STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155778	A. BUILDING 00 B. WING	09/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HEALTHCARE	1212 E MAIN ATTICA, IN 47918

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00239907. This resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00239907 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226 Survey dates: September 13 - 16, 2017 Facility number: 000323 Provider number: 155778 AIM number: 100288440 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 2 Medicaid: 30 Other: 9 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 22, 2017.	F 0000	October 6, 2017 Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID 692R11 Immediate Jeopardy (IJ) Dear Mathew Foster: Director Long-Term Care	

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

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			On September 16, 2017, a Complaint (IN00239907) Survey was conducted at the above referenced facility by the Division of Long Term Care, Indiana State Department of Health, to determine the facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Attached you will find the completed Plan of Correction (POC). Respectfully submitted, Melinda S. Jones, HFA Administrator Parkview Healthcare	
F 0223 SS=J Bldg. 00	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from			

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	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to prevent abuse in that a staff member was observed to physically restrain a resident to prevent getting out of a chair, which resulted in three areas of bruising. This affected 1 of 2 residents reviewed for abuse. (Resident B) The Immediate Jeopardy began on 09/6/17 when staff members observed Licensed Practical Nurse (LPN) #11 sitting on the lap of a resident in a wheelchair, in the hallway, to prevent the resident from rising. The nurse was then observed restraining the resident's arms, which resulted in bruising. The Administrator was notified of the immediate jeopardy on 9/14/17 at 3:25 p.m. Findings include: On 9/13/17, 10:25 a.m., Resident B was	F 0223	1. It is the intent of this facility to prevent abuse LPN #11 was terminated. Indiana Professional Licensing Board was contacted in order to report LPN# 11's allegation of abuse. Resident "B" was assessed for injuries. Resident "B"'s physician and family were notified of the incident. Police were called regarding incident and employee. Consulting company was hired September 15, 2017 to implement State and Federal regulations. Resident's weekly skin assessments were reviewed and no injuries of unknown origin were identified. 2. No other residents were identified, however, all residents had the potential to be affected. 3. All employees were in-serviced and given a pre- and post-test on	10/16/2017

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	observed seated in a wheelchair across from the nurses' station. She was very quiet, was alert, but did not respond verbally. Her arms above the wrists were observed and noted to be bruised. On 9/13 /17 at 10:55 a.m., Qualified Medication Aide (QMA) #1 was interviewed. She indicated she had come to the facility to work on 9/6/17 at 6:00 a.m. She indicated she had gone to the nurses' station to get keys for the medication cart and observed LPN #11 sitting on Resident B's lap and holding her hands down. She had reported it to the Restorative Aide #2 who had just come on duty, and asked her to walk the resident to get away from the situation and due to the resident being anxious and combative. The Restorative Aide took the resident for a walk and found the resident had been wet through her slacks. She was toileted and changed then walked to the dining room. The staff member indicated she had not known when LPN #11 had left the building, or where she had gone, after she intervened with the resident. The QMA indicated the LPN could be intimidating with staff. On 9/13/17, at 1:30 p.m., Restorative Aide #2 was interviewed. She indicated she had seen LPN #11 sitting on the resident's lap and holding Resident B's		Abuse Prevention Policies and Procedures. Emphasis was made on the following: 1.escorting the person from the facility who has been accused of abusing a resident and/or closely monitoring the accused; 2.immediately reporting all allegations of abuse to the Administrator; 3.thoroughly investigating all allegations of abuse. Social Services will inform residents in a Resident Council meeting of their right to be free from abuse. The Activity Director informs residents, in their monthly Resident Council meeting, of their Resident Rights. 4. Social Service Person/Designee will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedure. Administrator/Designee will conduct a random audit of five (5) employee weekly for four (4) consecutive weeks. These employees will be interviewed to verify understanding of current Abuse Policy and Procedures. Re-education will be provided at the time of the interview, if needed. DON/Designee will examine all residents' skin weekly for suspicious	

