STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185267	A. BUILDING _____ B. WING _____	C 03/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF LEBANON NURSING CENTER	337 SOUTH HARRISON STREET LEBANON, KY 40033

(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 An abbreviated standard survey (KY31471) and a COVID-19 focused infection control survey was initiated on 03/30/2020 and concluded on 03/31/2020. The complaint was substantiated and deficient practice was identified with the highest scope and severity at "D" level. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The total census was 52.	F 000		
F 600 SS=D	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; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 600		

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

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F 600	Continued From page 1 the facility policy it was determined the facility failed to ensure one (1) of two (2) sampled residents (Resident #2) was free from abuse. On the evening of 03/18/2020, Resident #2, who is cognitively impaired, wandered into the room of Resident #1. Resident #2 was subjected to nonconsensual sexual contact by Resident #1. The findings include: Review of the facility policy, "Abuse," revised 02/13/2019, revealed residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident. The policy also revealed sexual abuse was defined as nonconsensual sexual contact of any type with an elderly person. Review of the facility incident investigation, dated 03/18/2020, revealed a State Registered Nurse Aide (SRNA) reported to Registered Nurse (RN) #2 on 03/18/2020, that upon opening the door to Resident #1's room, she witnessed Resident #1, up in a power wheelchair, leaning to the left with Resident #2's shirt up and Resident #1's mouth over the right breast of Resident #2. The SRNA further reported that Resident #1 appeared to be sucking on Resident #2's breast. The investigation revealed the SRNA immediately separated the residents, Resident #2 was escorted from the room, and RN #2 was notified. Per the investigation, at that time the investigation was initiated and the Administrator and Social Services Director were notified. Per the investigation report, the local police department was contacted and officers responded and also initiated an investigation.	F 600		

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F 600	Continued From page 2 On 03/31/2020, several attempts were made to contact the SRNA who witnessed the incident on 03/18/2020 between Residents #1 and #2. However, attempts to reach the SRNA were unsuccessful and the SRNA did not return the call. Review of the Uniform Citation (Police Report) dated 03/18/2020 revealed Resident #1 was charged with sexual abuse, first degree, and has a scheduled court date of 04/27/2020. Review of incidents/investigations for the past six (6) months and of grievances for the last four (4) months revealed no incidents/grievances involving Resident #1. Observation of Resident #2 on 03/30/2020 at 11:19 AM, revealed the resident ambulating inside the facility independently. Review of Resident #2's medical record revealed the facility admitted the resident on 10/09/2018. The resident had diagnoses of Unspecified Dementia without Behaviors, Type 2 Diabetes Mellitus, Hypertension, and Other specified Anxiety. Review of the MDS dated 12/19/2019 revealed a BIMS score of five (5), which indicated the resident had severe cognitive impairment. A BIMS score of four (4) was provided to the surveyor on 03/30/2020. The MDS also revealed the resident was independent of transfers and ambulation. Review of the comprehensive care plan for Resident #2 revealed the resident was placed on a behavior management program on 10/22/2018 related to behaviors of wandering, exit seeking,	F 600		

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F 600	Continued From page 3	F 600		

and wandering into another resident's room. The care plan revealed multiple person-centered interventions for behaviors. Further review revealed the resident to be at risk for elopement, initiated on 10/09/2018, and was placed on every fifteen (15) minute checks.

Observation of Resident #1 on 03/30/2020 at 10:50 AM, revealed the resident was lying in bed and watching TV, which was pulled up to the right side of the bed. Observation also revealed a staff member was seated outside the door of Resident #1. Further observation of the resident's room at 11:16 AM, revealed a motion sensor mounted on the doorframe that chimed every time an individual entered or exited the room. The resident was observed at the time to be up in a power wheelchair in the room and a staff member was sitting outside of the resident's room.

Review of the comprehensive care plan for Resident #1 revealed the resident had alteration of mood/coping/behavior issues. The care plan listed specific behaviors of "flirting" with staff and making sexually inappropriate comments to staff, dated 04/25/2019. The care plan further revealed on 01/20/2020, the resident was taken off the behavior program with behaviors resolved. The review then revealed on 03/18/2020, the resident was placed back on the behavior management program related to inappropriate touching of Resident #2.

Interview with Resident #1 on 03/30/2020 at 10:50 AM, revealed Resident #2 entered the resident's room at about 9:00 PM on 03/18/2020. The resident stated Resident #2 came in and shut the door to the room and then raised his/her shirt in front of Resident #1. The surveyor asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 4	F 600		

Resident #1 if he/she placed his/her mouth on the breast of Resident #2 and the resident nodded his/her head "yes." The resident then stated, "I believe I was set up." Resident #1 then stated that almost immediately one of the staff members entered and escorted Resident #2 from the room. The resident revealed that Resident #2 had entered his/her room before but had never exposed him/herself, i.e., lifted his/her shirt. Resident #1 stated, "It was probably the stupidest thing I've ever done."

