PRINTED: 07/23/2020 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
	IT.	185281	B. WING		0.5	C 7/ 09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		110312020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-s	F0	00		
	KY#00031918 and a Infection Control Su 07/08/2020 and con Complaint KY#0003 deficiencies cited at Severity (S/S) of a "facility had impleme Disease Control and recommended pract COVID-19. Total cere from Abuse an CFR(s): 483.12(a)(1) §483.12 Freedom frexploitation The resident has the neglect, misappropriand exploitation as a cincludes but is not liccorporal punishmentary physical or chemical control of the control of the component of the component of the control of the component of the control of the component of the control	tices to prepare for ensus 124. Ind Neglect I) From Abuse, Neglect, and The right to be free from abuse, riation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and mical restraint not required to	F 6	00		
	treat the resident's n §483.12(a) The facil					
	§483.12(a)(1) Not us physical abuse, corp involuntary seclusion					
	by: Based on interview, the facility's policy, it	T is not met as evidenced record review, and review of was determined the facility				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	LTIPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED		
		185281	B. WING	i	¥	0.	C 7/09/2020
	PROVIDER OR SUPPLIER			7400 FRI	ADDRESS, CITY, STATE, ZIP IENDSHIP DRIVE VALLEY, KY 40056		10312020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPRO PRIATE	(X5) COMPLETION DATE
F 600	failed to have an effection residents were free three (3) sampled room of 100 o	ffective system to ensure a from abuse for one (1) of residents (Resident #2). approximately 8:00 PM, State Aide (SRNA) #1 witnessed ing close to and kneeling down 2 in the North Hallway #1 walked closer to the essed Resident #1 kiss eneck. SRNA #1 identified d; separated the residents; #2 to the nurses' station; and to go to his/her room. SRNA egation of abuse immediately e (RN) #1. RN #1 called the (DON) on 06/24/2020 at 10:15 witnessed allegation of abuse. Approximately 11:00 AM, A) #1 witnessed Resident #1 rub in the front of Resident #1 rub in the front of Resident #2 to the nurses' d Resident #2 to the nurses' d Resident #1 not to kiss and ints. HA #1 reported the immediately to Licensed PN) #2. LPN #2 notified the and reported the witnessed.	F 6	300			
	The findings include						
	Review of the facility	y's policy, "Alleged					

	T OF DEFICIENCIES OF CORRECTION	I IDENTIFICATION NUMBER:		TIPLE ((X3) DA	(X3) DATE SURVEY COMPLETED	
		185281	B. WING			0-	C
	PROVIDER OR SUPPLIER SHIP HEALTH AND RI	<u>. </u>		740	REET ADDRESS, CITY, STATE, ZIP CODE O FRIENDSHIP DRIVE WEE VALLEY, KY 40056	_ _ 01	7/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	revealed the facility promoted dignity ar prohibited abuse. Callegations were to and the resident's conceiving the report the Administrator are unavailable, the Director be notified. Per the would be reported to and investigative agrequirement. Per peresidents should be during the investigation of this policy reveals intentional infliction injury upon an elder The intentional act cophysical or psychologabuse" was defined committed for the seabuser and in the prelderly adult without	glect/Exploitation tion," dated 06/01/2017, provided an environment that ad respect for residents that Continued review revealed be reported to the supervisor harge nurse. Persons were to immediately inform ad if the Administrator was ector of Nursing (DON) was to policy, allegations of abuse the appropriate regulatory sencies in accordance to state policy, interventions to protect taken to avoid potential harm tion process. Further review ad "Abuse" was defined as an of physical or psychological ly person or disabled adult. could be expected to result in pigical injury. Further, "Sexual as an act of a sexual nature exual gratification of the resence of a disabled adult or consent.	F	600			
	oral or written report to State Agencies up abuse, neglect, or experience of the Long Reported Incident Fithe Office of Inspect 06/25/2020 at 1:36 Firesident occurrence SRNA #1 witnessed neck of Resident #2	was to be made immediately con knowledge of suspected exploitation of an adult. Term Care Facility-Self corm/ Initial Report, faxed to or General (OIG), on PM, revealed a "resident to happened on 06/24/2020. Resident #1 kiss and lick the Per report, the Physician, OIG, Adult Protective					o e

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185281	B. WING	3			C /09/2020	
	PROVIDER OR SUPPLIER	•		740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056	<u> </u>	USIZUZU	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
	Department for Cor (DCBS) were notified signs or symptoms incident occurred set thirty-six (36) minute and notifications. Review of the Long Reported Incident Fup/Final Report, fax 11:30 PM, (six (6) downward revealed there was occurrence" on 06/2 Resident #1 kiss an #2. Additionally, the separated, and no separated, and no separated, and no separated, and no separated with the separated since it boy/girlfriend since it boy/girlfriend. Addit education was proviated appropriateness for consent and ensuring married. Resident #1 agreed not to engage Resident #2. Continually the investigation cause of the incider having the mindset of satisfy his/her basic Per report, Resident and/or symptoms of incident; remained of and continued moniting the mindset of and continued moniting investigation and continued moniting investigations.	e Attorney General, and the immunity Based Services ied. Additionally, there were no is of injury noted. Further, this seventeen (17) hours and tes prior to the Initial Report Term Care Facility-Self Form/ Five (5) day/Follow xed to OIG, on 07/01/2020 at days after the initial report), as "resident to resident (24/2020. SRNA#1 witnessed and lick the neck of Resident ie residents were immediately signs or symptoms of injury ier review revealed, on the DON interviewed tated he/she did kiss the ie/she was looking for a he/she could not see his/her itional review revealed yided to Resident #1 related to refinding a mate, ensuring ing the person was not #1 voiced understanding and ge in these activities with inued review revealed the atted abuse or any harm based on and determined the Root in the was related to Resident #1 of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of a teenager and trying to eneeds of companionship. In the part of the	F	600				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING	3	4	0.	C 7/09/2020
	PROVIDER OR SUPPLIER	2		STF 740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056	<u> </u>	7/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Review of the Long Reported Incident I the OIG, on 06/30// "resident to resider 06/30/2020. HA #1 the neck of Reside Physician, POA, Ad Attorney General, a Additionally, skin as and there were no noted. Further, Reeducation and place checks. Review of the Long Reported Incident Fup/Final Report, fax 8:43 PM (seven (7) Initial Report), reveresident occurrence witnessed Resident #2. Additionally, the separated, and no swere noted. Further revealed, on 06/30/interviewed Resident he/she did kiss Resident he/she did kiss Resident he/she did kiss Resident to engage in the Further review reveusubstantiated about their investigation a Cause of the incident investigation a Cause of the incident investigation and cause of the incident investigation in the incident investigation and cause of the incident investigation in the incident investigation and cause of the incident investigation in the incident investigation in the incident investigation and cause of the incident investigation in the incident investigat	g Term Care Facility-Self Form/ Initial Report, faxed to /2020 at 1:26 PM, revealed a ent occurrence" happened on ent witnessed Resident #1 kiss ent #2. Per report, the administration, OIG, APS, the and DCBS were notified. essessments were completed, esigns or symptoms of injury esident #1 was provided ced on fifteen (15) minute g Term Care Facility-Self Form/ Five (5) day/Follow exed to OIG, on 07/07/2020 at exed to OIG, on 07/07/2020 at exel there was a "resident to exel on 06/30/2020. HA #1 exel there was a "resident to exel on 06/30/2020. HA #1 exel the residents were immediately exigns or symptoms of injury exercise of the report exel 2020, SS and the DON ent #1. Resident #1 stated exident #2 and did it again exel and the facility ge planning. Additional review exel to move out of the review revealed the facility ge planning. Additional review exel to move of the resident ced understanding and agreed exel activities with Resident #2.		600			

	FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185281	B. WING		0.7	C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	IP CODE	7/09/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	injuries or signs at occurring from the on fifteen (15) min placed across Res SS would continue psychological need. 1. Review of Resirevealed the facility 06/10/19 with diage Cerebral Infarction Intellectual Disabil Homonymous Bilatype II Diabetes Markey of Resider Set (MDS) Assess revealed the facility clear speech, made ability to understar revealed the facility Brief Interview for thirteen (13) out of cognition. Addition Assessment, Sectifacility assessed the exhibited. Further, resident required stransfers and ambit the resident was in locomotion on and Review of Residen Plan (CCP), initiated problem of "sexual sexual desires and residents." The Comparison of the c	Per report, Resident #2 had no nd/or symptoms of any harm incident, and he/she remained ute checks with a stop sign sident #1's old room. Further, to monitor for any other ds. dent #1's medical record y admitted the resident on noses including Sequelae of n, Depressive Disorder, Mild ity, Hypertension, Fibromyalgia, teral Field Defects (left), and lellitus. at #1's Annual Minimum Data ment, dated 06/17/2020, y assessed Resident #1 had e self understood, and had the dothers. Continued review y assessed the resident had a Mental Status (BIMS) score of fifteen (15), indicating intact hal review of the Annual MDS on 3 - Behavior, revealed the per resident as behavior not the facility assessed the upervision of one (1) for ulation. Also, per assessment, dependent with setup with	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		185281	B. WING	χ.		C	
