and symptoms of abuse, with no concerns identified. Interview with the SDC on 11/16/16 at 4:00 PM, ADON on 11/16/16 at 3:40 PM, and Registered Nurse (RN) #1 on 11/16/16 at 3:20 PM confirmed skin assessments had been conducted on 100% of facility residents on 11/02/16. 6) Review of the facility audits revealed all prior grievances were reviewed by the Administrator/Regional Controller on 11/03/16 for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) Further review of audits conducted by the facility revealed the Administrator/Regional Controller had reviewed all resident council notes from the past six (6) months on 11/03/16. Interview with the Regional Controller on 11/09/16 at 5:00 PM revealed he had identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) reported from November's meeting. All concerns were addressed and corrected by the Regional Controller. 8) Review of the facility's audits on 11/16/16, conducted by the Regional Controller, revealed the Regional Consulting Nurse had reviewed all reportable incidents for the last 12 months on 11/03/16. The Consulting Nurse had reviewed the allegations to ensure the facility's policy had been followed and that complete and thorough investigations had been conducted. Further review of the audits revealed the Consulting Nurse reviewed all reportable incidents, at least monthly when she visits the Center. Interview with the RVP on 11/16/16 at 4:30 PM revealed since 11/02/16 she had been involved as the Interim Administrator, and had remained on-site since 11/02/16. The RVP stated she had been involved in all reportable incidents to ensure they had been reported and that a thorough and complete investigation had been conducted. 9) Interviews with the Regional Consulting Nurse and the RVP on 11/16/16 at 4:15 PM and 4:30 PM, as well as review of the facility's audits revealed all residents' charts which included progress notes had been reviewed for the last 60-day timeframe on 11/03/16 and 11/04/16 to ensure no abuse allegations had been documented with no actions taken, and no concerns were identified, and that the resident's physician and family had been notified of any changes in condition, and no concerns were identified.

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) 10) Review of facility's documentation revealed 100% of the residents were verified to ensure no current residents were on the sex offender registry on 11/04/16 by Human Resources, and no concerns were identified. Interview with the RVP on 11/16/16 at 4:30 PM revealed she had validated that Human Resources had ensured that none of the residents were listed on the sex offender registry. 11) Review of facility's audits revealed all accidents and incidents from the last 30 days were reviewed on 11/04/16 for any unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by nurse management, the interim DON, SDC, and consulting nurse. Interviews with the SDC on 11/16/16 at 4:00 PM, the ADON on 11/10/16 at 5:10 PM, and the Regional Consulting Nurse verified they assisted with the audits. 12) Interview with the RVP on 11/16/16 at 4:30 PM and review of facility documentation revealed the she had held a Resident Council Meeting on 11/03/16 to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. Interviews with Residents A and B on 11/16/16 at 12:55 PM and 1:00 PM confirmed they had been educated, during a Resident Council Meeting, related to abuse and relationships in the facility. 13) Review of facility documentation related to staff training revealed the RVP, Consulting Nurse, and SDC nurse had initiated abuse education on 11/02/16 with all staff with validation of training with post-test requiring a score of 100% to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. Review of post tests revealed staff competency was acquired. Review of personnel records revealed certified letters were sent to staff informing them they would not be permitted to work until retrained. 14) Review of facility documentation of audits conducted revealed the Administrator/Regional Controller reviewed files of all new employees on 11/03/16, that had been hired in the past 6 months (25 employee files), for appropriate credentials and possible abuse allegations; and no concerns were identified. 15) Review of facility documentation revealed that on 11/03/16 and 11/04/16 staff was provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact SBAR and Stop and Watch form, care plans policy and procedure, to include appropriately updating the residents' care plans to reflect the residents' current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures with post-test score of 100 required, effective 11/04/16. Interview with the Consulting Nurse on 11/16/16 at 4:15 PM revealed the training was conducted with on 11/03/16 and 11/04/16. 16) Review of facility documentation revealed daily monitoring audits had been conducted from 11/03/16 through 11/16/16 by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator that included five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse, ten (10) random resident chart audits for change in resident condition that had not been followed through with as required, and ten (10) random staff abuse tests. Interviews with the interim DON on 11/16/16 at 3:40 PM and the Consulting Nurse on 11/16/16 at 4:15 PM revealed the audits were conducted. 17) Review of the facility's documentation and interview with the RVP on 11/16/16 at 4:30 PM revealed she, as well as the Consulting Nurse, Interim DON, SDC, and SSW conducted ten (10) random resident interviews (with BIMS scores of 8 and above) for any abuse allegations or concerns. 18) Review of facility documentation revealed on 11/04/16 staff initiated ongoing monitoring through clinical meetings five (5) times a week, which consisted of the following staff members in attendance: Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. Interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM, revealed staff reviewed the 24-hour report, all accident and incidents, physician orders, and daily charting for sign and symptoms of abuse or any unreported abuse allegations. 19) Interview with the RVP on 11/16/16 at 4:30 PM confirmed she had provided administrative oversight of the facility since 11/02/16. 20) Review of facility documentation and interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM revealed the QAPI committee met on 11/02/16 and 11/09/16 to review the plan and all audits for needed revisions, compliance, and or further education. 21) Review of facility documentation and interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM confirmed the Determining Decision-Making Capacity, Sexual Consent Capacity would be used as a guide or reference for the care plan team, physician, psychologists, and families to help generate the correct conversations and decisions effective 11/04/16.