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	arms down. She retrieved the resident's walker and escorted her to the restroom. She indicated she had been wet through her slacks. She was cleaned up, placed on the toilet, and voided. She then was ambulated to the dining room before breakfast, and provided with a banana. The resident was calm. The Restorative Aide, indicated she had reported the event to the Business Office Manager when she arrived in the facility, between 6:45 a.m. and 7:00 a.m. The staff member indicated she had not been aware of where LPN #11 was in the facility following the incident and did not know when she left the building. The aide indicated the LPN could be intimidating with staff, and she was not sure if she walked her out if she would hit her. On 9/14/17 at 10:30 a.m., CNA #12 was interviewed. She indicated the resident becomes "fidgety" when she needs to use the restroom, has pain, or is hungry. On 9/14/17 at 11:00 a.m., The Business Office Manager, the Administrator, The Interim Director of Nursing, and the Social Service designee were interviewed in a group interview. Employee #4 indicated she had notified the Administrator when she entered the facility. The Administrator indicated it was around 8:00 a.m. at which time an		injury/injury of unknown origin. If any resident is identified, Administrator/DON will implement abuse prevention policy and procedure. Summary of the interviews and incidence of re-education, if required, will be discussed in morning meeting weekly. This Plan of Correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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	investigation had begun. She indicated she had clocked LPN #11 out for 7:00 a.m., after she entered the building. The staff member had not clocked herself out. On 9/15/17 at 12:40 p.m., night shift QMA was interviewed on the telephone. She indicated she was suprised when she heard about the incident, but the LPN could be intimidating to staff. CNA #15 was interviewed by telephone on 9/15/17 at 12:45 p.m. She indicated the LPN could be intimidating staff members. The results of the investigation, completed on 9/8/17, concluded the staff member had been abusive to Resident B and was terminated. The skin assessment of the resident after the incident included three new bruised areas on the arms in the area that the staff member had been seen restraining. The measurements were documented on 9/6/17 at 3:49 p.m. (a) A bruise to the right forearm just proximal to the wrist 4 centimeters (cm) with irregular boarders. (b) 9/6/17 at 3:51 p.m.: left forearm bruise just proximal to wrist 7 cm with irregular boarder and (c) 9/6/17 at 3:51 p.m.: bruise right arm 1 cm round. Resident B's clinical record was reviewed			

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	on 9/14/17 at 2:38 p.m. Diagnoses included, but was not limited to, dementia with behaviors, anxiety, and history of falls. A quarterly Minimum Data Set assessment (MDS) dated 6/27/17, coded the resident's brief interview for mental status as 99 (resident unable to complete interview). The facility assessment of the resident's status was severely impaired. The resident's assessment included required extensive assistance for bed mobility, transfers, ambulation, dressing, hygiene and toileting, frequently incontinent of bowel and bladder. The resident utilized a wheelchair and walker. Care plans for the resident, in place prior to incident, included, but were not limited to: diagnosis of dementia without behavioral disturbance. She had severely impaired decision making ability, impaired memory, inattention and incoherent speech with original date of 6/27/17. Interventions included anticipate resident's needs and preferences, call the resident by name, smile and use gentle touch for communication, explain all care to be given prior to provision of care Anoter care plan with initial date of 2/8/17, with most recent review date of 9/6/17, addressed the resident had moderately			

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	impaired cognition. Interventions, dated , 6/22/17 indicated, but were not limited to ask the resident to try expressing herself with gestures, ask simple yes/no questions and give her time to answer. Most of the time she will respond "yes" first, repeat question and ask again. Another careplan with initial date of 2/8/17 and reviewed as current on 9/6/17, addressed new placement in facility may require time to adjust. Interventions included, but were not limited to, provide comfort, support and reassurance. Know that resident was a homemaker and an LPN, went to the Lutheran church, likes dogs, enjoys the outdoors, and likes country music. Make conversation with her and reminisce with her as able. The facility's policy titled "Residential Rights", no date, provided by the Administrator on 9/14/17 at 11:30 a.m., included but was not limited to: "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience			