	PROVIDER OR SUPPLIE	REHAB, LLC		STREET ADDRESS, CITY, STATE, Z 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	ZIP CODE	7/09/2020	
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	stated the resident what inappropriate other residents an as needed for self interventions includifiteen (15) minute time to self-please definition of conse behaviors toward offer vibrator; and psychosocial well-Further review of 106/30/2020, reveasymptoms." The return to the common was willing to breat The goal stated the would be managed on self and others returning to the conterventions, date (15) minute checks activities; redirect a public areas if behinappropriate. Review of the facil Investigation (IR) fo 06/25/2020 at 12:00 revealed SRNA #1 Resident #1 suckir licking his/her ear. redirected, and edutincident and was a situation. Per the I in the facility, and a situation. Per the I in the facility, and a situation.	nt would voice understanding of the sexual behaviors were toward and would be provided time alone lif-pleasure. The CCP uded 06/25/2020, place on the checks; assist with private ure; educate resident on the lent and inappropriate sexual others; provide information and disperve for changes in behavioral resident #1's CCP, initiated on alled a problem of "behavioral resident expressed wanting to munity and verbalized he/she ask rules to make that happen. The resident's behavior symptoms and assist the resident with formunity. The CCP and 06/30/2020, included: fifteen as; encourage diversional as needed; and remove from	F 60	00			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185281	B. WING	i		0.	7/09/2020
	PROVIDER OR SUPPLIER	EHAB, LLC	'	7400 FF	FADDRESS, CITY, STATE, ZIP CODE RIENDSHIP DRIVE E VALLEY, KY 40056		1109/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 600	were immediately of review revealed Renot sucking or licking gave Resident #2 a he/she was looking care of him/her bet (POA) passed aware Review of the facili Investigation for Renat 11:02 AM, signeral lerted LPN #2 she his/her hands down kiss Resident #2 of separated by HA #Resident #1 on why supposed to display Additionally, Reside observed at the time to person, place, time review revealed Renat were notified.	done on Resident #1. Further esident #1 stated he/she was ing on Resident #2; he/she a kiss on the cheek because of for a boy/girlfriend to take fore the Power-of-Attorney by. ty's Incident Report esident #1, dated 06/30/2020 dby LPN #2, revealed HA #1 witnessed Resident #1 slide in on Resident #2's chest and in the neck. The patients were 1, and education was given to by he/she could not and was not by those types of behaviors. Ent #1 had no injuries e of the incident and was alert me, and situation. Further sident #1's POA and Physician	F	600			
	revealed she spoke him/her kissing and resident verbalized but wanted to do it a facility where he/she broken, he/she was Resident #1 wanted he/she missed his/h they did together. F#1 was offered a vit facility would reach and other SS on an be more, appropriat SS explained to the	mentation, on 06/30/2020, with Resident #1 related to other resident. Additionally, the he/she remembered the rules anyway because in the last re resided, when the rules were able to leave. SS stated it to leave the facility because her boy/girlfriend and what the per documentation, Resident prator and was informed the out to the POA, Ombudsman, other placement, which might be for his/her needs. Further, resident he/she would need desident #2, and Resident #1					φ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185281	B. WING	·			C 7/09/2020	
	PROVIDER OR SUPPLIER SHIP HEALTH AND R	EHAB, LLC	<u>'</u>	740	REET ADDRESS, CITY, STATE, ZIP C 00 FRIENDSHIP DRIVE WEE VALLEY, KY 40056		11109/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	would be changing unit; Resident #1 vounderstanding. Observation of Res 3:00 PM, revealed	rooms and going to a different erbalized agreement and sident #1, on 07/08/2020 at the resident was sitting in a	F	600				
¥	Interview with Resider PM, revealed the rein" when the State I door. Additionally, not recall any incide involving a kiss or to chest. Further, the Services or the DO	dent #1, on 07/08/2020 at 3:00 esident said "hello and come inspector knocked on the Resident #1 stated he/she did ent with another resident ouching the other resident's resident did not recall Social N talking with him/her about a discharging from the facility.						
	revealed the facility 09/17/19 with diagn Stenosis of Vertebra Aphasia, Abnormali Spondylosis, Adult I Apnea, Alzheimer's Wandering in Disea Diabetes Mellitus, A	ent #2's medical record admitted the resident on oses including Occlusion and al Artery, Heart Failure, ties of Gait and Mobility, Failure to Thrive, Sleep Disease, Dementia, se, Atrial Fibrillation, Type II anxiety, and Insomnia.						
	Assessment, dated facility assessed the sometimes made se sometimes had the Continued review re the resident as havin out of fifteen (15), in impairment. Additio	#2's Quarterly MDS 05/27/2020, revealed the resident had clear speech, elf-understood, and ability to understand others. evealed the facility assessed ing a BIMS score of zero (0) dicating severe cognitive nal review of the MDS and the resident had signs and				¥		

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AND I LAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING _	· · · · · · · · · · · · · · · · · · ·	CC	OMPLETED	
		185281	B. WING			0:	C 7/09/2020	
	PROVIDER OR SUPPLIER PSHIP HEALTH AND RE			740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE WEE VALLEY, KY 40056	ET ADDRESS, CITY, STATE, ZIP CODE FRIENDSHIP DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	DULD BE	(X5) COMPLETION DATE	
F 600	fluctuating. Further resident required ex for transfers and an supervision of one (Also, per assessme independent with se unit. Review of Resident 09/18/2019, revealer risk/wanderer relater and impaired safety a problem was revealed ficit related to diff processing informated Dementia. On 06/3 to include resident has to include resident has to include resident has to make the laterventions, dated the resident from was diversions and wand 03/30/2020, added if facing the resident; communicating and observe for non-vertice yes or no questions interventions were find provide a stop sign to into. Review of the facility Investigation for Resident resident resident resident from was also as the resident resident; communicating and observe for non-vertice of the facility Investigation for Resident r	Inattention present and r, the facility assessed the extensive assistance of two (2) imbulation and required (1) with locomotion on the unit. The resident was etup with locomotion off the et #2's CCP, initiated on the et a problem of an elopement et to disorientation to place of a communication officulty expressing and tion/thoughts due to 80/2020, the CCP was revised that tendencies to migrate the rooms. The goals stated the met, and the resident of acility unattended. In 1991/18/2019, included distract the facility unattended of allow time to respond; the communication; and ask use short phrases when all allow time to respond; the communication; and ask on 06/30/2020, added of the facility unattended of the resident expond; the communication; and ask on 06/30/2020, added of the facility unattended of the resident expond; the communication; and ask on 06/30/2020, added of the facility unattended to go wis lincident Report sident #2, dated 06/25/2020 ovised on 06/25/2020 at 3:36	F	600				
	toward other female basic needs would k would not leave the Interventions, dated the resident from wadiversions and wand 03/30/2020, added if facing the resident; communicating and observe for non-vertices or no questions, interventions were fit provide a stop sign to into. Review of the facility Investigation for Resident 12:05 AM and reventions were fit provided a stop sign to into.	be rooms. The goals stated be met, and the resident facility unattended. 109/18/2019, included distract randering by offering pleasant der guard to left ankle. On interventions included speak use short phrases when allow time to respond; bal communication; and ask on 06/30/2020, added fifteen (15) minute checks and to rooms he/she tended to go y's Incident Report sident #2, dated 06/25/2020						

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F 600	and educated. Fur	ne patients were separated ther, Resident #2 had no t the time of the incident and	F6	00			
	Investigation for Re at 11:02 AM, signed immediately reporte his/her hands on R on his/her cheek. A separated, and edu #1. Further, Reside observed at the time	ty's Incident Report esident #2, dated 06/30/2020 d by LPN #1, revealed HA #1 ed she found Resident #1 with esident #2's chest and kissing Additionally, the patients were exaction was given to Resident ent #2 had no injuries e of the incident and was alert ed review revealed Resident ician were notified.					