F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy it was determined the facility failed to review and revise residents' plans of care when inappropriate sexual contact between residents was observed in the facility for two (2) of two (2) sampled residents (Residents #1 and #2). Resident #1 was observed to take Resident #2's hand and place it on his/her private part and rub himself/herself on 10/26/16. The incident was reported to the former Director of Nursing (DON) and the former Assistant DON on 10/26/16. However, staff failed to review and revise the residents' plans of care when the sexual contact was observed on 10/26/16. The facility's failure to ensure residents' plans of care were reviewed/revised when inappropriate sexual behavior was observed has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/10/16, and was determined to exist on 10/26/16. The facility submitted an acceptable Allegation of Compliance (AOC) on 11/16/16 alleging the Immediate Jeopardy was removed on 11/05/16. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the Immediate Jeopardy was removed on 11/05/16 prior to the SSA initiating the investigation on 11/09/16; therefore, it was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy titled Care Plans-Comprehensive, last reviewed 06/01/15, revealed that residents' care plans were designed to incorporate identified problem areas and risk factors associated with those problem areas identified by facility staff. Residents' care plans were to be revised as information about the resident and the resident's condition changed. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 05/20/16 with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 08/27/16, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident was interviewable. Review of Resident #1's Comprehensive Care Plan, last reviewed/revised in September 2016, revealed no documented evidence that staff had reviewed or revised the resident's plan of care when he/she was observed to inappropriately exhibit sexual behaviors toward Resident #2 on 10/26/16. Interview on 11/09/16 at 1:20 PM with Resident #1 revealed the resident was unable to recall the incident involving Resident #2 which occurred on 10/26/16. 2. Review of Resident #2's medical record revealed the facility admitted the resident on 05/28/15, with [DIAGNOSES REDACTED]. Review of Resident #2's Quarterly MDS assessment, dated 09/13/16, revealed the resident had a BIMS score of 6, which indicated the resident was not interviewable. Interview on 11/09/16 at 1:40 PM with Resident #2 revealed he/she had broken up with his/her significant other and he/she didn't live here. Resident #2 stated he/she felt safe in the facility. Interview on 11/09/16 at 3:45 PM with the Assistant Business Office Manager revealed she observed Resident #1 take Resident #2's hand and place it on his/her private part and rub himself/herself on 10/26/16. She immediately reported the incident to the former DON and the former ADON. She stated the former DON stated that the family was aware of it. Interview on 11/14/16 at 10:00 AM with the former DON confirmed that she and the former ADON were notified on 10/26/16 that Resident #1 was observed to place Resident #2's hand on his/her private part and rub him/herself. She stated she did not report it immediately to the former Administrator because the staff that informed her stated she was reporting the

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) allegation to the former Administrator. The former DON stated she was responsible for ensuring residents' care plans had been reviewed and revised when changes in the residents' condition or behaviors occurred. However, she had not reviewed or revised the residents' care plans related to the inappropriate sexual behaviors that were reported. She stated she should have revised the care plans. Interview was attempted with the former Administrator on 11/10/16, 11/14/16, and 11/16/16 and he was unable to be reached. Interview on 11/16/16 at 4:30 PM with the Regional Vice President (RVP) revealed staff should have followed the facility's policy and updated Resident #1 and Resident #2's care plans when the incident occurred on 10/26/16. **The facility provided an acceptable Allegation of Compliance (AOC) on 11/16/16. The facility implemented the following actions to remove the Immediate Jeopardy. 1) On 11/02/16, the Regional Vice President (RVP) was made aware of the incident, which was reported to the Administrator and the DON on 10/26/16; they were both suspended pending investigation. It was determined that the two (2) residents (Resident #1 and Resident #2) had been more physical with each other and nothing had been done to validate the relationship was appropriate. Staff had repeatedly reported their concerns of physical touching between these two (2) residents to Administration. However, Administration failed to follow the Center's abuse policy and procedures. The facility also failed to update the resident's care plans (Resident #1 and Resident #2). The Administrator and the DON were terminated from the facility. 2) Resident #1 had been on 15-minute checks since 10/27/16 and had made no attempts to go into Resident #2's room, or any other resident's room in the facility. Resident #1 was evaluated by a psychiatrist on 11/03/16, and again on 11/10/16, with medication recommendations, and to monitor the resident every 15 minutes, which were followed through as ordered. Resident #1 has not exhibited any further behaviors. Staff continued to monitor the resident every 15 minutes. A care plan meeting was conducted with Resident #1's Power of Attorney (POA), as well as his/her son on 11/04/16, and all concerns were discussed and all questions answered at that time. Resident #1 was provided spiritual support by the facility Chaplain on 11/04/16, and weekly visits will continue for one (1) month. 3) The Medical Director completed a physical examination on Resident #2 (the alleged victim) on 11/03/16, and no signs or symptoms of sexual abuse were identified. Resident #2 was evaluated by a psychiatrist on 11/03/16 and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on 11/10/16 with recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The facility's Chaplain provided spiritual support for the resident on 11/04/16 and will meet weekly with Resident #2 for the next thirty (30) days. A care plan/family meeting was conducted on 11/02/16 to discuss any concerns and to answer any questions that Resident #2's POAs may ask. All questions were answered and no concerns were voiced. 