STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. BUILDING _____ B. WING _____	C 01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER	600 S 27TH ST BILLINGS, MT 59101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Complaint survey was completed on 1/19/21. Facility Reported Incidents were investigated during the survey. The facility census on entrance was _62__. DEFICIENCIES CITED: Deficient practices were cited for the Facility Reported Incident(s) with Intake numbers(s): #MT00049856. DEFICIENCIES NOT CITED: Refer to FORM CMS-2567; Event ID: #HQNE11 for unsubstantiated findings. Deficient practices were NOT cited for the Complaint(s) with Intake number(s): #MT00050013. Glossary	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from 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 medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		1/27/21

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

Electronically Signed | 01/27/2021

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

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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent physical and verbal abuse by a staff member for 3 (#'s 1, 2, and 3) of 3 sampled residents. The physical abuse included the resident being hit, and the verbal abuse included name calling and a threat made to the resident. Findings include: During an interview on 01/19/21 at 12:45 p.m., staff member A stated he received a call from staff member B on 12/17/20 at 6:30 p.m. to report an allegation of abuse. Staff member B told staff member A resident #1 reported to staff member C that staff member D had hit her and stated staff member D, "Told me to shut the fuck up, or I'll shut you up." Staff member B stated resident #1 was very anxious when she reported the abuse, but she was very clear, and she repeated the information several times. During an interview on 01/19/21 at 12:58 p.m., staff member A stated he was not in the building when the incident occurred on 12/17/20. However, an investigation began immediately, written statements were gathered from staff members who were on duty, and staff member D was suspended immediately pending an investigation. Staff member A stated staff member B immediately assessed resident #1 for injuries. He stated the facility notified resident #1's physician and family representative of the allegation. Staff member A stated the Billings Police Department was notified of the incident on the morning of 12/18/20, and NF1 arrived at the facility to complete an interview and police report with resident #1. Staff member A stated resident #1 told NF1 that staff member D had pushed and	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

hit her right shoulder, called her a "bitch" and she stated she was afraid of him. Staff member A stated the facility expanded its investigation to include interviews with the majority of the other residents who resided at the facility. He stated two other residents, resident #2 and resident #3 stated staff member D was rough with them. Staff member A stated he shared this information with NF1. Staff member A stated the facility received orders from resident #1's physician, per the resident's family representative request, to have resident #1 transferred to St. Vincent's Emergency Room Department for a sexual assault evaluation. Resident #1 was transported, and the facility obtained X-rays of the resident's right humerus, right femur, and right forearm. No injuries were noted, and because resident #1 denied any sexual assault, the ER did not perform a sexual assault evaluation. Staff member A stated resident #1 returned to the facility, was assisted back to her room, and was stable, non-tearful, non-distressed, and appeared to be in a pleasant mood. Staff member A stated although staff member D denied the allegations, the facility believed physical and verbal abuse had occurred, the allegations were substantiated, and staff member D's contract with the facility was terminated.

Review of the facility's investigation notes, dated 12/18/20, showed an email sent by staff member A to the facility's staffing agency which read, "I am just writing to inform you all that [facility name] is terminating the CNA contract on [staff member D] effective 12/17/2020 6:30PM. Upon facility investigation regarding a residents allegation of abuse, it was noted that physical and verbal abuse was substantiated. [Staff member D] was immediately suspended on 12/17/2020 at 6:30PM

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F 600	Continued From page 3	F 600		

pending investigation. [Staff member D] will not be returning to the facility and is a non-rehirable contractual employee. Billings Police Department was contacted on 12/18/2020 and a police report was filed. Per Officer, CNA will likely be charged with assault. I recommend that you or your sub-contractual agency report this employee to the CNA Board for abuse as he is not a direct employee of [facility name]."

Review of the facility's investigation documents on 01/19/21 showed the facility was pro-active in ensuring that no further abuse was sustained to resident #1 or any other residents who resided in the facility. An investigation was started immediately upon notice of the allegation of abuse, resident #1 was assessed for injuries, notifications were made to the resident physician and family representative, witness statements were completed by all staff on duty, and the accused staff member was put on suspension pending the outcome of the investigation. The facility interviewed the majority of all residents in the facility to determine if any had been subjected to abuse by the accused staff member. Two residents in addition to resident #1 stated staff member D had been rough with them in the past, and these incidents were investigated and reported by the facility. When the allegation of abuse was substantiated by the facility, the facility immediately terminated the employment of staff member D. Ongoing monitoring, QAPI review, and Care plan revisions were completed for all affected residents. Additionally, all staff of the facility recieved documented Abuse and Neglect training following the incident.