	2:30 PM, revealed to wheelchair in his/he call light was on about assisting the reside unable to state why the need was when resident would not so the/she would only in State Inspector atterno 17/13/2020 at 11 worked at the facility years. Per interview approximately 8:00 #1 in the North Days Resident #1 was an	ident #2, on 07/08/2020 at the resident sitting in a per room at the bedside. The cove the door, and staff were not. However, he/she was the call light was on or what staff inquired. Further, the speak to the State Inspector. The make eye contact when the mpted to talk with him/her. One interview with SRNA #1, One interview with SRNA #					
	observed Resident a Resident #2. Contin	#1 bent over along the side of nued interview revealed SRNA t #1 was licking Resident #2,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 600	realized Resident # the neck. Additional knew this behavior to Resident #1 "you hugging on resident this." She revealed gave him/her a pec- interview revealed S residents, assisted station, directed Re- immediately reporter Further, SRNA #1 s mindset of a younge touching, hugging, a residents. Per inter- redirection to Resid- kiss others, and the and walk away. Per- confused with poor: Resident #2 would w staff constantly had Continued interview Resident #1's behave 06/24/2020, were at- (including nurses) w inappropriate behave others but had accee for Resident #1 beca Further, SRNA #1 st on 06/24/2020 toward because Resident # not make sound dec healthcare workers w residents with Deme- protect residents and interview with SRNA	hed the residents, she 1 was kissing Resident #2 on ally, SRNA #1 immediately was unacceptable and stated cannot be touching, kissing, ts; you have been told about Resident #1 stated, "I just k good night." Continued SRNA #1 separated the Resident #2 to the nurses' sident #1 to his/her room, and to the abuse to RN #1. tated Resident #1 had the er girl and was known for and kissing on other staff and view, staff provided ongoing ent #1 not to touch, hug, or resident would say "ok, ok" r interview, Resident #2 was safety awareness. Further, wander into others rooms and	F 6	00		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING	;		07	C 7/ 09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND R			740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056	2	IU312U2U
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	XIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES (CIENCY)	LD BE	(X5) COMPLETION DATE
F 600	06/24/2020; howey additional intervent 6/25/2020 to prote Interview with RN arevealed she had with (10) months and hon 06/25/2020. Pearound 10:00 PM, witnessed Resider ear and neck and a Additionally, the retime, and fifteen (1 for both residents. RN #1 immediately of the abuse, and the Further, RN #1 core	ever, there should have been nations implemented on ect residents. #1, on 07/09/2020 at 3:30 PM, worked at the facility for ten nad completed Resident #1's IR for interview, on 06/24/2020, SRNA #1 reported she nat #1 kiss and lick Resident #2's ask him/her if he/she liked it. esidents were separated at that 15) minute checks were initiated. Continued interview revealed by called the DON to notify her the DON came into building.	F6	600			
	Interview with HA # revealed she had we months. Per interview ambulatory and waknown, and Reside his/her wheelchair and could not make Continued interview around lunch, she was Unit and witnessed Resident #2 sliding #2's chest and kiss Additionally, HA #1 residents and told for the residents. Per reported what was assisted Resident #2 sliding #2 schest and kiss Additionally, HA #1 residents and told for the residents.	#1, on 07/09/2020 at 1:02 PM, worked at the facility for four (4) view, Resident #1 was as able to make his/her needs ent #2 required supervision in because he/she was confused to his/her needs know. We revealed, on 06/30/2020 was walking through the North de Resident #1 standing behind go his/her hands down Resident sing him/her on the cheek. It immediately separated the Resident #1 not to rub or kiss the interview, she immediately witnessed to LPN #2 and #2 to the nurses' station.					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING	i	1)		C 07/09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND R	EHAB, LLC		740	REET ADDRESS, CITY, STATE, ZIP (00 FRIENDSHIP DRIVE WEE VALLEY, KY 40056	CODE	7710312020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	PM, revealed on 06 HA #1 came to the #2 and reported sh slide his/her hands kiss his/her cheek. notified the DON, the representatives. Pebeen on fifteen (15) incident on 06/24/2 were worn out from and Resident #2 ap 06/30/2020, the day Resident #1 had an protect Resident #2 Interview with LPN: PM, revealed she his seven (7) months a Report Investigation 06/25/2020. Per interview with EPN: Resident #2 were beand resided on the standard supervision. Concept Resident #1 unders Resident #1 unders Resident #1 unders Resident #1 unders Resident #1 and Reside	#2, on 07/09/2020 at 12:30 6/30/2020 around lunch time, nurses' station with Resident e had witnessed Resident #1 down Resident #2's chest and Additionally, she immediately he Physician, and resident er interview, Resident #1 had minute checks since the first 020. LPN #2 stated the staff trying to keep Resident #1 had the interview in the inter	F	600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		185281	B. WING_		0	C 7/09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND F	REHAB, LLC		STREET ADDRESS, CITY, STATE, Z 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	ZIP CODE	10312020
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPRO PRIATE	(X5) COMPLETION DATE
F 600		page 14 act inappropriately to one	F 60	00		
	PM, revealed she four (4) months. On Resident #1 and Foundher, prior to the the nurses' station inappropriate interstated Resident #1 redirection related Additionally, on 06 stated she accompare-education to Reper interview, the Inhe/she could not kne/she was incapal was married. Furth on 06/30/2020, Resident #2, and stationally reminding Resident #2. LPN moved off the unit	N #3, on 07/09/2020 at 12:52 had worked at the facility for Continued interview revealed Resident #2 would sit by one he incident on 06/30/2020, at n; however, there were no ractions between them. LPN #3 if and Resident #2 required if to poor safety awareness. 6/30/2020 after lunch, LPN #3 if and panied the DON to provide resident #1 on sexual behaviors. DON explained to Resident #1 kiss Resident #2 because able of making decisions and ther, after the second incident resident #1 was trying to find she revealed she had to keep int #1 he/she could not sit near if #3 stated Resident #2.				
	revealed she had v (7) months. Per in message the night #1 kissing Residen staff could not keep were trying to redin 06/25/2020, the Cli (IDT) meeting, which and administrative occurrence between	on 07/09/2020 at 2:08 PM, worked at the facility for seven neterview, she received a t of 06/24/2020 about Resident nt #2's neck. Per message, by the residents apart, but they rect them. Additionally, on linical Interdisciplinary Team ich included department heads a staff, discussed the en Resident #1 and Resident (15) minute checks were				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
	v	185281	B. WING	37	*	С
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	ZIP CODE	7/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 600	implemented and seresidents were apadiscussion about for supervision for both interview revealed, interviewed Resident missed his/her boyed did together sexual discussion about sone's needs. Conton his/her behavior the end of the other resident of the other of the facility and resident #1 was lice of the facility separated. Addition policy and regulation of the other resident of the facility separated. Addition policy and regulation of the other resident of the other of the other resident of the other	staff were to ensure the art. However, there was no urther approaches to increase the residents. Continued on 06/25/2020, she ent #1 who stated he/she e/girlfriend and the things they elf-pleasure and how to meet inued interview revealed rules are were explained to Resident ent and how some residents do all capacity to give consent, or could be married. Resident #1 and and stated he/she would ntinued interview with SS cortant to maintain and protect esidents because healthcare ent advocates and protectors. expectation residents would be and it was important for resident ty's abuse policy to be re quality of life, health, safety, being, quality of care, dignity	F 6	00		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING	i		07	C 7/ 09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND RI	EHAB, LLC		E	10012020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	not feel kissing and an unusual occurre interview, she thoughours to report the wanted to investigathoroughly. Continue revealed she spoke about the incident woo6/25/2020, the day She stated she provegarding sexual be other residents with Resident #1 voiced he/she would not do with the DON, revealmediately identify as reported by SRN and Resident #2, as stated she felt it was interview, the occur reported within two 06/24/2020, and the increased supervision.	ence, and at that time, she did licking was sexual abuse but nce, a behavior. Per ght she had twenty-four (24) "Unusual Occurrence" and te the occurrence more ued interview with the DON with Resident #1 and SS	F	600			
	at 4:53 PM, revealed on 06/30/2020 at 11 Resident #1 and Re Hallway, and Resident #2 and rub the side of his/her revealed she ensured separated. Addition Resident #1's room	with the DON, on 07/09/2020 d she was notified by LPN #2, :00 AM, that HA #1 witnessed sident #2 in the North ent #1 walked up behind bed his/her chest and kissed eck. Continued interviewed the residents were ally, she and LPN #3 went to and talked to him/her about ith Resident #2. Per					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DA	J. 0938-0391 ATE SURVEY OMPLETED