4) All residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on 11/02/16 by the Social Services Worker (SSW), Staff Development Coordinator (SDC), ADON, and the Activity Director related to any concerns related to abuse in the facility. One (1) resident voiced concerns; the concern was reported and investigated as required, with no concerns identified. 5) Skin assessments for 100 percent of residents were conducted on 11/02/16, for signs and symptoms of abuse with no concerns identified. The assessments were conducted by facility staff nurses, as well as nurse management staff. All assessments were reviewed by the Consulting Nurse on 11/02/16. 6) All prior grievances were reviewed by the Administrator/Regional Controller on 11/03/16 for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) The Administrator/Regional Controller had reviewed all Resident Council Notes from the past six (6) months on 11/03/16. The Regional Controller identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) was reported from the November meeting. 8) All reportable incidents for the past twelve (12) months were reviewed on 11/03/16 to ensure complete and thorough investigations were completed and to ensure compliance with the facility's abuse policy. 9) All residents' charts, which included Progress Notes, were reviewed for the last 60-day timeframe on 11/03/16 and 11/04/16. Resident records were reviewed by the Consulting Nurse, DON, SDC from another facility, and one (1) Nurse Administrator, to ensure no abuse allegations had been documented with no actions taken and to ensure the resident's physician and family had been notified of any changes in condition. 10) All residents were verified to ensure no current residents were on the sex offender registry on 11/04/16 by Human Resources. No concerns were identified. 11) Facility audits revealed all accidents and incidents were reviewed on 11/04/16, for the last 30 days, for any unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by Nurse Management, the Interim DON, SDC, and Consulting Nurse. 12) Interviews and review of facility documentation revealed the RVP (Regional Vice President) held a Resident Council Meeting on 11/03/16 to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. 13) The RVP, Consulting Nurse, and SDC Nurse initiated abuse education on 11/02/16 with all staff with a post-test of 100 percent to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. The content of training was as follows: abuse policy and procedures, nine (9) types of abuse including use of any video or pictures of residents used in a demeaning way, and all reporting options (Regional team, Signature Caring Line, Ombudsman, Adult Protective Services and the Office of the Inspector General) if a staff member believed possible abuse was ongoing. Certified letters were sent to any employees that had not been re- educated on abuse on 11/03/16. The letter informed the employees that they would not be permitted to work until the abuse education was completed. 14) Files for all employees hired in the past six (6) months (25 employees) were reviewed for appropriate credentials and possible abuse allegations. 15) On 11/03/16 and 11/04/16, staff was also provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact Situation, Background, Assessment and Recommendation (SBAR) forms and stop and watch form, care plans policy and procedure, to include appropriately updating the resident's care plan to reflect the resident's current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures, with a post-test score of 100 required, effective 11/04/16. 16) Daily monitoring of audits will be conducted by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. The audits include the following: five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse; ten (10) random resident chart audits for change in resident condition that have not been followed through with as required to monitor for any unreported allegations of abuse; and, ten (10) random staff abuse tests that require a passing score of 100%. 17) The Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator, will continue to provide daily monitoring by conducting ten (10) random resident interviews (with BIMS score of 8 and above) for any abuse allegations or concerns. The audits will be conducted until IJ is removed, and then for two (2) weeks with weekly QAPI (Quality Assurance Performance Improvement Committee) Audits will be monitored through the QA committee, which will determine the frequency to continue the audits. 18) Clinical meetings five (5) times a week with the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator will be held to review the 24-Hour Report, all accident and incidents, physician orders, and daily charting. The interdisciplinary team will be monitoring for signs and symptoms of abuse or any unreported abuse allegations. 19) The RVP will provide administrative oversight of the Center effective 11/02/16. The RVP is the Interim Administrator and will be in place until an administrator has been hired. The Administrator will be provided with abuse training and reporting as part of orientation. 20) The Quality Assurance Performance Improvement (QAPI) committee (Interim Administrator and DON, SSW, SDC, Dietary Manager, Activity Director, Consulting Nurse and Medical Director by phone) meetings were conducted on 11/02/16 and 11/09/16, to review this plan and all audits for needed revisions, compliance, and/or further education. The QAPI committee will then determine the need for reduction of audits monthly, based on audit outcomes and compliance. 21) Determining Decision-Making Capacity, Sexual Consent Capacity will be used as a guide or reference for the care plan

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	185249	A. BUILDING _____ B. WING _____	11/16/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN	96 HIGHWAY 3444 ANNVILLE, KY 40402