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	and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints....The facility must develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Establish policies and procedures to investigate any such allegations, and Include training on policies and procedures developed. The facilities must also provide training to their staff that at a minimum educates staff on Activities that constitute abuse, neglect, exploitation, or the misappropriation of resident property. Dementia management and resident abuse prevention..." The facility's policy titled "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" provided by the Administrator on 9/14/17 at 11:30 a.m., included, but was not limited to: "Policy: It is the policy of Parkview Healthcare to protect the residents from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary selection [sic]			

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	and any physical or chemical restraint not required to treat the resident's medical symptoms. Responsibility: All Staff Definitions: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. The immediate jeopardy that began on 9/6/17 was removed on 9/16/17 when the facility inserviced all regular staff on the policies and procedures for abuse prohibition, and expanded the investigation of the allegation to include night shift staff members. Employee files were audited for current license, background checks, and completed references. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility need for continued monitoring. This federal tag is related to complaint IN0029907. 3.1-27(b)			

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F 0225 SS=J Bldg. 00	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the			

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	facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on observation, interview, and record review, the facility failed to prevent abuse in that a staff member was observed to physically restrain a resident to prevent getting out of a chair, which resulted in three areas of bruising. The	F 0225	It is the intent of this facility to prevent abuse. If abuse has occurred, it is the intent of this facility to immediately escort the suspected abuser from the facility and/or monitor closely the accused. Report immediately allegation of	10/16/2017

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	staff member was not escorted immediately from the facility, or closely monitored for a period of time. The incident was not immediately reported to the Administrator, and had not been thoroughly investigated. The staff member, hired in 2015, had not had reference checks done. This affected 1 of 2 residents reviewed for abuse. (Resident B) The Immediate Jeopardy began on 09/6/17 when staff members observed LPN #11 sitting on the lap of a resident in a wheelchair, in the hallway, to prevent the resident from rising. The nurse was then observed restraining the resident's arms, which resulted in bruising. The Administrator was notified of the immediate jeopardy on 9/14/17 at 3:25 p.m. Findings include: On 9/13/17, 10:25 a.m., Resident B was observed seated in a wheelchair across from the nurses' station. She was very quiet, was alert, but did not respond verbally. Her arms above the wrists were observed and noted to be bruised. On 9/13 /17 at 10:55 a.m., Qualified Medication Aide (QMA) #1 was interviewed. She indicated she had come		abuse to the Administrator and thoroughly investigate the allegation of abuse. 1. LPN #11 was terminated. Indiana Professional Licensing Board was contacted in order to report LPN# 11's allegation of abuse. Resident "B" was assessed for injuries. Resident "B"'s physician and family were notified of the incident. Police were called regarding incident and employee. Consulting company was hired September 15, 2017 to implement State and Federal regulations. Resident's weekly skin assessments were reviewed and no injuries of unknown origin were identified. 2. No other residents were identified, however, all residents had the potential to be affected. 3. All employees were in-serviced and given a pre- and post-test on Abuse Prevention Policies and Procedures. Emphasis was made on the following: a. escorting the person from the facility who has been accused of abusing a resident and/or closely monitoring the accused; b. immediately reporting all allegations of abuse to the Administrator; c. thoroughly investigating all allegations of abuse. Social Services will inform residents	