		185281	B. WING			0.	C 7/ 09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE	EHAB, LLC		7400	EET ADDRESS, CITY, STATE, ZIP CODE 0 FRIENDSHIP DRIVE WEE VALLEY, KY 40056	<u> </u>	1103/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 600	#1 on not engaging with residents that a Resident #1 verbali Resident #1 and Refifteen (15) minute a placed across Resident erview, the facility resources to assist facility per Resident interview with the D not identify the incidence of the reported by HA #1 be Resident #2, as an a stated she felt it was interview, the facility	tion was provided to Resident in sexual behaviors/desires could not give consent, and zed understanding. Further, esident #2 were placed on checks, and a stop sign was dent #1's old room. Per made contact with outside with placement at another #1's wishes. Further ON, revealed the facility did ent, on 06/30/2020, as etween Resident #1 and allegation of abuse. She is an unusual occurrence. Per material should have increased residents in order to prevent	Fe	600			
	5:27 PM, revealed h for eight (8) years. A hospital when the in and Resident #2 occ involved with the inv Per interview, the fa incidents as abuse, be free from abuse through policies, sta Continued interview abuse should be represented by the continued interview abuse should be represented by the continued interview abuse should be represented by the continued interview with the Adfacility should provided reduce risk factors the sure resident safe	dministrator, on 07/09/2020 at the had worked at the facility Additionally, he was in the cident between Resident #1 curred and was not as estigation as he usually was cility failed to identify the and residents had the right to with the facility ensuring this ff education, and regulation. revealed all allegations of corted within two (2) hours. It tank to maintain a resident's free of abuse. Continued ministrator revealed the e adequate supervision to not could be present to ty. Abuse/Neglect Policies	F 60	07			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/09/2020	
		185281	B. WING	i			
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE			740 PE	ODE	0110312020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	§483.12(b)(1) Prohineglect, and exploit misappropriation of §483.12(b)(2) Estable to investigate any su	ility must develop and solicies and procedures that: bit and prevent abuse, ation of residents and resident property,	F	607			
	by: Based on interview, Kentucky Revised S 209.030, and review determined the facili policy was implemer allegations of abuse for one (1) of three ((Resident #2)). On 06/24/2020 at ap Registered Nurse Aid Resident #1 standing beside Resident #2 i Dayroom. SRNA #1 residents and witnes Resident #2 on the indocumented evidence	record review, review of tatute (KRS) Chapter of the facility's policy, it was ty failed to ensure its abuse nted related to reporting and protection from abuse 3) sampled residents proximately 8:00 PM, State de (SRNA) #1 witnessed g close to and kneeling down in the North Hallway walked closer to the sed Resident #1 kiss seck. However, there was no se the facility implemented its related to reporting the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		185281	B. WING			C 7/09/2020	
	PROVIDER OR SUPPLIER			P CODE	7709/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	alleged violation to the resident through the alleguith at 8:00 PM, the not notified of the allegation until 06/(17) hours and thire Additionally, there adequate supervision residents after the allegation. (Refer to F-600, F-The findings included Review of the facility promoted dignity a prohibited abuse. To be reported to the Charge nurse. Per to immediately information and the policy, intervention be taken to avoid provestigation proce abuse would be reported allegation.	o State Agencies and protecting ghout the investigation. ation was witnessed by SRNA Director of Nursing (DON) was allegation until 10:15 PM and sewere not notified of the 25/2020 at 1:36 PM; seventeen ty-six (36) minutes later. was no documented evidence ion was provided to the facility learned of the sector of Nursing (DON). Per sector of Nursing (DON) of the sector of the appropriate section of the appropriate section in facility learned to the appropriate section in facility learned by the facility learne	Fé	607			
	oral or written repo to State Agencies u	apter 209.030, revealed an rt was to be made immediately upon knowledge of suspected exploitation of an adult.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		185281	B. WING	J	. 0-	C 7/ 09/2020		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE		
	Reported Incident the Office of Inspe 06/25/2020 at 1:36 resident occurrent SRNA #1 witnesse neck of Resident # residents were sepsigns or symptoms. There was no docupolicy was implement abuse to the State state requirements allegation was initia 06/24/2020 at 8:00 notified of the alleg PM. Review of the Long Reported Incident I up/Final Report review of the Long Reported Incident I up/Final Report review (SS) and #1 who stated he/she could Additional review reprovided to Reside appropriateness for ensuring consent with Resident #1 voiced not to engage in the There was no docupolicy was implementabuse throughout ano increased super	g Term Care Facility-Self Form/ Initial Report, faxed to ctor General (OIG), on 6 PM, revealed a "resident to be" happened on 06/24/2020. 2d Resident #1 kiss and lick the 2. Further review revealed barated, and there were no cof injury noted. Jumented evidence the facility ented related to reporting Agencies in accordance to go or immediately. Although the fally reported to the facility, on p PM, State Agencies were not gration until 06/25/2020 at 1:36 go Term Care Facility-Self Form/ Five (5) day/Follow realed, on 06/25/2020, Social the DON interviewed Resident he did kiss the Resident #2 as looking for a boy/girlfriend not see his/her boy/girlfriend. Evealed education was	Fé	607				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		185281	B. WING			C 07/09	1/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND F		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD (IE APPROPR	BE C	(X5) COMPLETION DATE
F 607	for Resident #1. Further review of a Facility-Self Report Report, faxed to the PM, related to a "rewhich happened of (HA) #1 witnessed Resident #2. Add were completed, a symptoms of injurt revealed Resident and placed on fifte 1. Review of Resirevealed the facilit 06/10/19 with diag Cerebral Infarction Intellectual Disabil Homonymous Bilat Type II Diabetes M. 2. Review of Resirevealed the facilit 09/17/19 with diag Stenosis of Verteb Aphasia, Abnorma Spondylosis, Adult Apnea, Alzheimer' Wandering in Dise Diabetes Mellitus, Post Survey telephon 07/13/ 2020 at 06/24/2020 at approximate approximate the process of	another Long Term Care red Incident Form/ Initial ne OIG, on 06/30/2020 at 1:26 resident to resident occurrence" on 06/30/2020. Hospitality Aide I Resident #1 kiss the neck of itionally, skin assessments and there were no signs or y noted. Further, the report #1 was provided education ren (15) minute checks. I dent #1's medical record y admitted the resident on noses including Sequelae of no Depressive Disorder, Mildity, Hypertension, Fibromyalgia, teral Field Defects (left), and	F 6	07			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CC	(X3) D	(X3) DATE SURVEY COMPLETED	
		405004	A. BUILD				C
NAME OF	PROVIDER OR SUPPLIER	185281	B. WING		ET ADDRESS, CITY, STATE, ZIP CO		7/09/2020
FRIEND	SHIP HEALTH AND RE	EHAB, LLC		7400	FRIENDSHIP DRIVE EE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	approached the res #1 was kissing Res Additionally, SRNA behavior was unacc Resident #1 "you ca hugging on resident this." She revealed gave him/her a peclinterview revealed Station, directed Reimmediately reporter Further, SRNA #1 smindset of a younge touching, hugging, a residents. Per interredirection to Reside kiss others, and the and walk away. Per confused with poor Resident #2 would wat staff constantly had interview with SRNA (15) minute checks 06/24/2020; however additional intervention 07/09/2020 at 12 and Resident #2 we mobility and resided time of the incident, Additionally, Resider required constant re Continued interview understood others; he was a continued interview understood others.	king Resident #2, but as she idents, she realized Resident ident #2 on the neck. #1 immediately knew this ceptable and stated to annot be touching, kissing, is; you have been told about Resident #1 stated "I just a good night." Continued SRNA #1 separated the Resident #2 to the nurses' sident #1 to his/her room, and id the Abuse to RN #1. tated Resident #1 had the er girl and was known for and kissing on other staff and view, staff provided ongoing ent #1 not to touch, hug, or resident would say "ok, ok" interview, Resident #2 was safety awareness. Further, wander into other rooms, and to redirect him/her. Further were effective for the night of er, there should have been ons implemented on	F 6	607			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILC		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING	з		0.	C 7/09/2020
	PROVIDER OR SUPPLIER	2	<u></u>	740	REET ADDRESS, CITY, STATE, ZIP CODE 100 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056	_ _ ∪,	7/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	or follow direction. 8:00 pm, Registere her that Resident # North television rook Resident #1 kiss R lick his/her ear. Interview with Socia 07/09/2020 at 2:08 message the night #1 kissing Residen message, staff coula apart. Additionally, Interdisciplinary Teaincluded departmens taff, discussed the Resident #1 and Reminute checks were to ensure the resident #2 and Reminute checks were to ensure the resident #3 and Reminute checks were to ensure the resident #4 and Reminute checks were to ensure the resident #3 and Reminute checks were to ensure the resident #4	Further, on 06/24/2020 at ed Nurse (RN) #1 reported to #1 and Resident #2 were in the form when SRNA #1 witnessed Resident #2 on the neck and resident #2 on the neck and sale of 06/24/2020 about Resident at #2's neck. Also, per all ont keep the residents of on 06/25/2020, the Clinical resident #2 and how fifteen (15) are implemented and staff were resident #2 and how fifteen (15) are implemented and staff were rease supervision for both resident #2 and how fifteen (15) are implemented and staff were rease supervision for both red interview revealed, on reterviewed Resident #1 who red his/her boy/girlfriend and red to consent and how some resident could be married. It understanding and stated		607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		185281	B. WING		0;	C 7/09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND R	REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		TOULUE