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 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) team, physician, psychologists and families to help generate the correct conversations and decisions effective 11/04/16. ***The State Survey Agency verified the removal of the jeopardy through the following actions on 11/16/16. 1) Interview with the Regional Vice President of Operations (RVP) on 11/09/16 revealed the Administrator and DON were terminated from employment on 11/04/16. 2) Review of Resident #1's record revealed documentation of 15-minute checks and an evaluation by a psychiatrist on 11/03/16 and 11/10/16. Further review of the record revealed documentation that the care plan meeting was conducted and the resident's care plan was revised. Review of the facility's documentation revealed the resident received visits from the Chaplain on 11/04/16 and 11/11/16. 3) Review of Resident #2's medical record revealed the Medical Director completed a physical examination of Resident #2 (the alleged victim) on 11/03/16, and no signs or symptoms of sexual abuse were identified. The record further revealed that Resident #2 was evaluated by a psychiatrist on 11/03/16 and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on 11/10/16 with a recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The record further revealed the Chaplain had provided spiritual support for the resident on 11/04/16 and again on 11/11/16. The record revealed a care plan/family meeting was conducted on 11/02/16. 4) Review of the facility's audits on 11/16/16 revealed all residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on 11/02/16 by the SSW, SDC, ADON, and the Activity Director related to any concerns related to abuse in the facility. Review of an investigation dated 11/02/16 revealed one (1) resident voiced a concern; the concern was reported and investigated as required, with no problems identified. Interview with the SSW on 11/10/16 at 3:20 PM, the SDC on 11/16/16 at 4:00 PM, and the ADON on 11/10/16 at 5:10 PM, revealed all residents with a BIMS score of eight (8) to fifteen (15) were interviewed on 11/02/16. 5) Review of the facility's audits on 11/16/16 revealed skin assessments for 100% of residents were conducted on 11/02/16, for signs and symptoms of abuse, with no concerns identified. Interview with the SDC on 11/16/16 at 4:00 PM, ADON on 11/16/16 at 3:40 PM, and Registered Nurse (RN) #1 on 11/16/16 at 3:20 PM confirmed skin assessments had been conducted on 100% of facility residents on 11/02/16. 6) Review of the facility audits revealed all prior grievances were reviewed by the Administrator/Regional Controller on 11/03/16 for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) Further review of audits conducted by the facility revealed the Administrator/Regional Controller had reviewed all resident council notes from the past six (6) months on 11/03/16. Interview with the Regional Controller on 11/09/16 at 5:00 PM revealed he had identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) reported from November's meeting. All concerns were addressed and corrected by the Regional Controller. 8) Review of the facility's audits on 11/16/16, conducted by the Regional Controller, revealed the Regional Consulting Nurse had reviewed all reportable incidents for the last 12 months on 11/03/16. The Consulting Nurse had reviewed the allegations to ensure the facility's policy had been followed and that complete and thorough investigations had been conducted. Further review of the audits revealed the Consulting Nurse reviewed all reportable incidents, at least monthly when she visits the Center. Interview with the RVP on 11/16/16 at 4:30 PM revealed since 11/02/16 she had been involved as the Interim Administrator, and had remained on-site since 11/02/16. The RVP stated she had been involved in all reportable incidents to ensure they had been reported and that a thorough and complete investigation had been conducted. 9) Interviews with the Regional Consulting Nurse and the RVP on 11/16/16 at 4:15 PM and 4:30 PM, as well as review of the facility's audits revealed all residents' charts which included progress notes had been reviewed for the last 60-day timeframe on 11/03/16 and 11/04/16 to ensure no abuse allegations had been documented with no actions taken, and no concerns were identified, and that the resident's physician and family had been notified of any changes in condition, and no concerns were identified. 10) Review of facility's documentation revealed 100% of the residents were verified to ensure no current residents were on the sex offender registry on 11/04/16 by Human Resources, and no concerns were identified. Interview with the RVP on 11/16/16 at 4:30 PM revealed she had validated that Human Resources had ensured that none of the residents were listed on the sex offender registry. 11) Review of facility's audits revealed all accidents and incidents from the last 30 days were reviewed on 11/04/16 for any unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by nurse management, the interim DON, SDC, and consulting nurse. Interviews with the SDC on 11/16/16 at 4:00 PM, the ADON on 11/10/16 at 5:10 PM, and the Regional Consulting Nurse verified they assisted with the audits. 12) Interview with the RVP on 11/16/16 at 4:30 PM and review of facility documentation revealed the she had held a Resident Council Meeting on 11/03/16 to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. Interviews with Residents A and B on 11/16/16 at 12:55 PM and 1:00 PM confirmed they had been educated, during a Resident Council Meeting, related to abuse and relationships in the facility. 13) Review of facility documentation related to staff training revealed the RVP, Consulting Nurse, and SDC nurse had initiated abuse education on 11/02/16 with all staff with validation of training with post-test requiring a score of 100% to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. Review of post tests revealed staff competency was acquired. Review of personnel records revealed certified letters were sent to staff informing them they would not be permitted to work until retrained. 14) Review of facility documentation of audits conducted revealed the Administrator/Regional Controller reviewed files of all new employees on 11/03/16, that had been hired in the past 6 months (25 employee files), for appropriate credentials and possible abuse allegations; and no concerns were identified. 