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	to the facility to work on 9/6/17 at 6:00 a.m. She indicated she had gone to the nurses' station to get keys for the medication cart and observed LPN #11 sitting on Resident B's lap and holding her hands down. She had reported it to the Restorative Aide #2 who had just come on duty,and asked her to walk the resident to get away from the situation and due to the resident being anxious and combative. The Restorative Aide took the resident for a walk and found the resident had been wet through her slacks. She was toileted and changed then walked to the dining room. The staff member indicated she had not known when LPN #11 had left the building, or where she had gone, after she intervened with the resident. The QMA indicated the LPN could be intimidating with staff. On 9/13/17, at 1:30 p.m., Restorative Aide #2 was interviewed. She indicated she had seen LPN #11 sitting on the resident's lap and holding Resident B's arms down. She retrieved the resident's walker and escorted her to the restroom. She indicated she had been wet through her slacks. She was cleaned up, placed on the toilet, and voided. She then was ambulated to the dining room before breakfast, and provided with a banana. The resident was calm. The Restorative Aide, indicated she had reported the		in a Resident Council meeting of their right to be free from abuse. The Activity Director informs residents, in their monthly Resident Council meeting, of their Resident Rights. 4. Social Service Person/Designee will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedure. Administrator/Designee will conduct a random audit of five (5) employee weekly for four (4) consecutive weeks. These employees will be interviewed to verify understanding of current Abuse Policy and Procedures. Re-education will be provided at the time of the interview, if needed. DON/Designee will examine all residents' skin weekly for suspicious injury/injury of unknown origin. If any resident is identified, Administrator/DON will implement abuse prevention policy and procedure. Summary of the interviews and incidence of re-education, if required, will be discussed in morning meeting weekly. This Plan of Correction will be monitored at the monthly Quality Assurance meeting until such time	

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	event to Employee #4 when she arrived in the facility, between 6:45 a.m. and 7:00 a.m. The staff member indicated she had not been aware of where LPN #11 was in the facility following the incident and did not know when she left the building. The aide indicated the LPN could be intimidating with staff, and she was not sure if she walked her out if she would hit her. On 9/14/17 at 9:55 a.m., the Administrator was interviewed. She indicated night shift staff had not been interviewed during the investigation as they had not witnessed the incident and were leaving. Upon review of the investigation, three day shift staff had been interviewed during the investigation and 15 residents had been interviewed. On 9/14/17 at 11:00 a.m., the Business Office Manager, the Administrator, The Interim Director of Nursing, and the Social Service designee were interviewed in a group interview. Employee #4 indicated she had notified the Administrator when she entered the facility. The Administrator indicated it was around 8:00 a.m. at which time an investigation had begun. She indicated she had clocked LPN #11 out for 7:00 a.m., after she entered the building. The staff member had not clocked herself out.		consistent substantial compliance has been met.	

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	155778	A. BUILDING 00 B. WING	09/16/2017

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	On 9/15/17 at 12:40 p.m., night shift QMA was interviewed on the telephone. She indicated she was suprised when she heard about the incident, but the LPN could be intimidating with staff. CNA #15 was interviewed by telephone on 9/15/17 at 12:45 p.m. She indicated the LPN could be intimidating with staff members. The results of the investigation, completed on 9/8/17, concluded the staff member had been abusive to Resident B and was terminated. The skin assessment of the resident after the incident included three new bruised areas on the arms in the area that the staff member had been seen restraining. The measurements were documented on 9/6/17 at 3:49 p.m. (a) A bruise to the right forearm just proximal to the wrist 4 centimeters (cm) with irregular boarders. (b) 9/6/17 at 3:51 p.m.: left forearm bruise just proximal to wrist 7 cm with irregular boarder and (c) 9/6/17 at 3:51 p.m.: bruise right arm 1 cm round. Resident B's clinical record was reviewed on 9/14/17 at 2:38 p.m. Diagnoses included, but was not limited to, dementia with behaviors, anxiety, and history of falls.			

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	A quarterly Minimum Data Set assessment (MDS) dated 6/27/17, coded the resident's brief interview for mental status as 99. The facility assessment of the resident's status was severely impaired. The resident's assessment included required extensive assistance for bed mobility, transfers, ambulation, dressing, hygiene and toileting, frequently incontinent of bowel and bladder. The resident utilized a wheelchair and walker. The facility's policy titled "Residential Rights", no date, provided by the Administrator on 9/14/17 at 11:30 a.m., included but was not limited to, "The facility must develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Establish policies and procedures to investigate any such allegations, and Include training on policies and procedures developed. The facilities must also provide training to their staff that at a minimum educates staff on Activities that constitute abuse, neglect, exploitation, or the misappropriation of resident property. Dementia management and resident abuse prevention..."			