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F 607	licking and kissing Additionally, she re regulation on sexual called the Clinical Soccurrence, and at kissing and licking unusual occurrence she thought she haversus two (2) hour Occurrence more the with the DON reveal occurrence, the fact supervision for both	age 24 Resident #2's ear and neck. ead the facility policy and ral abuse. The DON stated she Support Nurse to discuss the t that time, she did not feel was sexual abuse but an re, a behavior. Per interview, ad twenty-four (24) hours res to report the "Unusual vanted to investigate the horoughly. Further interview raled, after the 06/24/2020 cility should have increased the residents in order to prevent rouse to Resident #2 or other	F6	607		
SS=D	5:27 PM, revealed the incident betwee #2 occurred and wa investigation as he allegations of abuse two (2) hours. Furt facility should provice reduce risk factors ensure resident safe expectation that stapolicy and state reg Reporting of Alleger CFR(s): 483.12(c) (1) \$483.12(c) In response potential factors in the stapolicy and state reg Reporting of Alleger CFR(s): 483.12(c) In response potential factors in the stapolic factors in the	ed Violations	F 60	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		185281	B. WING			C 07/09/2020	
	PROVIDER OR SUPPLIER	EHAB, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPRO PRIATE	(X5) COMPLETION DATE	
	mistreatment, inclusource and misappare reported immed hours after the alleg that cause the alleg serious bodily injury the events that cause and do not rethe administrator of officials (including the administrator of officials (including t	ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if see the allegation do not involve esult in serious bodily injury, to the facility and to other the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established administrator or his or her intative and to other officials in ate law, including to the State in 5 working days of the alleged violation is verified we action must be taken. IT is not met as evidenced in record review, review of statutes (KRS), and review of statutes (KRS).	F 6	09			
	tne facility's policy, it failed to ensure all a	t was determined the facility illeged violations involving					

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		T DIOTAID OLIVIOLO				CIVID INC	<u>J. 0938-0391</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		ATE SURVEY DMPLETED
		185281	B. WING	·		07	C 7/09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE			7400	ET ADDRESS, CITY, STATE, ZIP CODE FRIENDSHIP DRIVE EE VALLEY, KY 40056		IVOIZOZO
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 609	no later than two (2 was made, to State (3) sampled resider On 06/24/2020 at a Registered Nurse A Resident #1 standir beside Resident #2 #2 on the neck. Alt witnessed by SRNA Nursing (DON) was until 10:15 PM and notified of the allegation.	were reported immediately, but 2) hours after the allegation e Agencies for one (1) of three ents (Resident #2). approximately 8:00 PM, State Aide (SRNA) #1 witnessed ing close to and kneeling down 2. Resident #1 kissed Resident though the allegation was A #1 at 8:00 PM, the Director of s not notified of the allegation the State Agencies were not pation until 06/25/2020 at 1:36 (1) hours and thirty-six (36)		309			
	oral or written report to State Agencies up abuse, neglect, or e Review of the facility Abuse/Potential Neg Reporting/Investigat revealed allegations to the supervisor an Per the policy, perso to immediately information of the continued review rewould be reported to and investigative agestate requirements.	eglect/Exploitation ation," dated 06/01/2017, so of abuse were to be reported and the resident's charge nurse. cons' receiving the report were remarked allegations of abuse to the appropriate regulatory gencies in accordance with					

PRINTED: 07/23/2020 FORM APPROVED

CLIVIL	NO POR MEDICARE	& MEDICAID SERVICES			OMB N	<u>10. 093</u> 8-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) [(X3) DATE SURVEY COMPLETED	
		185281	B. WING	2.5		C 07/09/2020	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	71709/2020	
FRIEND	SHIP HEALTH AND RI	EHAB, LLC		7400 FRIENDSHIP DRIVE			
			<u>. </u>	PEWEE VALLEY, KY 40056		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 609	Reported Incident F the Office of Inspec 06/25/2020 at 1:36	rige 27 Form/ Initial Report, faxed to extor General (OIG), on PM, revealed a "resident to e" happened on 06/24/2020.	F 6	09			
	SRNA #1 witnessed neck of Resident #2	d Resident #1 kiss and lick the 2. Further, the residents were re were no signs or symptoms					
	revealed the facility 06/10/19 with diagn Cerebral Infarction, Intellectual Disabilit	ent #1's medical record admitted the resident on oses including Sequelae of Depressive Disorder, Mild y, Hypertension, Fibromyalgia, eral Field Defects (left), and ellitus.					
×	Set (MDS) Assessn revealed the facility clear speech, made ability to understand revealed the resider Mental Status (BIMS fifteen (15), indicating review of the Annualandary - Behavior, revealed behavior not exhibite the facility assessed supervision of one (ambulation, but Resident and the setup with setup with locological setup.	ident #1 was independent motion on and off the unit.					
	Resident #1, dated (signed by RN #1, re #1 she witnessed Re	y's Incident Report (IR) for 06/25/2020 at 12:05 AM, vealed SRNA #1 alerted RN esident #1 sucking on and licking his/her ear. The					

patients were separated, redirected, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185281	B. WING	;		07	C //09/2020	
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE			740	REET ADDRESS, CITY, STATE, ZIP COD 10 FRIENDSHIP DRIVE WEE VALLEY, KY 40056)E	IUSILULU	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	educated. Additional injuries observed at was alert to person, Per the IR, Nursing facility, and an invest addition, fifteen (15) immediately done or revealed Resident # sucking or licking or Resident #2 a kiss of was looking for a both him/her before the repassed away. Observation of Resident in his/her line with him/her line with line with him/her line with him/her line with him/her line with line with him/her line with him/her line with him/her line with line with him/her line with line with him/her line with line	mally, Resident #1 had no at the time of the incident and an place, time, and situation. It had no stitue to the time of the incident and an place, time, and situation. It had no stigation was underway. In so, minute checks and labs were on Resident #1. Further review #1 stated he/she was not on Resident #2; he/she gave on the cheek because he/she oy/girlfriend to take care of resident representative sident #1, on 07/08/2020 at the resident sitting in a per room holding a cell phone. dent #1, on 07/08/2020 at 3:00 sident stated "hello and come linspector knocked on the Resident #1 stated he/she did ent with another resident ouching the other resident's resident did not recall Social to birector of Nursing (DON)		609				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		ATE SURVEY OMPLETED
	·	185281	B. WING		07	C 7/ 09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND R		740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDBE	(X5) COMPLETION DATE
F 609	Review of Resider Assessment, dated facility assessed the sometimes made is sometimes had the Continued review of the resident had a fifteen (15), indicated impairment. Additional assessment reveated symptoms delirium fluctuating. Further resident required effor transfers and a (1) with locomotion independent with sunit. Review of the facility o6/25/2020 at 12:006/25/2020 at 12:006/25/2020 at 3:36 revealed an SRNA #2 was found with neck and licking his patients were separated and Post Survey telephon 07/13/2020 at 106/24/2020 at approvitinessed Resident #2, Resident #2 was see Resident #2 was see Resident #2. Continued the incider of the incider was be resident #2. Continued the seident #2.	orage 29 Int #2's Quarterly MDS Int #3 sees and Interview of the MDS Interview of the MDS Interview of the MDS Interview of the MDS Interview assistance of two (2) Interview assistance of two (2) Interview assistance of two (2) Interview interview of the Interview interview of the Interview interview of the Interview interview of the Interview with SRNA #1, Interview with	F 609			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION) DATE SURVEY COMPLETED
		185281	B. WING			C 07/09/2020
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZII 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	P CODE	0//08/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION E DATE
	knew this behavior to Resident #1 "you hugging on resident this." She revealed gave him/her a per interview revealed residents, assisted station, directed Residents, assisted station, directed Resident #2 see he/she liked it. Addisched the kesident #2's ee he/she liked	nally, SRNA #1 immediately or was unacceptable and stated ou cannot be touching, kissing, ents; you have been told about ed Resident #1 stated "I just eck good night." Further d SRNA #1 separated the d Resident #2 to the nurses' Resident #1 to his/her room, and red the abuse to RN #1. #1, on 07/09/2020 at 3:30 PM, 1/2020 around 10:00 PM, SRNA ritnessed Resident #1 kiss and ear and neck and ask him/her if dditionally, the residents were time and fifteen (15) minute ted for both residents. Further I RN #1 immediately called the of the Abuse, and the DON	F 6	09		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING		·	07	C 7/ 09/2020
	PROVIDER OR SUPPLIER			7400 FI	T ADDRESS, CITY, STATE, ZIP C RIENDSHIP DRIVE EE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ıx	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609		•	F 6	309			
2	expectation State A timely as per facility	egation of abuse, it was her Agencies were to be notified ty policy. Per interview, the I have been reported within two 1/2020.					