15) Review of facility documentation revealed that on 11/03/16 and 11/04/16 staff was provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact SBAR and Stop and Watch form, care plans policy and procedure, to include appropriately updating the residents' care plans to reflect the residents' current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures with post-test score of 100 required, effective 11/04/16. Interview with the Consulting Nurse on 11/16/16 at 4:15 PM revealed the training was conducted with on 11/03/16 and 11/04/16. 16) Review of facility documentation revealed daily monitoring audits had been conducted from 11/03/16 through 11/16/16 by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator that included five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse, ten (10) random resident chart audits for change in resident condition that had not been followed through with as required, and ten (10) random staff abuse tests. Interviews with the interim DON on 11/16/16 at 3:40 PM and the Consulting Nurse on 11/16/16 at 4:15 PM revealed the audits were conducted. 17) Review of the facility's documentation and interview with the RVP on 11/16/16 at 4:30 PM revealed she, as well as the Consulting Nurse, Interim DON, SDC, and SSW conducted ten (10) random resident interviews (with BIMS scores of 8 and above) for any abuse allegations or concerns. 18) Review of facility documentation revealed on 11/04/16 staff initiated ongoing monitoring through clinical meetings five (5) times a week, which consisted of the following staff members in attendance: Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. Interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM, revealed staff reviewed the 24-hour report, all accident and incidents, physician orders, and daily charting for sign and symptoms of abuse or any unreported abuse allegations. 19) Interview with the RVP on 11/16/16 at 4:30 PM confirmed she had provided administrative oversight of the facility since 11/02/16. 20) Review of facility documentation and interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM revealed the QAPI committee met on 11/02/16 and 11/09/16 to review the plan and all audits for needed revisions, compliance, and or further education. 21) Review of facility documentation and interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM confirmed the Determining Decision-Making Capacity, Sexual Consent Capacity would be used as a guide or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0280 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 8) reference for the care plan team, physician, psychologists, and families to help generate the correct conversations and decisions effective 11/04/16.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy it was determined the facility failed to be administered in a manner that enabled its resources to be used effectively to maintain the highest practicable physical, mental, and psychosocial well-being of each resident when allegations of abuse were identified for one (1) of two (2) sampled residents (Resident #2). Facility staff reported to the former Director of Nursing (DON) and the former Assistant DON on 10/26/16 that Resident #1 was observed to take Resident #2's hand and place it on his/her private part and rub himself/herself. The allegation was discussed with the former Administrator on 10/27/16; however, the former Administrator and the administrative staff failed to conduct an investigation related to the alleged incident, failed to protect residents from further abuse, and failed to report the alleged incident to state agencies. The facility's failure to ensure allegations of abuse were thoroughly investigated, failure to ensure residents were protected from further abuse, failure to ensure abuse allegations were reported to state agencies, as well as failure to review/revise residents' plans of care when inappropriate sexual behavior was observed, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/10/16, and was determined to exist on 10/26/16. The facility submitted an acceptable Allegation of Compliance (AOC) on 11/16/16 alleging the Immediate Jeopardy was removed on 11/05/16. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the Immediate Jeopardy was removed on 11/05/16 prior to the SSA initiating the investigation on 11/09/16; therefore, it was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy titled, Facility Advisory Board (FAB), not dated, revealed the facility had designated the Administrator to be one of the persons responsible for establishing and implementing policies in the facility. The policy further stated the Administrator was responsible for the management of the facility. 1. Review of the medical record for Resident #1 revealed the facility admitted the resident on 05/20/16 with [DIAGNOSES REDACTED]. Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 08/27/16, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident was interviewable. 2. Record review revealed the facility admitted Resident #2 on 05/28/15, with [DIAGNOSES REDACTED]. Review of Resident #2's Quarterly MDS assessment, dated 09/13/16, revealed the resident had a BIMS score of 6, which indicated the resident was not interviewable. Per interview on 11/09/16 at 3:45 PM, with the Assistant Business Office Manager she witnessed Resident #1 take Resident #2's hand and place it on his/her private part and rub himself/herself on 10/26/16. She stated she felt this was potential abuse and so she immediately reported the incident to the former DON and the former ADON. The former DON told her the family was aware of it. Further interview revealed she did not witness the former DON or former ADON take any action related to the incident. Interview on 11/10/16 at 5:10 PM with the former ADON revealed she and the former DON were notified on 10/26/16 of the incident with Resident #1 and Resident #2. The former ADON stated she and the former DON followed up with the former Administrator the following day, on 10/27/16. She stated, He just walked out of the room and never acknowledged that we had told him anything. Interview on 11/14/16 at 10:00 AM with the former DON revealed she and the former ADON were notified on 10/26/16 of the incident related to Resident #1 and Resident #2. She stated she and the former ADON discussed the allegation with the former Administrator on 10/27/16. Continued interview revealed the