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

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

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

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185249 If continuation sheet Previous Versions Obsolete Page 1 of 11

STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCT A. BUILDING	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	IDENNTIFICATION	B. WING		11/16/2016	
CORRECTION	NUMBER 185249				
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, STA	ATE, 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 deficien	cy, please contact the nursing hon	ne or the state survey agency.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY	
F 0225	(continued from page 1) 1) On [DATE], the Regional Vice	Precident (RVP) was made awars	e of the incident, which was repor	ted to the Administrator and	
Level of harm - Immediate	the DON on [DATE]; they were I	ooth suspended pending investiga	tion. It was determined that the tw	o (2) residents (Resident	
jeopardy	appropriate. Staff had repeatedly	reported their concerns of physica	othing had been done to validate that touching between these two (2)	residents to	
Residents Affected - Few			er's abuse policy and procedures. The Administrator and the DON w		
	2) Resident #1 had been on 15-mi				
	medication recommendations, and	to monitor the resident every 15	a psychiatrist on [DATE], and aga minutes, which were followed the	rough as ordered. Resident	
			itor the resident every 15 minutes. ell as his/her son on [DATE], and a		
	and all questions answered at that weekly visits will continue for on	time. Resident #1 was provided	spiritual support by the facility Ch	aplain on [DATE], and	
	3) The Medical Director complete	d a physical examination on Resi	dent #2 (the alleged victim) on [D ted by a psychiatrist on [DATE] a		
	recommended and followed throu	gh as ordered. A follow-up visit	with the psychiatrist was conducte	d on [DATE] with	
	recommendation to change the re facility's Chaplain provided spirit	sident to every fifteen (15) minute ual support for the resident on [D	e monitoring and no other concern ATE] and will meet weekly with I	s were noted. The Resident #2 for the	
			n [DATE] to discuss any concerns swered and no concerns were voice		
	4) All residents with a Brief Interv	riew for Mental Status (BIMS) sc		e interviewed on	
		he facility. One (1) resident voice	d concerns; the concern was repor		
	5) Skin assessments for 100 perce	nt of residents were conducted on			
	were reviewed by the Consulting	Nurse on [DATE].	, as well as nurse management sta		
	<li>6) All prior grievances were revie identify any abuse allegations tha</li>		al Controller on [DATE] for appro st six (6) months, and no concerns		
	<ol><li>The Administrator/Regional Co</li></ol>	ontroller had reviewed all Residen		(6) months on [DATE]. The	
	reported from the November mee 8) All reportable incidents for the	ting.		•	
	investigations were completed an	d to ensure compliance with the f	acility's abuse policy.		
		by the Consulting Nurse, DON, SI	DC from another facility, and one	(1) Nurse Administrator, to	
	been notified of any changes in co	ondition.	taken and to ensure the resident's p		
	10) All residents were verified to Resources. No concerns were ide		on the sex offender registry on [DA	ATE] by Human	
	11) Facility audits revealed all acc		ed on [DATE], for the last 30 days to concerns were identified. These		
	by Nurse Management, the Interior 12) Interviews and review of facil	m DON, SDC, and Consulting Nu	irse.		
	Meeting on [DATE] to educate re	sidents on all types of abuse, repo	orting abuse, and to discuss approp		
	relationships. All residents under 13) The RVP, Consulting Nurse, a	and SDC Nurse initiated abuse ed	ucation on [DATE] with all staff v		
			policy and procedures, nine (9) ty		
			and all reporting options (Regiona e of the Inspector General) if a sta		
	possible abuse was ongoing. Cert	ified letters were sent to any empl	loyees that had not been re- educa d to work until the abuse education	ted on abuse on [DATE].	
	14) Files for all employees hired i possible abuse allegations.				
	15) On [DATE] and [DATE], staf				
	stop and watch form, care plans p	olicy and procedure, to include a	ground, Assessment and Recommon ppropriately updating the resident	s care plan to reflect	
	All new hires will be educated on		s staff training was conducted by t with a post-test score of 100 requ		
	[DATE]. 16) Daily monitoring of audits wil	l be conducted by the Consulting	Nurse, Interim DON, SDC, SSW	, and the Interim	
			kin assessments on residents with ident chart audits for change in re-		
		vith as required to monitor for any	unreported allegations of abuse;		
	17) The Consulting Nurse, Interin	DON, SDC, SSW, and the Interi			
	audits will be conducted until IJ i	s removed, and then for two (2) w	of 8 and above) for any abuse alle yeeks with weekly QAPI (Quality	Assurance Performance	
	the audits.		A committee, which will determin		
	18) Clinical meetings five (5) time will be held to review the 24-Hou		rse, Interim DON, SDC, SSW, and ts, physician orders, and daily cha		
	interdisciplinary team will be mo		of abuse or any unreported abuse a fective [DATE]. The RVP is the I		
			trator will be provided with abuse		
	20) The Quality Assurance Perfor				
	to review this plan and all audits	for needed revisions, compliance,	or by phone) meetings were condu and/or further education. The QA		
	determine the need for reduction 21) Determining Decision-Making	g Capacity, Sexual Consent Capac	city will be used as a guide or refer		
	team, physician, psychologists an ***The State Survey Agency veri		rrect conversations and decisions of hrough the following actions on [I		
	Interview with the Regional Vi- terminated from employment on	ce President of Operations (RVP)			
	2) Review of Resident #1's record	revealed documentation of 15-mi	inute checks and an evaluation by that the care plan meeting was co		
	care plan was revised. Review of		that the care plan meeting was co- aled the resident received visits from		
	[DATE] and [DATE].  3) Review of Resident #2's medical				
	alleged victim) on [DATE], and r	no signs or symptoms of sexual ab	ouse were identified. The record fu	orther revealed that	
	1				