Interview with RN #1 on 03/31/2020 at 10:50 AM, revealed she was working the evening of 03/18/2020 when the incident between Resident #1 and Resident #2 occurred. She stated she was assigned to the opposite hall and was asked to help out on Davis Hall (where Residents #1 and #2 reside) at the time of the incident. She further stated she was familiar with both residents. The RN stated Resident #1 would occasionally make sexual comments to staff but she had never observed or been aware of the resident making comments or doing anything inappropriate to any other resident. She then revealed that Resident #2 was on every fifteen (15) minute checks due to advanced dementia and wandering behavior. She added she had never observed or been aware of this resident raising his/her shirt or disrobing in public.

Interview with RN #2 on 03/31/2020 at 1:00 PM, revealed she was assigned to the Davis Hall on 03/18/2020 and was assigned to both Residents #1 and #2. She revealed that on the evening of 03/18/2020 she was preparing for medication administration for the residents. She stated she had Resident #2 sitting in a chair at the nurses' station and was preparing the resident's

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	185267	A. BUILDING _____ B. WING _____	C 03/31/2020

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CEDARS OF LEBANON NURSING CENTER	337 SOUTH HARRISON STREET LEBANON, KY 40033

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F 600	Continued From page 5 medication. She stated the resident had been ambulating in the halls just prior to this with an SRNA. RN #2 stated she looked for the resident at the nurses' station about five (5) minutes later and the resident was not there. She stated this was not uncommon as the resident ambulated in the halls a lot and did not stay in one place long. Per RN #2, she heard an SRNA yell for her and observed the SRNA with Resident #2. She stated the time was 9:04 PM as she remembered checking her watch. The SRNA proceeded to inform RN #2 that she had found Resident #2 in the room of Resident #1 and that Resident #1 had his/her mouth on Resident #2's breast. She stated Resident #2 was calm and she noted no difference in the resident's mood at this point. The RN stated she immediately assigned one (1) on one (1) supervision for both Residents #1 and #2, and then made calls to the Administrator, Director of Nursing, and Social Services Director to report the incident. At this time, the RN stated she assessed Resident #2 for any injury and a skin assessment was performed. She revealed the resident had no skin impairment or bruising noted. After the skin assessment was completed, the RN stated she notified the police. The RN stated that Resident #2 often had the increased behavior of wandering and restlessness in the evenings, and the behaviors displayed on this evening were no different. She stated the resident was on every fifteen (15) minute checks. Interview with the Social Services Director (SSD) on 03/31/2020 at 1:40 PM, revealed she was notified by RN #2 at about 9:00 PM on the evening of 03/18/2020. She stated that the next morning she spoke with both residents and stated Resident #1 had a sad appearance while Resident #2 had no change in mood or	F 600		

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F 600	Continued From page 6	F 600		

disposition. She further stated that Resident #1 revealed he/she did not mean to do it and did not know why he/she did it. The SSD stated the resident revealed that Resident #2 entered his/her room and then Resident #2 lifted his/her shirt in front of Resident #1. She added that Resident #1 and Resident #2 were always friendly with each other but she had never witnessed any sexually inappropriate behavior between them. The SSD stated she had no knowledge of Resident #1 ever touching other residents inappropriately. Per the SSD, the reason Resident #1 was removed from a behavior management program was because the resident's behaviors had ceased since the last review of the resident's care plan.

Interview with the Administrator, who is also a Registered Nurse, on 03/31/2020 at 1:25 PM, revealed she was notified by RN #2 and she immediately came in to the facility. She stated she was coming in anyway as she was covering the night shift and relieving RN #2. She further stated that when she arrived the police were present and due to the condition of Resident #1 and the current COVID-19 virus situation, they would not transport the resident to jail. She also revealed that when she arrived, both Residents #1 and #2 were on one (1) on one (1) supervision. The Administrator stated she also performed a skin assessment on Resident #2 and found no concerns. She stated the SRNA was looking for Resident #2, as it was time for the every fifteen (15) minute check and found the resident in the room of Resident #1. She further revealed she had no knowledge of Resident #2 ever raising his/her shirt in front of other residents. Per the Administrator, Resident #1 had never touched or been verbally inappropriate with

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F 600	Continued From page 7 another resident. The Administrator stated the resident's comments had always been directed at staff.	F 600		

Office of Inspector General

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N 000	Initial Comments A complaint investigation (KY31471) and a COVID-19 focused infection control survey was initiated on 03/30/2020 and concluded on 03/31/2020. The complaint was substantiated and deficient practice was identified pursuant to 42 CFR 483.10-483.95. No deficient practice was identified related to the infection control survey.	N 000		

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 03/30/2020 and concluded on 03/31/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		

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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.