former Administrator did not assign the investigation to her. She further stated that no investigation was done or directed, because he always did that stuff; he was the Abuse Coordinator. The former DON stated it was not her responsibility to report or coordinate investigations in the facility because the former Administrator usually took care of all of that. Interview was attempted with the former Administrator on 11/10/16, 11/14/16, and 11/16/16 and he was unable to be reached. Interview on 11/16/16 at 4:30 PM with the Regional Vice President (RVP) revealed the former Administrator should have followed the facility's policy when he was notified of the allegation on 10/27/16. The RVP stated that Administrators were responsible to ensure residents were protected and allegations of abuse were investigated and reported to state agencies as required. **The facility provided an acceptable Allegation of Compliance (AOC) on 11/16/16. The facility implemented the following actions to remove the Immediate Jeopardy. 1) On 11/02/16, the Regional Vice President (RVP) was made aware of the incident, which was reported to the Administrator and the DON on 10/26/16; they were both suspended pending investigation. It was determined that the two (2) residents (Resident #1 and Resident #2) had been more physical with each other and nothing had been done to validate the relationship was appropriate. Staff had repeatedly reported their concerns of physical touching between these two (2) residents to Administration. However, Administration failed to follow the Center's abuse policy and procedures. The facility also failed to update the resident's care plans (Resident #1 and Resident #2). The Administrator and the DON were terminated from the facility. 2) Resident #1 had been on 15-minute checks since 10/27/16 and had made no attempts to go into Resident #2's room, or any other resident's room in the facility. Resident #1 was evaluated by a psychiatrist on 11/03/16, and again on 11/10/16, with medication recommendations, and to monitor the resident every 15 minutes, which were followed through as ordered. Resident #1 has not exhibited any further behaviors. Staff continued to monitor the resident every 15 minutes. A care plan meeting was conducted with Resident #1's Power of Attorney (POA), as well as his/her son on 11/04/16, and all concerns were discussed and all questions answered at that time. Resident #1 was provided spiritual support by the facility Chaplain on 11/04/16, and weekly visits will continue for one (1) month. 3) The Medical Director completed a physical examination on Resident #2 (the alleged victim) on 11/03/16, and no signs or symptoms of sexual abuse were identified. Resident #2 was evaluated by a psychiatrist on 11/03/16 and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on 11/10/16 with recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The facility's Chaplain provided spiritual support for the resident on 11/04/16 and will meet weekly with Resident #2 for the next thirty (30) days. A care plan/family meeting was conducted on 11/02/16 to discuss any concerns and to answer any questions that Resident #2's POAs may ask. All questions were answered and no concerns were voiced. 4) All residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on 11/02/16 by the Social Services Worker (SSW), Staff Development Coordinator (SDC), ADON, and the Activity Director related to any concerns related to abuse in the facility. One (1) resident voiced concerns; the concern was reported and investigated as required, with no concerns identified. 5) Skin assessments for 100 percent of residents were conducted on 11/02/16, for signs and symptoms of abuse with no concerns identified. The assessments were conducted by facility staff nurses, as well as nurse management staff. All assessments were reviewed by the Consulting Nurse on 11/02/16. 6) All prior grievances were reviewed by the Administrator/Regional Controller on 11/03/16 for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) The Administrator/Regional Controller had reviewed all Resident Council Notes from the past six (6) months on 11/03/16. The Regional Controller identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) was reported from the November meeting. 8) All reportable incidents for the past twelve (12) months were reviewed on 11/03/16 to ensure complete and thorough investigations were completed and to ensure compliance with the facility's abuse policy. 9) All residents' charts, which included Progress Notes, were reviewed for the last 60-day timeframe on 11/03/16 and 11/04/16. Resident records were reviewed by the Consulting Nurse, DON, SDC from another facility, and one (1) Nurse Administrator, to ensure no abuse allegations had been documented with no actions taken and to ensure the resident's physician and family had been notified of any changes in condition. 10) All residents were verified to ensure no current residents were on the sex offender registry on 11/04/16 by Human

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) Resources. No concerns were identified. 11) Facility audits revealed all accidents and incidents were reviewed on 11/04/16, for the last 30 days, for any unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by Nurse Management, the Interim DON, SDC, and Consulting Nurse. 12) Interviews and review of facility documentation revealed the RVP (Regional Vice President) held a Resident Council Meeting on 11/03/16 to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. 13) The RVP, Consulting Nurse, and SDC Nurse initiated abuse education on 11/02/16 with all staff with a post-test of 100 percent to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. The content of training was as follows: abuse policy and procedures, nine (9) types of abuse including use of any video or pictures of residents used in a demeaning way, and all reporting options (Regional team, Signature Caring Line, Ombudsman, Adult Protective Services and the Office of the Inspector General) if a staff member believed possible abuse was ongoing. Certified letters were sent to any employees that had not been re- educated on abuse on 11/03/16. The letter informed the employees that they would not be permitted to work until the abuse education was completed. 