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED		
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		11/16/2016		
CORRECTION	NUMBER			11/10/2010		
NAME OF PROVIDER OF SU	185249 PPI IER		KTREET ADDRESS CITY ST.	ATE ZIP		
	NAME OF PROVIDER OF SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP  96 HIGHWAY 3444					
			ANNVILLE, KY 40402			
(X4) ID PREFIX TAG	home's plan to correct this deficient SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICI	me or the state survey agency.  ENCY MUST BE PRECEDED BY	Y FULL REGULATORY		
F 0225	(continued from page 2)					
Level of harm - Immediate jeopardy	ordered. A follow-up visit with the every fifteen (15) minute monitor	ne psychiatrist was conducted on ring and no other concerns were n	cation changes were recommended [DATE] with a recommendation to noted. The record further revealed in [DATE]. The record revealed a contract of the record revealed as contract of the record revealed revea	change the resident to the Chaplain had		
Residents Affected - Few	eight (8) to fifteen (15) were inter concerns related to abuse in the fa concern; the concern was reporter [DATE] at 3:20 PM, the SDC on score of eight (8) to fifteen (15) w 5) Review of the facility's audits of signs and symptoms of abuse, with 3:40 PM, and Registered Nurse (1 facility residents on [DATE]. (5) Review of the facility audits residents on the facility audits resident of the facility audits resident of the facility audits resident council notes from the prevealed he had identified nine (9 reported from November's meetir (8) Review of the facility's audits of had reviewed all reportable incide to ensure the facility's policy had review of the audits revealed the Center. Interview with the RVP of Administrator, and had remained ensure they had been reported and	rviewed on [DATE] by the SSW, acality. Review of an investigation of an dinvestigated as required, wi [DATE] at 4:00 PM, and the AD were interviewed on [DATE]. on [DATE] revealed skin assessm th no concerns identified. Intervie RN) #1 on [DATE] at 3:20 PM covered and to identify any abuse allegate entified. Intervied by the facility revealed the A ast six (6) months on [DATE]. Into prevances that he stated needed and place and the stated needed and place and place and the stated needed and place and p	with a Brief Interview for Mental: SDC, ADON, and the Activity Din dated [DATE] revealed one (1) rith no problems identified. Interview ON on [DATE] at 5:10 PM, revealed the summar of	rector related to any essident voiced a sweet with the SSW on led all residents with a BIMS conducted on [DATE], for 20 PM, ADON on [DATE] at an conducted on 100% of cional Controller on or the last six (6) and reviewed all ler on [DATE] at 5:00 PM let on [DATE] at 5:00		
	facility's audits revealed all reside timeframe on [DATE] and [DAT were identified, and that the resid concerns were identified.  10) Review of facility's document the sex offender registry on [DAT at 4:30 PM revealed she had valid offender registry.  11) Review of facility's audits revunidentified change of condition, were conducted by nurse manage PM, the ADON on [DATE] at 5:  12) Interview with the RVP on [D Council Meeting on [DATE] at 5:  12) Interview with the RVP on [D Council Meeting on [DATE] at 5:  13) Review of facility documental intitated abuse education on [DA']	ents' charts which included progrees to ensure no abuse allegations ent's physician and family had be ation revealed 100% of the reside (E] by Human Resources, and no dated that Human Resources had ealed all accidents and incidents and any non-reported abuse allegment, the interim DON, SDC, and DPM, and the Regional Consult ATE] at 4:30 PM and review of ducate residents on all types of all stood and felt comfortable and mand 1:00 PM confirmed they had ility.	ess notes had been reviewed for the had been documented with no active en notified of any changes in concents were verified to ensure no cure of concerns were identified. Interviewensured that none of the residents from the last 30 days were reviewe gations, and no concerns were identified documentation revealed the buse, reporting abuse, and to discuore informed after the meeting. Interviewensure informed after the meeting, and to discuore informed after the meeting. Interviewensure informed after the meeting in the deen educated, during a Resident laded the RVP, Consulting Nurse, are of training with post-test requiring work until they had been re-educated.	e last 60-day ions taken, and no concerns ilition, and no rent residents were on w with the RVP on [DATE] were listed on the sex ed on [DATE] for any tified. These audits n the SDC on [DATE] at 4:00 th the audits. e she had held a Resident ss appropriate resident erviews with Residents Council Meeting, related to and SDC nurse had a score of 100% to		
	certified letters were sent to staff 14) Review of facility documentar all new employees on [DATE], th possible abuse allegations; and no 15) Review of facility documentar with a score of 100% related to fa- care plans policy and procedure, tournent care needs along with sup will be educated on the abuse pol the Consulting Nurse on [DATE] 16) Review of facility documentar Consulting Nurse, Interim DON, residents with BIMS scores of se- change in resident condition that Interviews with the interim DON conducted. 17) Review of the facility's docum Consulting Nurse, Interim DON, for any abuse allegations or conculting Nurse, Interim Con- (5) times a week, which consisted and the Interim Administrator. In revealed staff reviewed the 24-ho	informing them they would not be tion of audits conducted revealed hat had been hired in the past 6 m to concerns were identified. It on revealed that on [DATE] and mily and physician notification, to include appropriately updating servision needs. This staff training icy and procedures with post-test at 4:15 PM revealed the training icy and procedures with post-test at 4:15 PM revealed the training icon revealed daily monitoring au SDC, SSW, and the Interim Adm ven (7) and below for signs or sy had not been followed through w on [DATE] at 3:40 PM and the Conentation and interview with the FSDC, and SSW conducted ten (1) terms. It is no revealed on [DATE] staff init of the following staff members it terviews with the Consulting Nur ur report, all accident and incider	vas acquired. Review of personnel be permitted to work until retrained the Administrator/Regional Contronths (25 employee files), for appliance of the Administrator (25 employee files), for appliance of the resident rights, Interact SBAR and the residents' care plans to reflect gwas conducted by the Consulting score of 100 required, effective [I was conducted with on [DATE] addits had been conducted from [DA dits had been conducted from [DA ministrator that included five (5) ramptoms of abuse, ten (10) random ith as required, and ten (10) rando Consulting Nurse on [DATE] at 4:30 PM revea (0) random resident interviews (with itiated ongoing monitoring through in attendance: Consulting Nurse, I see on [DATE] at 4:15 PM and the ints, physician orders, and daily characteristics.	l. oller reviewed files of ropriate credentials and re-education and a post-test Stop and Watch form, the residents' Nurse. All new hires DATE]. Interview with nd [DATE] by the adom skin assessments on resident chart audits for m staff abuse tests. 15 PM revealed the audits were led she, as well as the h BIMS scores of 8 and above) a clinical meetings five interim DON, SDC, SSW, RVP on [DATE] at 4:30 PM,		
	[DATE]. 20) Review of facility documental 4:30 PM revealed the QAPI commonpliance, and or further educat 21) Review of facility documental 4:30 PM confirmed the Determin	ATE] at 4:30 PM confirmed she tion and interviews with the Consmittee met on [DATE] and [DAT tion. tion and interviews with the Consing Decision-Making Capacity, S	had provided administrative overs sulting Nurse on [DATE] at 4:15 P TE] to review the plan and all audit: sulting Nurse on [DATE] at 4:15 P Sexual Consent Capacity would be elp generate the correct conversation	M and the RVP on [DATE] at s for needed revisions,  M and the RVP on [DATE] at used as a guide or reference		