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	The facility's policy titled "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" provided by the Administrator on 9/14/17 at 11:30 a.m., included, but was not limited to: "Policy: It is the policy of Parkview Healthcare to protect the residents from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary selection [sic] and any physical or chemical restraint not required to treat the resident's medical symptoms. Responsibility: All Staff Definitions: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being....8. All abuse allegations must be reported to the Administrator immediately and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action; up to and including immediate termination. 9. The Administrator is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations and for assuring that all			

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	policies and procedures are followed..." The immediate jeopardy that began on 9/6/17 was removed on 9/16/17 when the facility inserviced all regular staff on the policies and procedures for abuse prohibition policies, and expanded the investigation of the allegation to include night shift staff members. Employee files were audited for current license, background checks, and completed references. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility need for continued monitoring. This federal tag is related to complaint IN0029907. 3.1-28(c) 3.1-28(d)			
F 0226 SS=J Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and			

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	(3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on observation, interview, and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse. After a witnessed physical staff to resident abuse, policies to protect, report, and investigate were not implemented for 1 of 2 abuse investigations reviewed. (Resident B) The Immediate Jeopardy began on 09/6/17 when staff members observed LPN #11 sitting on the lap of a resident in a wheelchair, in the hallway, to prevent the resident from rising. The nurse was then observed restraining the resident's arms, which resulted in bruising. The	F 0226	1. It is the intent of this facility to implement written policies and procedures that prohibit and prevent abuse. LPN #11 was terminated. Indiana Professional Licensing Board was contacted in order to report LPN# 11's allegation of abuse. Resident "B" was assessed for injuries. Resident "B"'s physician and family were notified of the incident. Police were called regarding incident and employee. Consulting company was hired September 15, 2017 to implement State and Federal regulations. Resident's weekly skin assessments were reviewed and no injuries of	10/16/2017

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	Administrator was notified of the immediate jeopardy on 9/14/17 at 3:25 p.m. Findings include: On 9/13/17, 10:25 a.m., Resident B was observed seated in a wheelchair across from the nurses' station. She was very quiet, was alert, but did not respond verbally. Her arms above the wrists were observed and noted to be bruised. On 9/13 /17 at 10:55 a.m., Qualified Medication Aide (QMA) #1 was interviewed. She indicated she had come to the facility to work on 9/6/17 at 6:00 a.m. She indicated she had gone to the nurses' station to get keys for the medication cart and observed LPN #11 sitting on Resident B's lap and holding her hands down. She had reported it to the Restorative Aide #2 who had just come on duty,and asked her to walk the resident to get away from the situation and due to the resident being anxious and combative. The Restorative Aide took the resident for a walk and found the resident had been wet through her slacks. She was toileted and changed then walked to the dining room. The staff member indicated she had not known when LPN #11 had left the building, or where she had gone, after she intervened		unknown origin were identified. 2. No other residents were identified, however, all residents had the potential to be affected. 3. All employees were in-serviced and given a pre- and post-test on Abuse Prevention Policies and Procedures. Emphasis was made on the following: 1.escorting the person from the facility who has been accused of abusing a resident and/or closely monitoring the accused; 2.immediately reporting all allegations of abuse to the Administrator; 3.thoroughly investigating all allegations of abuse. Social Services will inform residents in a Resident Council meeting of their right to be free from abuse. The Activity Director informs residents, in their monthly Resident Council meeting, of their Resident Rights. 4. Social Service Person/Designee will conduct a random audit of five (5)residents weekly for four (4) consecutive weeks. These residents will be interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedure. Administrator/Designee will conduct a random audit of five (5) employee	