14) Files for all employees hired in the past six (6) months (25 employees) were reviewed for appropriate credentials and possible abuse allegations. 15) On 11/03/16 and 11/04/16, staff was also provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact Situation, Background, Assessment and Recommendation (SBAR) forms and stop and watch form, care plans policy and procedure, to include appropriately updating the resident's care plan to reflect the resident's current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures, with a post-test score of 100 required, effective 11/04/16. 16) Daily monitoring of audits will be conducted by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. The audits include the following: five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse; ten (10) random resident chart audits for change in resident condition that have not been followed through with as required to monitor for any unreported allegations of abuse; and, ten (10) random staff abuse tests that require a passing score of 100%. 17) The Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator, will continue to provide daily monitoring by conducting ten (10) random resident interviews (with BIMS score of 8 and above) for any abuse allegations or concerns. The audits will be conducted until IJ is removed, and then for two (2) weeks with weekly QAPI (Quality Assurance Performance Improvement Committee) Audits will be monitored through the QA committee, which will determine the frequency to continue the audits. 18) Clinical meetings five (5) times a week with the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator will be held to review the 24-Hour Report, all accident and incidents, physician orders, and daily charting. The interdisciplinary team will be monitoring for signs and symptoms of abuse or any unreported abuse allegations. 19) The RVP will provide administrative oversight of the Center effective 11/02/16. The RVP is the Interim Administrator and will be in place until an administrator has been hired. The Administrator will be provided with abuse training and reporting as part of orientation. 20) The Quality Assurance Performance Improvement (QAPI) committee (Interim Administrator and DON, SSW, SDC, Dietary Manager, Activity Director, Consulting Nurse and Medical Director by phone) meetings were conducted on 11/02/16 and 11/09/16, to review this plan and all audits for needed revisions, compliance, and/or further education. The QAPI committee will then determine the need for reduction of audits monthly, based on audit outcomes and compliance. 21) Determining Decision-Making Capacity, Sexual Consent Capacity will be used as a guide or reference for the care plan team, physician, psychologists and families to help generate the correct conversations and decisions effective 11/04/16. ***The State Survey Agency verified the removal of the jeopardy through the following actions on 11/16/16. 1) Interview with the Regional Vice President of Operations (RVP) on 11/09/16 revealed the Administrator and DON were terminated from employment on 11/04/16. 2) Review of Resident #1's record revealed documentation of 15-minute checks and an evaluation by a psychiatrist on 11/03/16 and 11/10/16. Further review of the record revealed documentation that the care plan meeting was conducted and the resident's care plan was revised. Review of the facility's documentation revealed the resident received visits from the Chaplain on 11/04/16 and 11/11/16. 3) Review of Resident #2's medical record revealed the Medical Director completed a physical examination of Resident #2 (the alleged victim) on 11/03/16, and no signs or symptoms of sexual abuse were identified. The record further revealed that Resident #2 was evaluated by a psychiatrist on 11/03/16 and medication changes were recommended and followed through as ordered. A follow-up visit with the psychiatrist was conducted on 11/10/16 with a recommendation to change the resident to every fifteen (15) minute monitoring and no other concerns were noted. The record further revealed the Chaplain had provided spiritual support for the resident on 11/04/16 and again on 11/11/16. The record revealed a care plan/family meeting was conducted on 11/02/16. 4) Review of the facility's audits on 11/16/16 revealed all residents with a Brief Interview for Mental Status (BIMS) score of eight (8) to fifteen (15) were interviewed on 11/02/16 by the SSW, SDC, ADON, and the Activity Director related to any concerns related to abuse in the facility. Review of an investigation dated 11/02/16 revealed one (1) resident voiced a concern; the concern was reported and investigated as required, with no problems identified. Interview with the SSW on 11/10/16 at 3:20 PM, the SDC on 11/16/16 at 4:00 PM, and the ADON on 11/10/16 at 5:10 PM, revealed all residents with a BIMS score of eight (8) to fifteen (15) were interviewed on 11/02/16. 5) Review of the facility's audits on 11/16/16 revealed skin assessments for 100% of residents were conducted on 11/02/16, for signs and symptoms of abuse, with no concerns identified. Interview with the SDC on 11/16/16 at 4:00 PM, ADON on 11/16/16 at 3:40 PM, and Registered Nurse (RN) #1 on 11/16/16 at 3:20 PM confirmed skin assessments had been conducted on 100% of facility residents on 11/02/16. 6) Review of the facility audits revealed all prior grievances were reviewed by the Administrator/Regional Controller on 11/03/16 for appropriate follow-up and to identify any abuse allegations that had not been reported for the last six (6) months, and no concerns were identified. 7) Further review of audits conducted by the facility revealed the Administrator/Regional Controller had reviewed all resident council notes from the past six (6) months on 11/03/16. Interview with the Regional Controller on 11/09/16 at 5:00 PM revealed he had identified nine (9) grievances that he stated needed to be addressed more appropriately and one (1) reported from November's meeting. All concerns were addressed and corrected by the Regional Controller. 