F 0226  Level of harm - Immediate jeopardy  Residents Affected - Few	Based on interview, record review policies and procedures were imp	TS HAVE BEEN EDITED TO PR , and review of the facility's poli-	f residents or theft of  ROTECT CONFIDENTIALITY** cy it was determined the facility fa use were reported for one (1) of tw sing (DON) and the former Assista	iled to ensure to (2) sampled residents		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRU A. BUILDING	CTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	IDENNTIFICATION	B. WING		11/16/2016		
CORRECTION	NUMBER					
NAME OF PROVIDER OF SU	185249 PPLJER		STREET ADDRESS	CITY STATE ZIP		
NAME OF PROVIDER 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 deficien	cy, please contact the nursing h	nome or the state survey	agency.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		CIENCY MUST BE PRI	ECEDED BY FULL REGULATORY		
F 0226	(continued from page 3)	- ,				
Level of harm - Immediate jeopardy	that Resident #1 was observed to facility failed to follow their polici incident, failed to protect resident	cy and procedures as they did n	ot conduct an investigati	on related to the alleged		
Residents Affected - Few	outlined in the facility policy.  The facility's failure to ensure its p					
	were thoroughly investigated, fail allegations were reported to state					
	inappropriate caused or is likely t identified on 11/10/16, and was d Compliance (AOC) on 11/16/16	o cause serious injury, harm, in etermined to exist on 10/26/16 alleging the Immediate Jeopard	npairment, or death to a . The facility submitted a ly was removed on 11/05	resident. Immediate Jeopardy was		
	the investigation on 11/09/16; the The findings include:	refore, it was determined to be	Past Immediate Jeopard	y.		
	Review of the facility's policy title facility to ensure all alleged viola in accordance with federal and sta violations that occurred in the fac	tions involving abuse were rep ate law. Staff was required to c ility. The policy stated when a	orted to the administrato onduct a reasonable inve resident exhibited any for	estigation of all alleged orm of abuse toward another		
	the residents had no access to one	another until the circumstance	es of the incident were de			
	Review of Resident #1's Quarterly resident to have a Brief Interview	Minimum Data Set (MDS) as for Mental Status (BIMS) sco with Resident #1 revealed the	sessment, dated 08/27/16 re of 8, which indicated to	15/20/16 with [DIAGNOSES REDACTED]. 6, revealed the facility assessed the the resident was interviewable. ecall the incident involving Resident		
	2. Resident #2's medical record re	vealed the facility admitted the essment, dated 09/13/16, reveal		ith [DIAGNOSES REDACTED]. the resident to have a BIMS score of		
		with Resident #2 revealed the ere. Resident #2 stated he/she t with the Assistant Business O	elt safe in the facility.  ffice Manager revealed s	d broken up with his/her significant he had observed Resident #1 take 6. She stated she felt she had		
	witnessed potential abuse and im-	mediately reported the incident tily was aware of it. The Assist	to the former DON and ant Business Office Man	the former ADON. She stated the larger stated she never witnessed the		
	Interview on 11/10/16 at 5:10 PM Resident #1 had placed Resident stated she did not report the incid	with the former ADON confir #2's hand on his/her private parent immediately to the former.	med that she and the form rt and was observed to ru Administrator, because t	mer DON were notified on 10/26/16 that hb him/herself. The former ADON he Assistant Business Office r, the former ADON stated she and the		
	out of the room and never acknow Interview on 11/14/16 at 10:00 Al	vledged that we had told him a M with the former DON reveal	nything. ed she and the former Al	d the former Administrator just walked  DON were notified on 10/26/16 that		
	allegation with the former Admin	ormer Administrator because the mer Administrator. However, t iistrator, who was also the abus anything to do and no investig ne stated it was not her respons	the staff that informed her he former DON stated shall be coordinator, on 10/27/ ation was done or direct ibility to report or coord	of the incident stated she was he and the former ADON discussed the 16. The former DON stated the former and, because he always did that stuff;		
	Interview was attempted with the	former Administrator on 11/10 with the Regional Vice Presid s policy when allegations of ab d to conduct a reasonable inves	11/16, 11/14/16, and 11/16 ent (RVP) revealed the fouse were reported in the stigation of all alleged vi	olations that occurred. The		
	removed/separated to ensure their should have protected the residen agencies, and investigated the inc	r safety. The RVP stated when ts involved as well as other fac	the allegation was report ility residents, reported t	ed to administrative staff they		
	**The facility provided an accepta actions to remove the Immediate	able Allegation of Compliance Jeopardy.	(AOČ) on 11/16/16. The	e facility implemented the following		
	and the DON on 10/26/16; they w (Resident #1 and Resident #2) ha was appropriate. Staff had repeate	vere both suspended pending in d been more physical with each edly reported their concerns of	vestigation. It was deter n other and nothing had be physical touching betwe	been done to validate the relationship		
	to update the resident's care plans facility.	(Resident #1 and Resident #2)	). The Administrator and	the DON were terminated from the o go into Resident #2's room, or any		
	other resident's room in the facilit medication recommendations, and #1 has not exhibited any further b	ty. Resident #1 was evaluated by d to monitor the resident every behaviors. Staff continued to m	by a psychiatrist on 11/03 15 minutes, which were onitor the resident every	8/16, and again on 11/10/16, with followed through as ordered. Resident 15 minutes. A care plan meeting		
	was conducted with Resident #1's discussed and all questions answer 11/04/16, and weekly visits will of 3) The Medical Director complete	ered at that time. Resident #1 we continue for one (1) month.	as provided spiritual sur			
	symptoms of sexual abuse were in	dentified. Resident #2 was eval through as ordered. A follow- sident to every fifteen (15) mir	luated by a psychiatrist of up visit with the psychiat nute monitoring and no o	on 11/03/16 and medication changes trist was conducted on 11/10/16 with ther concerns were noted. The		
	next thirty (30) days. A care plan questions that Resident #2's POA 4) All residents with a Brief Interv	/family meeting was conducted s may ask. All questions were view for Mental Status (BIMS) Vorker (SSW), Staff Developm	on 11/02/16 to discuss a answered and no concern score of eight (8) to fifte tent Coordinator (SDC),	any concerns and to answer any ss were voiced. een (15) were interviewed on ADON, and the Activity Director related		
	investigated as required, with no 5) Skin assessments for 100 perce concerns identified. The assessments were reviewed by the	concerns identified. nt of residents were conducted ents were conducted by facility	on 11/02/16, for signs as staff nurses, as well as r	nd symptoms of abuse with no		
	6) All prior grievances were revie identify any abuse allegations tha 7) The Administrator/Regional Co	wed by the Administrator/Regi t had not been reported for the ontroller had reviewed all Resid d nine (9) grievances that he st	onal Controller on 11/03 last six (6) months, and dent Council Notes from	1/16 for appropriate follow-up and to no concerns were identified. the past six (6) months on 11/03/16. sed more appropriately and one (1)		
	8) All reported incidents for the investigations were completed an	past twelve (12) months were		ensure complete and thorough		
FORM CMS-2567(02-99)	Event ID: YL1O11	Facility ID: 1	185249	If continuation sheet		