F 656 SS=D	5:27 PM, revealed for eight (8) years. hospital when the in and Resident #2 or involved with the in Per interview, the faincidents as abuse, be free from abuse through policies, standard continued interview abuse should be re	Administrator, on 07/09/2020 at he had worked at the facility Additionally, he was in the incident between Resident #1 ccurred and was not as a nestigation as he usually was. Facility failed to identify the e, and residents had the right to e with the facility ensuring this taff education, and regulation. We revealed all allegations of eported within two (2) hours. In the Comprehensive Care Plan (1)	F 6	56		¥	
	§483.21(b)(1) The fimplement a compression for each resident rights set for §483.10(c)(3), that is objectives and time medical, nursing, an needs that are identical assessment. The codescribe the following (i) The services that or maintain the resident physical, mental, an required under §483 (ii) Any services that	ehensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable eframes to meet a resident's and mental and psychosocial ntified in the comprehensive comprehensive care plan must ing - at are to be furnished to attain ident's highest practicable and psychosocial well-being as i3.24, §483.25 or §483.40; and at would otherwise be required is 33.25 or §483.40 but are not					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	ILTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		185281	B. WING	3	0.	C 7/09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE			STREET ADDRESS, CITY, STATE, 2 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	ZIP CODE	109/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE AC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	provided due to the under §483.10, inclute treatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. If findings of the PASA rationale in the residentionale in the residentionale in the residential of the resident	e resident's exercise of rights fluding the right to refuse 183.10(c)(6). It services or specialized ces the nursing facility will of PASARR If a facility disagrees with the EARR, it must indicate its ident's medical record. with the resident and the stative(s)-goals for admission and coreference and potential for acilities must document acilities must document ont's desire to return to the sessed and any referrals to sies and/or other appropriate	F	656		
	by: Based on observati and review of the Ce Medicaid Services (Instrument (RAI) Ma the facility failed to d comprehensive pers related to supervisio sampled residents (I	ion, interview, record review, renters for Medicare and (CMS), "Resident Assessment anual 3.0," it was determined develop and implement a son-centered care plan on for one (1) of three (3) (Resident #1).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185281	B. WING			07/09/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	ODE 1	109/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Registered Nurse Resident #1 kiss f Additionally, on 06 11:00 AM, Hospita Resident #1 rub h Resident #2's che cheek. The facility failed t Comprehensive C with additional inte #1's problems and was provided adea	Aide (SRNA) #1 witnessed Resident #2 on the neck. 6/30/2020 at approximately ality Aide (HA) #1 witnessed is/her hands down the front of st and kiss Resident #2 on the o develop and implement the are Plan (CCP), on 06/24/2020, erventions to address Resident I risks, to ensure each resident quate supervision and remained Therefore, abuse reoccurred on -607, and F-689)	F 6	56			
	Instrument (RAI) N 2016, revealed the communication too measurable object describe the service maintain the reside physical, mental, a Additionally, the Co- implement interver address the individed psychosocial need risks. Further, the effective clinical de- resident needs to e- quality of life needs met.	Resident Assessment Manual 3.0," dated October CCP was an interdisciplinary of which must include rives and time frames and must rese to be furnished to attain or rent's highest practicable and psychosocial well-being. CP should identify and ritions and treatments to really physical, functional, respectively, and reare plan was driven by recision making and identified resure quality of care and residents were	3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROV IDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		185281	B. WING_		07	C / 09/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		10312020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	the facility admitted diagnoses including Infarction, Depress Disability, Hyperter Homonymous Bilat Type II Diabetes Markey of Residen Set (MDS) Assessing revealed the facility clear speech, made ability to understanged the reside Mental Status (BIM fifteen (15), indicating review of the Annual Behavior, revealed behavior not exhibit the facility assesse supervision of one ambulation, but the with setup with local Review of Resident 06/26/2020, revealed active: resident expexpresses interest was revised on 06/3 declined vibrator." would voice unders sexual behaviors would be provided to self-pleasure. The 06/25/2020, place of assist with private tiresident on the defining propriate sexual provide information.	If the resident on 06/10/19 with g Sequelae of Cerebral ive Disorder, Mild Intellectual asion, Fibromyalgia, eral Field Defects (left), and	F 65	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING			C 07/09/2020	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
F 656	evidence the facilit and implement add treatments to addresupervision of Res residents throughouthe fifteen (15) min 06/25/2020. Review of Fifteen (Resident #1, on 06 resident was in the 12:00 PM. Howeve #1 on the North Ha AM rubbing his/her Resident #2's chest the cheek. Interview with HA # revealed she used each resident need for the CCP to incluse to ensure resident use to ensure resident eccepton 07/13/2020 at 1 the CCP to know heresident. Additional increased supervision specific intervention fifteen (15) minute care for residents wothers. Further, she CCP to be developed.	is no further documented by identified the need to develop ditional interventions and less the increased need for ident #1 to protect other lead to investigation except for lead to interventiated on intervention of the investigation except for lead to intervention of the investigation except for lead to intervention of intervention of its and kissing Resident #2 on its intervention of its and kissing Resident #2 on its intervention of its int	F	656			
	to ensure safety for Interview with Social						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		(X3) DA	(X3) DATE SURVEY COMPLETED	
		185281	B. WING	<u></u> د			C 7/ 09/2020
	PROVIDER OR SUPPLIER PSHIP HEALTH AND RE	REHAB, LLC		740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE WEE VALLEY, KY 40056		110312020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDBE	(X5) COMPLETION DATE
F 656	be developed and in continuity of care and needs. Additionally provide adequate so ensure their safety. responsibility to identify interventions to additionally of care and the residents. Interview with RN # revealed the CCP with Interview with RN # revealed the CCP with Interview interventions to meet residents. Further, residents with behavious all residents and to outcomes. Interview with MDS 4:43 PM, revealed so for five (5) years. Accollaboratively to identify the CCP for each incomposition of the CCP for each incomposition of the composition of the c	B PM, revealed the CCP should implemented to ensure and meet each resident's y, it was important for staff to supervision to all residents to y. Further, it was the facility's entify, develop, and implement dress the individual resident's problems, and risks to ensure to protect the well-being of \$\frac{\psi}{2}\$1, on \$07/09/2020 at 3:30 PM,	F	656			
		Pirector of Nursing (DON), on PM_revealed at the time of					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	ULTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		185281	B. WING	3	0.	C 7/09/2020
ĺ	PROVIDER OR SUPPLIER SHIP HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP O 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		IVOIEVEV
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656		•	Ff	656		
	kissing and licking with behavior. Additional #1 would have the serious #1, on 06/25/2020, would not kiss Resifelt fifteen (15) minutes an effective into safety. However, so have implemented it residents in order to abuse to Resident #106/24/2020 occurre revealed it was implement the CCP	a 06/24/2020, she did not feel was sexual abuse but a lally, she did not think Resident same behaviors again toward use in discussion with Resident the resident verbalized he/she sident #2 again. Therefore she lute checks for Resident #1 tervention to ensure resident she stated the facility should increased supervision for both to prevent further potential #2 or other residents after the lence. Further, the DON cortant to develop and to ensure residents were supervision to protect them buse.				