8) Review of the facility's audits on 11/16/16, conducted by the Regional Controller, revealed the Regional Consulting Nurse had reviewed all reportable incidents for the last 12 months on 11/03/16. The Consulting Nurse had reviewed the allegations to ensure the facility's policy had been followed and that complete and thorough investigations had been conducted. Further review of the audits revealed the Consulting Nurse reviewed all reportable incidents, at least monthly when she visits the Center. Interview with the RVP on 11/16/16 at 4:30 PM revealed since 11/02/16 she had been involved as the Interim Administrator, and had remained on-site since 11/02/16. The RVP stated she had been involved in all reportable incidents to ensure they had been reported and that a thorough and complete investigation had been conducted. 9) Interviews with the Regional Consulting Nurse and the RVP on 11/16/16 at 4:15 PM and 4:30 PM, as well as review of the facility's audits revealed all residents' charts which included progress notes had been reviewed for the last 60-day timeframe on 11/03/16 and 11/04/16 to ensure no abuse allegations had been documented with no actions taken, and no concerns were identified, and that the resident's physician and family had been notified of any changes in condition, and no concerns were identified. 10) Review of facility's documentation revealed 100% of the residents were verified to ensure no current residents were on the sex offender registry on 11/04/16 by Human Resources, and no concerns were identified. Interview with the RVP on 11/16/16 at 4:30 PM revealed she had validated that Human Resources had ensured that none of the residents were listed on the sex offender registry. 11) Review of facility's audits revealed all accidents and incidents from the last 30 days were reviewed on 11/04/16 for any

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN	**96 HIGHWAY 3444 ANNVILLE, KY 40402**

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 10) unidentified change of condition, and any non-reported abuse allegations, and no concerns were identified. These audits were conducted by nurse management, the interim DON, SDC, and consulting nurse. Interviews with the SDC on 11/16/16 at 4:00 PM, the ADON on 11/10/16 at 5:10 PM, and the Regional Consulting Nurse verified they assisted with the audits. 12) Interview with the RVP on 11/16/16 at 4:30 PM and review of facility documentation revealed the she had held a Resident Council Meeting on 11/03/16 to educate residents on all types of abuse, reporting abuse, and to discuss appropriate resident relationships. All residents understood and felt comfortable and more informed after the meeting. Interviews with Residents A and B on 11/16/16 at 12:55 PM and 1:00 PM confirmed they had been educated, during a Resident Council Meeting, related to abuse and relationships in the facility. 13) Review of facility documentation related to staff training revealed the RVP, Consulting Nurse, and SDC nurse had initiated abuse education on 11/02/16 with all staff with validation of training with post-test requiring a score of 100% to determine competency. No employees were permitted to return to work until they had been re-educated and passed the competency test. Review of post tests revealed staff competency was acquired. Review of personnel records revealed certified letters were sent to staff informing them they would not be permitted to work until retrained. 14) Review of facility documentation of audits conducted revealed the Administrator/Regional Controller reviewed files of all new employees on 11/03/16, that had been hired in the past 6 months (25 employee files), for appropriate credentials and possible abuse allegations; and no concerns were identified. 15) Review of facility documentation revealed that on 11/03/16 and 11/04/16 staff was provided with re-education and a post-test with a score of 100% related to family and physician notification, resident rights, Interact SBAR and Stop and Watch form, care plans policy and procedure, to include appropriately updating the residents' care plans to reflect the residents' current care needs along with supervision needs. This staff training was conducted by the Consulting Nurse. All new hires will be educated on the abuse policy and procedures with post-test score of 100 required, effective 11/04/16. Interview with the Consulting Nurse on 11/16/16 at 4:15 PM revealed the training was conducted with on 11/03/16 and 11/04/16. 16) Review of facility documentation revealed daily monitoring audits had been conducted from 11/03/16 through 11/16/16 by the Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator that included five (5) random skin assessments on residents with BIMS scores of seven (7) and below for signs or symptoms of abuse, ten (10) random resident chart audits for change in resident condition that had not been followed through with as required, and ten (10) random staff abuse tests. Interviews with the interim DON on 11/16/16 at 3:40 PM and the Consulting Nurse on 11/16/16 at 4:15 PM revealed the audits were conducted. 17) Review of the facility's documentation and interview with the RVP on 11/16/16 at 4:30 PM revealed she, as well as the Consulting Nurse, Interim DON, SDC, and SSW conducted ten (10) random resident interviews (with BIMS scores of 8 and above) for any abuse allegations or concerns. 18) Review of facility documentation revealed on 11/04/16 staff initiated ongoing monitoring through clinical meetings five (5) times a week, which consisted of the following staff members in attendance: Consulting Nurse, Interim DON, SDC, SSW, and the Interim Administrator. Interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM, revealed staff reviewed the 24-hour report, all accident and incidents, physician orders, and daily charting for sign and symptoms of abuse or any unreported abuse allegations. 19) Interview with the RVP on 11/16/16 at 4:30 PM confirmed she had provided administrative oversight of the facility since 11/02/16. 20) Review of facility documentation and interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM revealed the QAPI committee met on 11/02/16 and 11/09/16 to review the plan and all audits for needed revisions, compliance, and or further education. 21) Review of facility documentation and interviews with the Consulting Nurse on 11/16/16 at 4:15 PM and the RVP on 11/16/16 at 4:30 PM confirmed the Determining Decision-Making Capacity, Sexual Consent Capacity would be used as a guide or reference for the care plan team, physician, psychologists, and families to help generate the correct conversations and decisions effective 11/04/16.