(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER A. BUILDING B. WING 11/16/2016 185249 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 96 HIGHWAY 3444 ANNVILLE, KY 40402 SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0226 (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 Level of harm - Immediate jeopardy Residents Affected - Few 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 nidentified 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 to the control of the co 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 wre 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 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 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. 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 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 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.

(a) Review of the facility audits revealed all prior grievances were reviewed by the Administrator/Regional Controller on 11/102/16. 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. 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. 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.

Facility ID: 185249

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:2/28/2017 FORM APPROVED

CENTERS FOR WEDICARE	WE WIEDICAND SERVICES			OMB NO. 0938-0391	
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED	
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		11/16/2016	
CORRECTION	NUMBER			11/10/2010	
VALUE OF PROVIDER OF SV	185249		CORPORATION CONTRACTOR CONTRACTOR		
NAME OF PROVIDER OF SU		A O MITTER T NI	STREET ADDRESS, CITY, ST	ATE, ZIP	
SIGNATURE HEALTHCAR	E AT JACKSON MANOR REHA	A & WELLN	96 HIGHWAY 3444 ANNVILLE, KY 40402		
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hor	me or the state survey agency.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED E	3Y FULL REGULATORY	
F 0226	(continued from page 5) 10) Review of facility's document	ation revealed 100% of the reside	ents were verified to ensure no cu	urrent residents were on	
Level of harm - Immediate jeopardy	the sex offender registry on 11/0/11/16/16 at 4:30 PM revealed she the sex offender registry.	4/16 by Human Resources, and no	concerns were identified. Interv	riew with the RVP on	
Residents Affected - Few	PM, the ADON on 11/10/16 at 5: 12) Interview with the RVP on 11 Council Meeting on 11/03/16 to a resident relationships. All resider Residents A and B on 11/16/16 a related to abuse and relationships 13) Review of facility documenta initiated abuse education on 11/0 to determine competency. No em competency test. Review of post	and any non-reported abuse allegment, the interim DON, SDC, and 110 PM, and the Regional Consult /16/16 at 4:30 PM and review of educate residents on all types of a tsunderstood and felt comfortable t 12:55 PM and 1:00 PM confirms in the facility.  tion related to staff training revea 2/16 with all staff with validation ployees were permitted to return tests revealed staff competency w	gations, and no concerns were ide d consulting nurse. Interviews witting Nurse verified they assisted t facility documentation revealed t buse, reporting abuse, and to discle and more informed after the med they had been educated, durin led the RVP, Consulting Nurse, at of training with post-test requirit to work until they had been re-educated. Review of personne	entified. These audits ith the SDC on 11/16/16 at 4:00 with the audits. the she had held a Resident cuss appropriate eeting. Interviews with 19 a Resident Council Meeting, and SDC nurse had 19 a score of 100% lucated and passed the el records revealed	
	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.				
	<ul> <li>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.</li> <li>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</li> </ul>				
	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 Detern reference for the care plan team, decisions effective 11/04/16.				
F 0280	Allow the resident the right to p	participate in the planning or re	vision of the resident's		
Level of harm - Immediate jeopardy Residents Affected - Few	care plan. **NOTE- TERMS IN BRACKET Based on interview, record review revise residents' plans of care wh (2) of two (2) sampled residents ( his/her private part and rub himse and the former Assistant DON or sexual contact was observed on 1	v, and review of the facility's policen inappropriate sexual contact be (Residents #1 and #2). Resident #1 lf/herself on 10/26/16. The inciden 10/26/16. However, staff failed	cy it was determined the facility the tween residents was observed in a was observed to take Resident the twas reported to the former Di	failed to review and the facility for two #2's hand and place it on irector of Nursing (DON)	
	The facility's failure to ensure resi observed has caused or is likely t identified on 11/10/16, and was d Compliance (AOC) on 11/16/16	idents' plans of care were reviewe o cause serious injury, harm, imp letermined to exist on 10/26/16. T alleging the Immediate Jeopardy as determined the Immediate Jeo	airment, or death to a resident. In The facility submitted an acceptab was removed on 11/05/16. Based pardy was removed on 11/05/16	nmediate Jeopardy was ble Allegation of I on the State Survey Agency's	
	Review of the facility's policy title were designed to incorporate idea facility staff. Residents' care plan changed.	ntified problem areas and risk fact	tors associated with those probler	m areas identified by	
	I. Review of Resident #1's medic. Review of Resident #1's Quarterly resident to have a Brief Interview Review of Resident #1's Compret that staff had reviewed or revised behaviors toward Resident #2 on	y Minimum Data Set (MDS) asset of for Mental Status (BIMS) score nensive Care Plan, last reviewed/r I the resident's plan of care when I	ssment, dated 08/27/16, revealed of 8, which indicated the resident revised in September 2016, reveal	the facility assessed the t was interviewable. led no documented evidence	
	Interview on 11/09/16 at 1:20 PM		sident was unable to recall the inc	cident involving Resident	
	#2 which occurred on 10/26/16.  2. Review of Resident #2's medical Review of Resident #2's Quarterly indicated the resident was not interpretated.	y MDS assessment, dated 09/13/1			