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	with the resident. The QMA indicated the LPN could be intimidating with staff. On 9/13/17, at 1:30 p.m., Restorative Aide #2 was interviewed. She indicated she had seen LPN #11 sitting on the resident's lap and holding Resident B's arms down. She retrieved the resident's walker and escorted her to the restroom. She indicated she had been wet through her slacks. She was cleaned up, placed on the toilet, and voided. She then was ambulated to the dining room before breakfast, and provided with a banana. The resident was calm. The Restorative Aide, indicated she had reported the event to the Business Office Managerwhen she arrived in the facility, between 6:45 a.m. and 7:00 a.m. The staff member indicated she had not been aware of where LPN #11 was in the facility following the incident and did not know when she left the building. The aide indicated the LPN could be intimidating with staff, and she was not sure if she walked her out if she would hit her. On 9/14/17 at 9:55 a.m., the Administrator was interviewed. She indicated night shift staff had not been interviewed during the investigation as they had not witnessed the incident and were leaving. She indicated three day		weekly for four (4) consecutive weeks. These employees will be interviewed to verify understanding of current Abuse Policy and Procedures. Re-education will be provided at the time of the interview, if needed. DON/Designee will examine all residents' skin weekly for suspicious injury/injury of unknown origin. If any resident is identified, Administrator/DON will implement abuse prevention policy and procedure. Summary of the interviews and incidence of re-education, if required, will be discussed in morning meeting weekly. This Plan of Correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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	shift staff members had been interviewed, and 15 residents interviewed. On 9/14/17 at 11:00 a.m., the Business Office Manager, the Administrator, The Interim Director of Nursing, and the Social Service designee were interviewed in a group interview. The Office Manager indicated she had notified the Administrator when she entered the facility. The Administrator indicated it was around 8:00 a.m. at which time an investigation had begun. She indicated she had clocked LPN #11 out for 7:00 a.m., after she entered the building. The staff member had not clocked herself out. On 9/15/17 at 12:40 p.m., night shift QMA was interviewed on the telephone. She indicated she was suprised when she heard about the incident, but the LPN could be intimidating with staff. CNA #15 was interviewed by telephone on 9/15/17 at 12:45 p.m. She indicated the LPN could be intimidating with staff members. The results of the investigation, completed on 9/8/17, concluded the staff member had been abusive to Resident B and was terminated. The skin assessment of the resident after the incident included three new bruised areas on the arms in			

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	the area that the staff member had been seen restraining. The measurements were documented on 9/6/17 at 3:49 p.m. (a) A bruise to the right forearm just proximal to the wrist 4 centimeters (cm) with irregular boarders. (b) 9/6/17 at 3:51 p.m.: left forearm bruise just proximal to wrist 7 cm with irregular boarder and (c) 9/6/17 at 3:51 p.m.: bruise right arm 1 cm round. The facility's policy titled "Residential Rights", no date, provided by the Administrator on 9/14/17 at 11:30 a.m., included but was not limited to, "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints....The facility must develop and implement written policies			

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	and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Establish policies and procedures to investigate any such allegations, and Include training on policies and procedures developed. The facilities must also provide training to their staff that at a minimum educates staff on Activities that constitute abuse, neglect, exploitation, or the misappropriation of resident property. Dementia management and resident abuse prevention..." The facility's policy titled "Abuse Prohibition, Reporting, and Investigation Policy and Procedure" provided by the Administrator on 9/14/17 at 11:30 a.m., included, but was not limited to: "Policy: It is the policy of Parkview Healthcare to protect the residents from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary selection [sic] and any physical or chemical restraint not required to treat the resident's medical symptoms. Responsibility: All Staff Definitions: Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation			

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	by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being....8. All abuse allegations must be reported to the Administrator immediately and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action; up to and including immediate termination. 9. The Administrator is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations and for assuring that all policies and procedures are followed..." The immediate jeopardy that began on 9/6/17 was removed on 9/16/17 when the facility inserviced all regular staff on the policies and procedures for abuse prohibition policies, and expanded the investigation of the allegation to include night shift staff members. Employee files were audited for current license, background checks, and completed references. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility need for continued monitoring. This federal tag is related to complaint			

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