SS≃D	5:27 PM, revealed h problems and risks expected the IDT to CCP to include appr factors that might be important to identify CCP to ensure quali Free of Accident Ha CFR(s): 483.25(d)(1 §483.25(d) Accident The facility must ens §483.25(d)(1) The re as free of accident h	nts. esure that - resident environment remains hazards as is possible; and	F 6	389		
		resident receives adequate sistance devices to prevent		1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		185281	B. WING_		0	C 7/00/2020	
	PROVIDER OR SUPPLIEF	R		STREET ADDRESS, CITY, STATE, ZIP C 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		7/09/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULDBE	(X5) COMPLETION DATE	
F 689	Continued From p	age 38	F 68	39			
	by: Based on observa and review of the f determined the fac resident environme accident hazards a receives adequate (3) sampled reside On 06/24/2020 at a Registered Nurse a Resident #1 kiss R Additionally, on 06, 11:00 AM, Hospita Resident #2's ches cheek. Further, the residents adequate resident remained reoccurred, on 06/AM.	ation, interview, record review, facility's policy, it was cility failed to ensure the ent remained as free of as possible and each resident e supervision for one (1) of three ents (Resident #2). approximately 8:00 PM, State Aide (SRNA) #1 witnessed Resident #2 on the neck. 6/30/2020 at approximately ality Aide (HA) #1 witnessed is/her hands down the front of st and kiss Resident #2 on the ne facility failed to provide e supervision to ensure each free from abuse, and abuse /30/2020 at approximately 11:00					
	(Refer to F-600, F- The findings include	,					
	Supervision of Res revealed it was the environment free fr	lity's policy, "Safety and sidents," revised July 2017, e facility's priority to make the from accident hazards to afety, supervision, and		e			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO	O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DA	ATE SURVEY OMPLETED
		185281	B. WING_		07	C 7/09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND R			STREET ADDRESS, CITY, STATE 7400 FRIENDSHIP DRIVE	E, ZIP CODE	10012025
				PEWEE VALLEY, KY 4005	56	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From pa	age 39	F 68	89		
	assistance to prevereview revealed the to safety, facility ori resident centered, vimplement a system Additionally, resident component of the seriod per policy, the type supervision was deresident's assessed in the environment. frequency of reside among residents arresident. Per policy increased for temporesident's condition policy revealed facilincluded identifying ongoing monitoring policy, individualized approaches include obtained from assed identify specific haz residents. Further, interventions to redit to hazards in the ensupervision. Conting revealed implement accident hazards we specific interventions; providensuring intervention documenting intervention documenting intervention implemented corrections.	ent accidents. Continued e facility used a dual approach riented and individualized which were used together to ms approach to safety. Ent supervision was a core systems approach to safety. End and frequency of resident etermined by the individual and needs and identified hazards are supervision could vary and over time for the same by, supervision might need to be corary hazards or change in a new and reporting processes. Per end resident centered ed analyzing information essments and observations to exards or risks for individual and the care team targeted duce individualized risks related environment, including adequate mued review of the policy and include: communicating insto all relevant staff; bility for carrying out ding necessary training; ons were implemented; and rentions. Additionally, ctiveness of interventions		58		
	modifying or replaci	ing interventions as needed;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) ML IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185281	B. WING			٠.	C 7/00/2020
	PROVIDER OR SUPPLIER		<u>, </u>	740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056		7/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	and evaluating the revised intervention Review of the Long Reported Incident Fithe Office of Inspect 06/25/2020 at 1:36 resident occurrence Continued review received the Resident #1 kiss and #2. Per report, the Administration, OIG (APS), the Attorney for Community Basinotified. Additionall symptoms of injury	effectiveness of new or is. Term Care Facility-Self Form/ Initial Report, faxed to stor General (OIG), on PM, revealed a "resident to e" happened on 06/24/2020. evealed SRNA #1 witnessed ad lick the neck of Resident Physician, POA, is, Adult Protective Services General, and the Department ed Services (DCBS) were y, there were no signs or noted. Further, this incident is (17) hours and thirty-six (36)	F	689			
	Reported Incident F up/Final Report, fax 11:30 PM, (six (6) d revealed there was occurrence" on 06/2 revealed SRNA #1 v and lick the neck of residents were imm signs or symptoms review revealed, on interviewed Resider kiss the resident bed a boy/girlfriend since boy/girlfriend. Addit education was proviappropriateness for consent and ensuring	Term Care Facility-Self form/ Five (5) day/Follow ed to OIG, on 07/01/2020 at ays after the initial report), a "resident to resident 24/2020. Continued review witnessed Resident #1 kiss Resident #2. Additionally, the ediately separated, and no of injury were noted. Further 06/25/2020, SS and the DON at #1 who stated he/she did cause he/she was looking for e he/she could not see his/her ional review revealed ded to Resident #1 related to finding a mate, ensuring ag the person was not \$1 voiced understanding and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		185281	B. WING	i		l	C
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIF 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	ODE .	<u> </u>	/09/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 689	agreed not to eng Resident #2. Per unsubstantiated at their investigation Cause of the incid having the mindse satisfy his/her bas Per report, Reside and/or symptoms incident; remained and continued morpsychological nee Review of the Lon Reported Incident the OIG, on 06/30 "resident to reside 06/30/2020. Cont witnessed Resider #2. Per report, the Administration, OI and DCBS were nassessments were signs or symptoms Resident #1 was pon fifteen (15) min Review of the Lon Reported Incident up/Final Report, fa 8:43 PM (seven (7) Initial Report), reversident occurrence review revealed Hakiss the neck of Reresidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisgins or symptoms review of the reported incidents were immisging or symptoms review of the reported incidents.	age in these activities with the report, the facility buse or any harm based on and determined the Root lent was related to Resident #1 et of a teenager and trying to ic needs of companionship. ent #2 had no injuries or signs of any harm occurring from the d on fifteen (15) minute checks; nitoring for any other ds would be done by SS. g Term Care Facility-Self Form/ Initial Report, faxed to /2020 at 1:26 PM, revealed a int occurrence" happened on inued review revealed HA #1 int #1 kiss the neck of Resident e Physician, POA, G, APS, the Attorney General, otified. Additionally, skin e completed, and there were no is of injury noted. Further, provided education and placed	F6	689			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DA	(X3) DATE SURVEY COMPLETED		
		185281	B. WING		<u></u>	0.	C 7/ 09/2020	
	PROVIDER OR SUPPLIER SHIP HEALTH AND R		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 689	again because he/facility. Continued discussed discharg revealed re-educat #1, and he/she voin not to engage in the Per the report, the or any harm based determined the Rorelated to Resident companionship and facility. Per report, signs and/or sympt from the incident, a (15) minute checks across Resident #1 would continue to resychological need Review of Resident the facility admitted diagnoses including Infarction, Depress Disability, Hyperten	lid kiss Resident #2 and did it she wanted to move out of the review revealed the facility ge planning. Additional review tion was provided to Resident ced understanding and agreed rese activities with Resident #2. facility unsubstantiated abuse on their investigation and to Cause of the incident was that trying to find downting to move out of the Resident #2 had no injuries or toms of any harm occurring and he/she remained on fifteen with a stop sign placed the swith a stop sign placed the resident on 06/10/19 with general seconds of Cerebral sive Disorder, Mild Intellectual asion, Fibromyalgia, reral Field Defects (left), and	F	689				
	Assessment, dated facility assessed the made self-understo understand others. the facility assessed Interview for Mental thirteen (13) out of cognition. Additional Assessment, Section	al Minimum Data Set (MDS) 1 06/17/2020, revealed the e resident had clear speech, ood, and had the ability to Continued review revealed d the resident had a Brief I Status (BIMS) score of fifteen (15), indicating intact al review of the Annual MDS on E - Behavior, revealed the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				TIPLE CONST	(X3) D	(X3) DATE SURVEY COMPLETED	
		185281	B. WING				C 7/09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND R			7400 FRIE	DDRESS, CITY, STATE, ZIP CO ENDSHIP DRIVE VALLEY, KY 40056		110312020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI EACH CORRECTIVE ACTION S COSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	resident required stransfers and ambindependent with soff the unit. Review of Resident Plan (CCP), initiate problem of "sexual sexual desires and residents." The Coto include "resident stated the resident what inappropriate other residents and as needed for self-interventions include fifteen (15) minute time to self-pleasur definition of conserbehaviors toward offer vibrator; and offer vibrator; and offer vibrator; and offer vibrator; and offer vibrator and implement add treatments to addressupervision of Resiresidents throughout the fifteen (15) minute (15) minu	age 43 her, the facility assessed the supervision of one (1) for ulation, but Resident #1 was betup with locomotion on and at #1's Comprehensive Care ed on 06/26/2020, revealed a ly active: resident experiencing lexpresses interest in other CP was revised on 06/30/2020 to declined vibrator." The goal would voice understanding of sexual behaviors were toward downled be provided time alone pleasure. The CCP ded: 06/25/2020, place on checks; assist with private re; educate resident on the ent and inappropriate sexual others; provide information and observe for changes in peing, dated 06/26/2020. In formation and observe for changes in the pleasure of the need to develop ditional interventions and east the increased need for indent #1 to protect other ut the investigation except for utes checks initiated on	F	589	DEFICIENCY)		