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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(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 11/16/2016 185249 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 96 HIGHWAY 3444 ANNVILLE, KY 40402 SIGNATURE HEALTHCARE AT JACKSON MANOR REHA & WELLN For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0280 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 Level of harm - Immediate jeopardy have revised the care plans. nave 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 contents to recent the Large and the Large and the contents are set to the contents of the set of the contents of the set of the Residents Affected - Few 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 to update the resident's care plans (Resident #1 and Resident #2). The Additional Tourist the resident's room in the facility. Resident #1 and Resident #2 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. 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. assessments were reviewed by the Consulting Nutse on 170210.

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. 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 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 (7) and below for Signs or symptoms of abuse, each (70) faintom restrict chart adults to charge in Festician 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. 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 will be in place until an administrator has been fired. The Administrator will be provided with a case distinct 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

(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
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NUMBER A. BUILDING B. WING \_\_\_\_ 11/16/2016 185249 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. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0280 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. Level of harm - Immediate jeopardy 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. Residents Affected - Few provided spiritual support for the resident on 11/04/16 and again on 11/11/16. The record revealed a care plan/tamily 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. 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 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 as the internal 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 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 and possible abuse anegarions, and no concerns were tearnined.

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 11/04/10.
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 parties uses conducted. 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 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 Facility ID: 185249

FORM CMS-2567(02-99) Previous Versions Obsolete

				OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		11/16/2016
CORRECTION	NUMBER			11/10/2010
NAME OF PROVIDER OF SU	185249 PPI IER		STREET ADDRESS, CITY, STA	ATE 7IP
	E AT JACKSON MANOR REHA	A & WELLN	96 HIGHWAY 3444	TIE, ZII
			ANNVILLE, KY 40402	
	home's plan to correct this deficien			WELL DEGLE LEONY
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR		IENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0280	(continued from page 8)	1	T	
Level of harm - Immediate jeopardy	decisions effective 11/04/16.	physician, psychologists, and fan	nilies to help generate the correct c	onversations and
Residents Affected - Few				
F 0490  Level of harm - Immediate		TS HAVE BEEN EDITED TO P	being of each resident. ROTECT CONFIDENTIALITY** icy it was determined the facility fa	
jeopardy	mental, and psychosocial well-be	ing of each resident when allega-	ectively to maintain the highest pra tions of abuse were identified for o	one (1) of two (2)
Residents Affected - Few	DOÑ on 10/26/16 that Resident #himself/herself. The allegation wand the administrative staff failed residents from further abuse, and The facility's failure to ensure alle protected from further abuse, fail review/revise residents' plans of a serious injury, harm, impairment, to exist on 10/26/16. The facility Immediate Jeopardy was remove determined the Immediate Jeopart therefore, it was determined to be The findings include: Review of the facility's policy title Administrator to be one of the pefurther stated the Administrator v. 1. Review of the medical record for REDACTED]. Resident #1's Quaresident to have a Brief Interview 2. Record review revealed the faci Quarterly MDS assessment, dated interviewable.  Per interview on 11/09/16 at 3:45 #2's hand and place it on his/her procession of the resident on the staff of the s	If was observed to take Resident as discussed with the former Adr to conduct an investigation rela failed to report the alleged incid gations of abuse were thoroughly ure to ensure abuse allegations we have when inappropriate sexual by or death to a resident. Immediat submitted an acceptable Allegati do no 11/05/16. Based on the State dy was removed on 11/05/16 price Past Immediate Jeopardy.  End, Facility Advisory Board (FAI sroons responsible for establishing was responsible for the managem or Resident #1 revealed the facility rerly Minimum Data Set (MDS) for Mental Status (BIMS) score flity admitted Resident #2 on 05/d 109/13/16, revealed the resident PM, with the Assistant Business orivate part and rub himself/hersen incompared to the contract of the property of the p	y investigated, failure to ensure resvere reported to state agencies, as we hehavior was observed, has caused the Jeopardy was identified on 11/10 ion of Compliance (AOC) on 11/10 ion of Compliance (SSA) validation to the SSA initiating the investigation of the SSA initiating the investigation of the facility. In the sent of the facility admitted the resident on 05/20/1) assessment, dated 08/27/16, reveatof 8, which indicated the resident of SSA initiating the investigation of SSA in the sent of the facility. In the sent of the facility admitted the resident on 05/20/1) assessment, dated 08/27/16, reveatof 8, which indicated the resident of SSA in the Indicated the resident of SSA in the Indicated the resident of SSA in the Indicated the resident of SA in the Indicated the Indicated the resident of SA in the Indicated the In	rivate part and rub the former Administrator o protect idents were yell as failure to or is likely to cause 0/16, and was determined 5/16 alleging the n of the AOC it was gation on 11/09/16;  had designated the facility. The policy 16 with [DIAGNOSES aled the facility assessed the was interviewable. CTED]. Review of Resident #2's cated the resident was not sident #1 take Resident this was potential
	abuse and so she immediately refamily was aware of it. Further in related to the incident.  Interview on 11/10/16 at 5:10 PM incident with Resident #1 and Re Administrator the following day,	orted the incident to the former laterview revealed she did not with with the former ADON revealed sident #2. The former ADON states	DON and the former ADON. The f ness the former DON or former AI d she and the former DON were no ated she and the former DON follow walked out of the room and never	former DON told her the DON take any action tified on 10/26/16 of the wed up with the former
	incident related to Resident #1 an former Administrator on 10/27/10 her. She further stated that no inv	d Resident #2. She stated she an 6. Continued interview revealed estigation was done or directed, ated it was not her responsibility	d she and the former ADON were n d the former ADON discussed the the former Administrator did not as because he always did that stuff; he to report or coordinate investigation	allegation with the ssign the investigation to e was the Abuse
	Interview was attempted with the Interview on 11/16/16 at 4:30 PM followed the facility's policy whe	former Administrator on 11/10/1 with the Regional Vice Presider n he was notified of the allegation	16, 11/14/16, and 11/16/16 and he vant (RVP) revealed the former Admin on 10/27/16. The RVP stated that abuse were investigated and reported	inistrator should have at Administrators were
	**The facility provided an accepta		AOC) on 11/16/16. The facility imp	plemented the following
	and the DON on 10/26/16; they v (Resident #1 and Resident #2) ha was appropriate. Staff had repeat Administration. However, Admir	e President (RVP) was made awa were both suspended pending invi- d been more physical with each edly reported their concerns of pi sistration failed to follow the Cer	are of the incident, which was reporestigation. It was determined that to other and nothing had been done to hysical touching between these two tter's abuse policy and procedures. The Administrator and the DON w	he two (2) residents o validate the relationship o (2) residents to The facility also failed
	2) Resident #1 had been on 15-mi other resident's room in the facili medication recommendations, an #1 has not exhibited any further b was conducted with Resident #1's discussed and all questions answo 11/04/16, and weekly visits will of	ty. Resident #1 was evaluated by d to monitor the resident every 1 behaviors. Staff continued to mor is Power of Attorney (POA), as we ered at that time. Resident #1 wa continue for one (1) month.	had made no attempts to go into Re a psychiatrist on 11/03/16, and ag 5 minutes, which were followed th hitor the resident every 15 minutes. vell as his/her son on 11/04/16, and s provided spiritual support by the	ain on 11/10/16, with rough as ordered. Resident A care plan meeting all concerns were facility Chaplain on
	3) The Medical Director complete symptoms of sexual abuse were i were recommended and followed recommendation to change the re facility's Chaplain provided spirit next thirty (30) days. A care plan	od a physical examination on Residentified. Resident #2 was evaluthrough as ordered. A follow-up sident to every fifteen (15) minuth ual support for the resident on 1 //family meeting was conducted of	sident #2 (the alleged victim) on 11 ated by a psychiatrist on 11/03/16; o visit with the psychiatrist was corte monitoring and no other concert 1/04/16 and will meet weekly with on 11/02/16 to discuss any concern swered and no concerns were voic	and medication changes iducted on 11/10/16 with as were noted. The Resident #2 for the s and to answer any
	All residents with a Brief Inters 11/02/16 by the Social Services V to any concerns related to abuse i investigated as required, with no 5) Skin assessments for 100 perce	view for Mental Status (BIMS) so Vorker (SSW), Staff Developme in the facility. One (1) resident vo- concerns identified. int of residents were conducted o	core of eight (8) to fifteen (15) wer nt Coordinator (SDC), ADON, and oiced concerns; the concern was re- on 11/02/16, for signs and symptom	re interviewed on I the Activity Director related ported and
	assessments were reviewed by th 6) All prior grievances were revie identify any abuse allegations tha 7) The Administrator/Regional Ct The Regional Controller identifie	e Consulting Nurse on 11/02/16. wed by the Administrator/Region it had not been reported for the la ontroller had reviewed all Reside d nine (9) grievances that he stat	nal Controller on 11/03/16 for appr ast six (6) months, and no concerns ant Council Notes from the past six ted needed to be addressed more ap	ropriate follow-up and to were identified. (6) months on 11/03/16.
	investigations were completed an 9) All residents' charts, which incl 11/04/16. Resident records were Administrator, to ensure no abuse physician and family had been no	past twelve (12) months were re d to ensure compliance with the luded Progress Notes, were revie reviewed by the Consulting Nurse a allegations had been document officed of any changes in condition	wed for the last 60-day timeframe se, DON, SDC from another facility ed with no actions taken and to ens	on 11/03/16 and y, and one (1) Nurse ure the resident's

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 185249 If continuation sheet Page 9 of 11

STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCT A. BUILDING	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED
AND PLAN OF	IDENNTIFICATION	B. WING		11/16/2016
CORRECTION	NUMBER 185249			
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, STA	ATE, ZIP
	E AT JACKSON MANOR REHA	A & WELLN	96 HIGHWAY 3444 ANNVILLE, KY 40402	,
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hor	ne or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY
F 0490	(continued from page 9) Resources. No concerns were ide			
Level of harm - Immediate jeopardy	11) Facility audits revealed all accunidentified change of condition,	and any non-reported abuse alleg	ations, and no concerns were iden	
Residents Affected - Few	were conducted by Nurse Manage 12) Interviews and review of facil	ity documentation revealed the R	VP (Regional Vice President) held	
	Meeting on 11/03/16 to educate r relationships. All residents under	stood and felt comfortable and mo	ore informed after the meeting.	
		. No employees were permitted to	return to work until they had bee	n re-educated and passed
	use of any video or pictures of res	sidents used in a demeaning way,	policy and procedures, nine (9) ty and all reporting options (Regions	al team, Signature
	possible abuse was ongoing. Cert	ified letters were sent to any empl	e of the Inspector General) if a sta loyees that had not been re- educa e permitted to work until the abuse	ted on abuse on
	completed. 14) Files for all employees hired i		•	
	possible abuse allegations. 15) On 11/03/16 and 11/04/16, sta	. ,,		
	family and physician notification	, resident rights, Interact Situation	n, Background, Assessment and Ro o include appropriately updating the	ecommendation (SBAR)
	to reflect the resident's current car	re needs along with supervision n	eeds. This staff training was conducy and procedures, with a post-tes	ucted by the
	required, effective 11/04/16. 16) Daily monitoring of audits wil	_		
	Administrator. The audits include	the following: five (5) random sl	kin assessments on residents with ident chart audits for change in re-	BIMS scores of seven
	have not been followed through v staff abuse tests that require a pas	with as required to monitor for any		
	17) The Consulting Nurse, Interin	n DON, SDC, SSW, and the Interi	im Administrator, will continue to of 8 and above) for any abuse alle	
	audits will be conducted until IJ i	s removed, and then for two (2) w	veeks with weekly QAPI (Quality A committee, which will determin	Assurance Performance
	the audits.  18) Clinical meetings five (5) time			
	will be held to review the 24-Hou	r Report, all accident and inciden	ts, physician orders, and daily cha	rting. The
	19) The RVP will provide administration	strative oversight of the Center ef		Interim Administrator and
	reporting as part of orientation.		strator will be provided with abuse	<u> </u>
		sulting Nurse and Medical Director	or by phone) meetings were condu	cted on 11/02/16 and
	will then determine the need for r	eduction of audits monthly, based	ompliance, and/or further education and outcomes and compliance	ce.
	21) Determining Decision-Making team, physician, psychologists an	d families to help generate the co	rrect conversations and decisions	effective 11/04/16.
	***The State Survey Agency veri 1) Interview with the Regional Vi	ce President of Operations (RVP)		
	terminated from employment on 2) Review of Resident #1's record	revealed documentation of 15-mi		
	resident's care plan was revised. I	Review of the facility's documenta	that the care plan meeting was contion revealed the resident receive	
	Chaplain on 11/04/16 and 11/11/ 3) Review of Resident #2's medical	al record revealed the Medical Dir		
	Resident #2 was evaluated by a p	sychiatrist on 11/03/16 and medic	buse were identified. The record feation changes were recommended	l and followed through as
	every fifteen (15) minute monitor	ing and no other concerns were n	11/10/16 with a recommendation toted. The record further revealed	the Chaplain had
	provided spiritual support for the meeting was conducted on 11/02/	16.		
	4) Review of the facility's audits of eight (8) to fifteen (15) were in	iterviewed on 11/02/16 by the SS	W, SDC, ADON, and the Activity	Director related to any
	concern; the concern was reported	d and investigated as required, wi	n dated 11/02/16 revealed one (1) the no problems identified. Interview	w with the SSW on
	BIMS score of eight (8) to fifteen	(15) were interviewed on 11/02/		
	5) Review of the facility's audits of for signs and symptoms of abuse,	with no concerns identified. Inter	rview with the SDC on 11/16/16 a	t 4:00 PM, ADON on
	100% of facility residents on 11/0	02/16.	t 3:20 PM confirmed skin assessm	
	6) Review of the facility audits rev 11/03/16 for appropriate follow-u	p and to identify any abuse allega		
	months, and no concerns were ide 7) Further review of audits conduction	cted by the facility revealed the A		
	resident council notes from the pa PM revealed he had identified nir	ne (9) grievances that he stated ne	eded to be addressed more approp	riately and one (1)
	reported from November's meetir 8) Review of the facility's audits of	on 11/16/16, conducted by the Reg	gional Controller, revealed the Reg	gional Consulting Nurse
	had reviewed all reportable incide to ensure the facility's policy had	been followed and that complete	and thorough investigations had b	een conducted. Further
	Center. Interview with the RVP of	n 11/16/16 at 4:30 PM revealed s		ed as the Interim
	ensure they had been reported and	d that a thorough and complete in		
	Interviews with the Regional C facility's audits revealed all resident	ents' charts which included progre	ess notes had been reviewed for the	e last 60-day
	timeframe on 11/03/16 and 11/04 concerns were identified, and that			
	no concerns were identified. 10) Review of facility's document		, ,	
	the sex offender registry on 11/04	1/16 by Human Resources, and no	concerns were identified. Interviences had ensured that none of the	ew with the RVP on
	the sex offender registry.  11) Review of facility's audits reve			
	,			- · · · · · · · · · · · · · · · · · · ·

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    STATE SURVEY COMPLETED   1/16/2016   1	DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:2/28/2017 FORM APPROVED OMB NO. 0938-0391
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the attention on the nursing home or the plan to correct this deficiency, please contact the nursing home or the attention of the nursing home or the state survey agency.  [X4] ID PREFIX TAG  F 0490  Level of harm - Immediate jeopardy  R Level of harm - Immediate jeopardy  R Esidents Affected - Few  Residents Affected - Few  R	DEFICIENCIES AND PLAN OF	CLIA IDENNTIFICATION NUMBER	À. BUILDING	CTION	(X3) DATE SURVEY COMPLETED
ANNVILLE, KY 40402  (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  Annual 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 Resident featings 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 bade 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 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 of such sconducted revealed the Administrator/Regional Controller reviewed files of all new employees on 11/03/16, that had been hired in the past 6 months of the past 6					TATE, ZIP
F 0490 Level of harm - Immediate jeopardy  Residents Affected - Few  R	SIGNATURE HEALTHCAR	E AT JACKSON MANOR REHA	A & WELLN		
F 0490  Level of harm - Immediate jeopardy  Residents Affected - Few  Residents A and B on 11/16/16 at 42:30 PM and revolve 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 est. Review of post tests revealed staff competency as caquired. Review of presonnel 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 redentials 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 training wa					
Level of harm - Immediate pepardy  Residents Affected - Few  Residents Ain B on 11/16/16 at 4:50 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 confortable and more informed after the meeting. Interviews with Residents A and B on 11/16/16 at 12:55 PM and 1:00 PM confortable and more informed after the meeting. Interviews with Residents A and B on 11/16/16 to 1:30 PM and 1:00 PM confortable and more informed after the meeting. Interviews with Residents A and B on 11/16/16 to 1:00 PM and 1:00 PM confortable and more informed after the meeting. Interviews with residents A and B on 11/16/16 at 4:10 PM and 1:00 PM consulting Nurse, and SDC nurse had initiated abuse education on 11/16/16 at 4:10 PM and 1:00 PM consulting Nurse, and SDC nurse had initiated abuse education on 11/16/16 at 4:10 PM and 1:00 PM consulting Nurse, and SDC nurse had initiated abuse educated to staff training revealed the RVP, Consulting Nurse, and SDC nurse had initiated abuse educated by the Consulting Nurse and 11/16/16 at 4:10 PM and 1:10 P	(X4) ID PREFIX TAG			IENCY MUST BE PRECEDED I	BY FULL REGULATORY
Level of harm - Immediate jeopardy  Residents Affected - Few  Residents A and B on 11/6/16 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 tretained.  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	F 0490		and any man managed above all	acations and no assucement were ide	entified Those audits
Residents Affected - Few  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		were conducted by nurse manage PM, the ADON on 11/10/16 at 5:	ment, the interim DON, SDC, a 10 PM, and the Regional Consu	nd consulting nurse. Interviews wilting Nurse verified they assisted	th the SDC on 11/16/16 at 4:00 with the audits.
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-bour 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 11/10/216.  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 11/10/16 to review the plan and all audits for needed revisions, compliance, and of ruthred 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.		12) Interview with the RVP on 11 Council Meeting on 11/03/16 to cresident relationships. All resider Residents A and B on 11/16/16 a related to abuse and relationships 13) Review of facility documenta initiated abuse education on 11/0 to determine competency. No em competency test. Review of post certified letters were sent to staff 14) Review of facility documenta all new employees on 11/03/16, t and possible abuse allegations; at 15) Review of facility documenta post-test with a score of 100% rel Watch form, care plans policy an residents' current care needs alon, new hires will be educated on the Interview with the Consulting Nu 11/04/16. 16) Review of facility documenta the Consulting Nurse, Interim DC on residents with BIMS scores of for change in resident condition t tests. Interviews with the interim audits were conducted. 17) Review of the facility's docun Consulting Nurse, Interim DON, for any abuse allegations or concils) Review of facility documenta (5) times a week, which consisted and the Interim Administrator. In PM, revealed staff reviewed the 2 and symptoms of abuse or any ut 19) Interview with the RVP on 11 11/02/16. 20) Review of facility documenta at 4:30 PM revealed the QAPI co compliance, and or further educal 21) Review of facility documenta at 4:30 PM revealed the Detern reference for the care plan team,	/16/16 at 4:30 PM and review o educate residents on all types of its understood and felt comfortal t 12:55 PM and 1:00 PM confirm in the facility.  In the facility.  In the facility tion related to staff training reve 2/16 with all staff with validatio ployees were permitted to return tests revealed staff competency informing them they would not tion of audits conducted reveale hat had been hired in the past 6 and no concerns were identified. The provided in the past 6 and no concerns were identified and physician no deprocedure, to include approprig with supervision needs. This sea abuse policy and procedures were on 11/16/16 at 4:15 PM revealed that on 11/16/16 at 4:15 PM revealed that on the past 6 and 11/16/16 at 3:40 PM and 11/16/16 at 3:40 PM and 11/16/16 at 3:40 PM and 11/16/16 at 4:30 PM conducted ten (terns. tion revealed on 11/04/16 staff if 1 of the following staff members terviews with the Consulting New York of the following staff members terviews with the Consulting New York of the following staff members terviews with the Consulting New York of the following staff members terviews with the Consulting New York of the York of the York of the Confirmed should be the York of the Confirmed should be provided abuse with the Confirmed should be provided and interviews with the Confirmed should be provided and the provided and the Provided Should be provided and the provided shoul	f facility documentation revealed a abuse, reporting abuse, and to dissible and more informed after the med they had been educated, during the test of	the she had held a Resident class appropriate electing. Interviews with g a Resident Council Meeting, and SDC nurse had ing a score of 100% lucated and passed the latecords revealed ed.  It records revealed ed.  It records revealed st.  It re-education and a SBAR and Stop and blans to reflect the Consulting Nurse. All effective 11/04/16. vith on 11/03/16 and with the saled she, as well as the eated she, as well as the eated she, as well as the ith BIMS scores of 8 and above) gh clinical meetings five Interim DON, SDC, SSW, he RVP on 11/16/16 at 4:30 illy charting for sign resight of the facility since  PM and the RVP on 11/16/16 audits for needed revisions,  PM and the RVP on 11/16/16 to be used as a guide or

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