	resident was in the 12:00 PM. Howeve #1 on the North Hal AM rubbing his/her	bathroom from 10:45 AM untiler, HA #1 witnessed Resident llway at approximately 11:00 hands down the front of t and kissing Resident #2 on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		185281	B. WING			1	C (00/2020	
	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 689	the cheek. Addit Minute Checks re evidence of who comonitoring form with signature or title of the comonitoring of the comonitoring with signature of the comonitoring of the comon	page 44 tional review of Fifteen (15) evealed no documented completed them. The was not developed to include the of staff completing each check. esident #1, on 07/08/2020 at d the resident was sitting in a //her room holding a cell phone. sident #1, on 07/08/2020 at 3:00 resident said "hello and come e Inspector knocked on the //, Resident #1 stated he/she did dent with another resident r touching the other resident's he resident did not recall Social ON talking with him/her about or discharging from the facility. Int #2's medical record revealed ed the resident on 09/17/19 with hing Occlusion and Stenosis of Heart Failure, Aphasia, Gait and Mobility, Spondylosis, hrive, Sleep Apnea, Alzheimer's ia, Wandering in Disease, Atrial I Diabetes Mellitus, Anxiety, and Int #2's Quarterly MDS and 05/27/2020, revealed the he resident had clear speech, self-understood, and he ability to understand others. revealed the facility assessed eving a BIMS score of zero (0) indicating severe cognitive tional review of the MDS	F 6	389				

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<u> </u>	TO TOT MEDIONIL	A MEDICAID SERVICES				D. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
		185281	B. WING		07	C 7/ 09/2020	
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE	EHAB, LLC		STREET ADDRESS, CITY, STATE, ZI 7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	symptoms delirium/ fluctuating. Further resident required ex for transfers and an supervision of one (Also, per assessme independent with se unit. Review of Resident 09/18/2019, reveale risk/wanderer relate and impaired safety a problem was reve deficit related to diff processing informat Dementia. On 06/3 to include resident h toward other female basic needs would be would not leave the Interventions, dated the resident from wa diversions and wand 03/30/2020, added i facing the resident; communicating and observe for non-vert yes or no questions, interventions were fi provide a stop sign to into. Observation of Resid 2:30 PM, revealed th wheelchair in his/her call light was on abo	ed the resident had signs and inattention present and the facility assessed the stensive assistance of two (2) abulation and required 1) with locomotion on the unit. Int, the resident was etup with locomotion off the #2's CCP, initiated on a problem of an elopement of the disorientation to place awareness. On 03/30/2020, aled of a communication iculty expressing and ion/thoughts due to 0/2020, the CCP was revised and tendencies to migrate rooms. The goals stated be met, and the resident	F 6	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED			
		185281	B. WING	s		٥.	C 7/09/2020	
	PROVIDER OR SUPPLIER			740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE 0WEE VALLEY, KY 40056	_ <u> </u>	0110012020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 689	the need was when resident would not a He/she would only state Inspector atterno no 17/13/2020 at 1 #1 had the mindset known for touching, others, staff and resprovided ongoing rekiss others to Resident #2 was consumed awareness; he/she rooms, and staff con him/her. Additional revealed she felt fift effective for the night there should have beimplemented on 06/Further, it was imposed behaviors to have in ensure all residents.	y the call light was on or what in staff inquired. Further, the speak to the State Inspector. make eye contact when the empted to talk with him/her. It is a speak to the State Inspector. make eye contact when the empted to talk with him/her. It is a speak to the State Inspector. make eye contact when the empted to talk with him/her. It is a speak to the State Inspector. The speak to talk with Stand was and was and was and the resident and walk away. Per interview, and walk away.	F	689				
	on 07/09/2020 at 12 and Resident #2 we mobility and resided time of the incident, 06/30/2020. Addition lot and required consupervision. Contin Resident #1 undersident #2 was counderstand others of LPN #2 stated staff	nsed Practical Nurse (LPN) #2, 2:30 PM, revealed Resident #1 ere both independent with d on the same hallway at the , only two (2) doors apart until onally, Resident #1 roamed a nstant redirection and nued interview revealed stood others; however, onfused and usually could not or follow direction. Further, should provide ntions to meet the ongoing						

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			O. 0938-039° ATE SURVEY OMPLETED
		185281	B. WING	G			C 7/09/2020
	PROVIDER OR SUPPLIER DSHIP HEALTH AND RE	REHAB, LLC		740	TREET ADDRESS, CITY, STATE, ZIP CODE 400 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056		110312020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
	ensure residents wi adequate supervision well-being of all resirisk for negative out Interview with Social 07/09/2020 at 2:08 the Clinical Interdiscon which included departments which included departments which included departments with the ensure displaying the approaches to increase on 06/30/2020. Addinterviewed Resident stated he/she misses the things they did to why he/she kissed Formules related to sexually voiced understand the did increased supervision checks. Further, she responsibility to ident to address the individent of the control of the cont	lents, and it was important to with behaviors received ion to ensure the safety and sidents and to decrease the utcomes. al Services (SS), on PM, revealed on 06/25/2020, sciplinary Team (IDT) meeting, partment heads and F, discussed the occurrence that and Resident #2 and how checks was the approach sure the residents were apart. It is no discussion about each or implementing further ease supervision for both second occurrence of abuse, iditionally, she stated she ent #1, on 06/25/2020, who ed his/her boy/girlfriend and together sexually and that was Resident #2. Per interview, on about self-pleasure and ual desires to which Resident inding and stated he/she would wever, after speaking with id not identify the need for ion beyond fifteen (15) minute the revealed it was the facility's intify approaches/interventions ridual resident's risks to ure, to protect from harm, and	F	689			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185281	B. WING			07	C 7 /09/2020
	PROVIDER OR SUPPLIER SHIP HEALTH AND RE	EHAB, LLC		740	REET ADDRESS, CITY, STATE, ZIP CODE 00 FRIENDSHIP DRIVE WEE VALLEY, KY 40056	<u>. </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	on 06/24/2020, she regulation on sexual called the Clinical Soccurrence, and at kissing and licking wan unusual occurrent interview, she did not have the same behalf 2 because in discut 06/25/2020, the resinot kiss Resident #2 fifteen (15) minute offective approach/is safety. However, the need to modify or in prevent further pote other residents, untitioccurrence. Further important to ensure adequate supervision type of abuse. Interview with the Activation of the incident between #2 occurred and was investigation as he up the facility should idea supervision to reduct the ensure residents of the ensure residents.	It's ear and neck. Additionally, read the facility policy and all abuse. The DON stated she support Nurse to discuss the that time, she did not feel was sexual abuse but it was nee, a behavior. Per cot think Resident #1 would aviors again toward Resident assion with Resident #1, on ident verbalized he/she would again. Therefore, she felt checks for Resident #1 was an intervention to ensure resident e facility did not identify the crease supervision, to intial abuse to Resident #2 or after the 06/30/2020 residents were provided on to protect them from any diministrator, on 07/09/2020 at the was in the hospital when in Resident #1 and Resident so not as involved with the isually was. Per interview, antify and provide adequate the risk factors that may be sident safety. Further, he pervision was important to	F	689			

		AND HUMAN SERVICES & MEDICAID SERVICES			PR	INTED: 07/23/2020 FORM APPROVED		
	T	OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185281	B. WING		C 07/09/2020			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	DE 0770372020		
FRIENDSHIP HEALTH AND REHAB, LLC				7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	E COMPLETION ATE DATE			
E 000	Initial Comments		E 00	00				
	Survey was initiated concluded on 07/09	/2020. It was determined erns with 42 CFR §483.73						
		et.						
						5		
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	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.

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C 100355 B. WING 07/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE FRIENDSHIP HEALTH AND REHAB, LLC PEWEE VALLEY, KY 40056 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#00031918 and a COVID-19 Focused Infection Control Survey was initiated on 07/08/2020 and concluded on 07/09/2020. Complaint KY#00031918 was substantiated with deficiencies cited. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 124.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE