STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated 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 at the highest Scope and Severity (S/S) of a "D". 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.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility	F 600		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1	F 600		

failed to have an effective system to ensure residents were free from abuse for one (1) of three (3) sampled residents (Resident #2).

On 06/24/2020 at approximately 8:00 PM, State Registered Nurse Aide (SRNA) #1 witnessed Resident #1 standing close to and kneeling down beside Resident #2 in the North Hallway Dayroom. SRNA #1 walked closer to the residents and witnessed Resident #1 kiss Resident #2 on the neck. SRNA #1 identified abuse had occurred; separated the residents; assisted Resident #2 to the nurses' station; and asked Resident #1 to go to his/her room. SRNA #1 reported the allegation of abuse immediately to Registered Nurse (RN) #1. RN #1 called the Director of Nursing (DON) on 06/24/2020 at 10:15 PM, to report the witnessed allegation of abuse.

On 06/30/2020 at approximately 11:00 AM, Hospitality Aide (HA) #1 witnessed Resident #1 standing behind Resident #2, who was on the North Hallway. HA #1 witnessed Resident #1 rub his/her hands down the front of Resident #2's chest and kiss Resident #2 on the cheek. HA #1 identified abuse had occurred; separated the residents by assisting Resident #2 to the nurses' station; and directed Resident #1 not to kiss and rub on other residents. HA #1 reported the allegation of abuse immediately to Licensed Practical Nurse (LPN) #2. LPN #2 notified the DON immediately and reported the witnessed allegation of abuse.

(Refer to F-607, F-609, F-656, and F-689)

The findings include:

Review of the facility's policy, "Alleged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2	F 600		

Abuse/Potential Neglect/Exploitation Reporting/Investigation," dated 06/01/2017, revealed the facility provided an environment that promoted dignity and respect for residents that prohibited abuse. Continued review revealed allegations were to be reported to the supervisor and the resident's charge nurse. Persons receiving the report were to immediately inform the Administrator and if the Administrator was unavailable, the Director of Nursing (DON) was to be notified. Per the policy, allegations of abuse would be reported to the appropriate regulatory and investigative agencies in accordance to state requirement. Per policy, interventions to protect residents should be taken to avoid potential harm during the investigation process. Further review of this policy revealed "Abuse" was defined as an intentional infliction of physical or psychological injury upon an elderly person or disabled adult. The intentional act could be expected to result in physical or psychological injury. Further, "Sexual Abuse" was defined as an act of a sexual nature committed for the sexual gratification of the abuser and in the presence of a disabled adult or elderly adult without consent.

Review of KRS Chapter 209.030, revealed an oral or written report was to be made immediately to State Agencies upon knowledge of suspected abuse, neglect, or exploitation of an adult.

Review of the Long Term Care Facility-Self Reported Incident Form/ Initial Report, faxed to the Office of Inspector General (OIG), on 06/25/2020 at 1:36 PM, revealed a "resident to resident occurrence" happened on 06/24/2020. SRNA #1 witnessed Resident #1 kiss and lick the neck of Resident #2. Per report, the Physician, POA, Administration, OIG, Adult Protective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3	F 600		

Services (APS), the Attorney General, and the Department for Community Based Services (DCBS) were notified. Additionally, there were no signs or symptoms of injury noted. Further, this incident occurred seventeen (17) hours and thirty-six (36) minutes prior to the Initial Report and notifications.

Review of the Long Term Care Facility-Self Reported Incident Form/ Five (5) day/Follow up/Final Report, faxed to OIG, on 07/01/2020 at 11:30 PM, (six (6) days after the initial report), revealed there was a "resident to resident occurrence" on 06/24/2020. SRNA #1 witnessed Resident #1 kiss and lick the neck of Resident #2. Additionally, the residents were immediately separated, and no signs or symptoms of injury were noted. Further review revealed, on 06/25/2020, SS and the DON interviewed Resident #1 who stated he/she did kiss the resident because he/she was looking for a boy/girlfriend since he/she could not see his/her boy/girlfriend. Additional review revealed education was provided to Resident #1 related to appropriateness for finding a mate, ensuring consent and ensuring the person was not married. Resident #1 voiced understanding and agreed not to engage in these activities with Resident #2. Continued review revealed the facility unsubstantiated abuse or any harm based on their investigation and determined the Root Cause of the incident was related to Resident #1 having the mindset of a teenager and trying to satisfy his/her basic needs of companionship. Per report, Resident #2 had no injuries or signs and/or symptoms of any harm occurring from the incident; remained on fifteen (15) minute checks; and continued monitoring for any other psychological needs would be done by SS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4	F 600		

Review of the Long Term Care Facility-Self Reported Incident Form/ Initial Report, faxed to the OIG, on 06/30/2020 at 1:26 PM, revealed a "resident to resident occurrence" happened on 06/30/2020. HA #1 witnessed Resident #1 kiss the neck of Resident #2. Per report, the Physician, POA, Administration, OIG, APS, the Attorney General, and DCBS were notified. Additionally, skin assessments were completed, and there were no signs or symptoms of injury noted. Further, Resident #1 was provided education and placed on fifteen (15) minute checks.

Review of the Long Term Care Facility-Self Reported Incident Form/ Five (5) day/Follow up/Final Report, faxed to OIG, on 07/07/2020 at 8:43 PM (seven (7) days after OIG received the Initial Report), revealed there was a "resident to resident occurrence" on 06/30/2020. HA #1 witnessed Resident #1 kiss the neck of Resident #2. Additionally, the residents were immediately separated, and no signs or symptoms of injury were noted. Further review of the report revealed, on 06/30/2020, SS and the DON interviewed Resident #1. Resident #1 stated he/she did kiss Resident #2 and did it again because he/she wanted to move out of the facility. Continued review revealed the facility discussed discharge planning. Additional review revealed re-education was provided to Resident #1, and he/she voiced understanding and agreed not to engage in these activities with Resident #2. Further review revealed the facility unsubstantiated abuse or any harm based on their investigation and determined the Root Cause of the incident was related to Resident #1 trying to find companionship and wanting to move

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5	F 600		

out of the facility. Per report, Resident #2 had no injuries or signs and/or symptoms of any harm occurring from the incident, and he/she remained on fifteen (15) minute checks with a stop sign placed across Resident #1's old room. Further, SS would continue to monitor for any other psychological needs.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 06/10/19 with diagnoses including Sequelae of Cerebral Infarction, Depressive Disorder, Mild Intellectual Disability, Hypertension, Fibromyalgia, Homonymous Bilateral Field Defects (left), and Type II Diabetes Mellitus.

Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 06/17/2020, revealed the facility assessed Resident #1 had clear speech, made self understood, and had the ability to understand others. Continued review revealed the facility assessed the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating intact cognition. Additional review of the Annual MDS Assessment, Section 3 - Behavior, revealed the facility assessed the resident as behavior not exhibited. Further, the facility assessed the resident required supervision of one (1) for transfers and ambulation. Also, per assessment, the resident was independent with setup with locomotion on and off the unit.

Review of Resident #1's Comprehensive Care Plan (CCP), initiated on 06/26/2020, revealed a problem of "sexually active: resident experiencing sexual desires and expresses interest in other residents." The CCP was revised on 06/30/2020 to include "resident declined vibrator." The goal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

stated the resident would voice understanding of what inappropriate sexual behaviors were toward other residents and would be provided time alone as needed for self-pleasure. The CCP interventions included 06/25/2020, place on fifteen (15) minute checks; assist with private time to self-pleasure; educate resident on the definition of consent and inappropriate sexual behaviors toward others; provide information and offer vibrator; and observe for changes in psychosocial well-being.

Further review of Resident #1's CCP, initiated on 06/30/2020, revealed a problem of "behavioral symptoms." The resident expressed wanting to return to the community and verbalized he/she was willing to break rules to make that happen. The goal stated the resident's behavior symptoms would be managed to reduce the negative impact on self and others and assist the resident with returning to the community. The CCP interventions, dated 06/30/2020, included: fifteen (15) minute checks; encourage diversional activities; redirect as needed; and remove from public areas if behavior was socially inappropriate.

Review of the facility's Incident Report Investigation (IR) for Resident #1, dated 06/25/2020 at 12:05 AM, signed by RN #1, revealed SRNA #1 alerted RN #1 she witnessed Resident #1 sucking on Resident #2's neck and licking his/her ear. The patients were separated, redirected, and educated. Additionally, Resident #1 had no injuries observed at the time of the incident and was alert to person, place, time, and situation. Per the IR, Nursing Administration was in the facility, and an investigation was underway. In addition, fifteen (15) minute checks and labs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7	F 600		

were immediately done on Resident #1. Further review revealed Resident #1 stated he/she was not sucking or licking on Resident #2; he/she gave Resident #2 a kiss on the cheek because he/she was looking for a boy/girlfriend to take care of him/her before the Power-of-Attorney (POA) passed away.

Review of the facility's Incident Report Investigation for Resident #1, dated 06/30/2020 at 11:02 AM, signed by LPN #2, revealed HA #1 alerted LPN #2 she witnessed Resident #1 slide his/her hands down on Resident #2's chest and kiss Resident #2 on the neck. The patients were separated by HA #1, and education was given to Resident #1 on why he/she could not and was not supposed to display those types of behaviors. Additionally, Resident #1 had no injuries observed at the time of the incident and was alert to person, place, time, and situation. Further review revealed Resident #1's POA and Physician were notified.

Review of SS documentation, on 06/30/2020, revealed she spoke with Resident #1 related to him/her kissing another resident. Additionally, the resident verbalized he/she remembered the rules but wanted to do it anyway because in the last facility where he/she resided, when the rules were broken, he/she was able to leave. SS stated Resident #1 wanted to leave the facility because he/she missed his/her boy/girlfriend and what they did together. Per documentation, Resident #1 was offered a vibrator and was informed the facility would reach out to the POA, Ombudsman, and other SS on another placement, which might be more, appropriate for his/her needs. Further, SS explained to the resident he/she would need to stay away from Resident #2, and Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

would be changing rooms and going to a different unit; Resident #1 verbalized agreement and understanding.

Observation of Resident #1, on 07/08/2020 at 3:00 PM, revealed the resident was sitting in a wheel chair in his/her room holding a cell phone.

Interview with Resident #1, on 07/08/2020 at 3:00 PM, revealed the resident said "hello and come in" when the State Inspector knocked on the door. Additionally, Resident #1 stated he/she did not recall any incident with another resident involving a kiss or touching the other resident's chest. Further, the resident did not recall Social Services or the DON talking with him/her about sexual behaviors or discharging from the facility.

2. Review of Resident #2's medical record revealed the facility admitted the resident on 09/17/19 with diagnoses including Occlusion and Stenosis of Vertebral Artery, Heart Failure, Aphasia, Abnormalities of Gait and Mobility, Spondylosis, Adult Failure to Thrive, Sleep Apnea, Alzheimer's Disease, Dementia, Wandering in Disease, Atrial Fibrillation, Type II Diabetes Mellitus, Anxiety, and Insomnia.

Review of Resident #2's Quarterly MDS Assessment, dated 05/27/2020, revealed the facility assessed the resident had clear speech, sometimes made self-understood, and sometimes had the ability to understand others. Continued review revealed the facility assessed the resident as having a BIMS score of zero (0) out of fifteen (15), indicating severe cognitive impairment. Additional review of the MDS assessment revealed the resident had signs and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9	F 600		

symptoms delirium/ inattention present and fluctuating. Further, the facility assessed the resident required extensive assistance of two (2) for transfers and ambulation and required supervision of one (1) with locomotion on the unit. Also, per assessment, the resident was independent with setup with locomotion off the unit.

Review of Resident #2's CCP, initiated on 09/18/2019, revealed a problem of an elopement risk/wanderer related to disorientation to place and impaired safety awareness. On 03/30/2020, a problem was revealed of a communication deficit related to difficulty expressing and processing information/thoughts due to Dementia. On 06/30/2020, the CCP was revised to include resident had tendencies to migrate toward other female rooms. The goals stated basic needs would be met, and the resident would not leave the facility unattended. Interventions, dated 09/18/2019, included distract the resident from wandering by offering pleasant diversions and wander guard to left ankle. On 03/30/2020, added interventions included speak facing the resident; use short phrases when communicating and allow time to respond; observe for non-verbal communication; and ask yes or no questions. On 06/30/2020, added interventions were fifteen (15) minute checks and provide a stop sign to rooms he/she tended to go into.

Review of the facility's Incident Report Investigation for Resident #2, dated 06/25/2020 at 12:05 AM and revised on 06/25/2020 at 3:36 PM, signed by LPN #2, revealed an SRNA alerted LPN #2 that Resident #2 was found with Resident #1 sucking on his/her neck and licking his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

ear. Additionally, the patients were separated and educated. Further, Resident #2 had no injuries observed at the time of the incident and was alert to person only.

Review of the facility's Incident Report Investigation for Resident #2, dated 06/30/2020 at 11:02 AM, signed by LPN #1, revealed HA #1 immediately reported she found Resident #1 with his/her hands on Resident #2's chest and kissing on his/her cheek. Additionally, the patients were separated, and education was given to Resident #1. Further, Resident #2 had no injuries observed at the time of the incident and was alert to person. Continued review revealed Resident #2's POA and Physician were notified.

Observation of Resident #2, on 07/08/2020 at 2:30 PM, revealed the resident sitting in a wheelchair in his/her room at the bedside. The call light was on above the door, and staff were assisting the resident. However, he/she was unable to state why the call light was on or what the need was when staff inquired. Further, the resident would not speak to the State Inspector. He/she would only make eye contact when the State Inspector attempted to talk with him/her.

Post Survey telephone interview with SRNA #1, on 07/13/ 2020 at 10:30 AM, revealed she had worked at the facility for one and one-half (1.5) years. Per interview, on 06/24/20202 at approximately 8:00 PM, she witnessed Resident #1 in the North Dayroom with Resident #2; Resident #1 was ambulatory and Resident #2 was seated in a wheelchair. She stated she observed Resident #1 bent over along the side of Resident #2. Continued interview revealed SRNA #1 thought Resident #1 was licking Resident #2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

but as she approached the residents, she realized Resident #1 was kissing Resident #2 on the neck. Additionally, SRNA #1 immediately knew this behavior was unacceptable and stated to Resident #1 "you cannot be touching, kissing, hugging on residents; you have been told about this." She revealed Resident #1 stated, "I just gave him/her a peck good night." Continued interview revealed SRNA #1 separated the residents, assisted Resident #2 to the nurses' station, directed Resident #1 to his/her room, and immediately reported the abuse to RN #1. Further, SRNA #1 stated Resident #1 had the mindset of a younger girl and was known for touching, hugging, and kissing on other staff and residents. Per interview, staff provided ongoing redirection to Resident #1 not to touch, hug, or kiss others, and the resident would say "ok, ok" and walk away. Per interview, Resident #2 was confused with poor safety awareness. Further, Resident #2 would wander into others rooms and staff constantly had to redirect him/her.

Continued interview with SRNA #1 revealed Resident #1's behaviors towards Resident #2, on 06/24/2020, were abuse. Additionally, staff (including nurses) were aware of his/her inappropriate behaviors (hugging and kissing) on others but had accepted it as a normal behavior for Resident #1 because of his/her mentality. Further, SRNA #1 stated Resident #1's behaviors, on 06/24/2020 toward Resident #2, were abuse because Resident #2 had Dementia and could not make sound decisions. Per interview, healthcare workers were the only voices for residents with Dementia and must advocate and protect residents and their rights. Further interview with SRNA #1 revealed she felt fifteen (15) minute checks were effective for the night of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

06/24/2020; however, there should have been additional interventions implemented on 6/25/2020 to protect residents.

Interview with RN #1, on 07/09/2020 at 3:30 PM, revealed she had worked at the facility for ten (10) months and had completed Resident #1's IR on 06/25/2020. Per interview, on 06/24/2020 around 10:00 PM, SRNA #1 reported she witnessed Resident #1 kiss and lick Resident #2's ear and neck and ask him/her if he/she liked it. Additionally, the residents were separated at that time, and fifteen (15) minute checks were initiated for both residents. Continued interview revealed RN #1 immediately called the DON to notify her of the abuse, and the DON came into building. Further, RN #1 completed a skin assessment for Resident #2 and notified the POA and Physician of the event.

Interview with HA #1, on 07/09/2020 at 1:02 PM, revealed she had worked at the facility for four (4) months. Per interview, Resident #1 was ambulatory and was able to make his/her needs known, and Resident #2 required supervision in his/her wheelchair because he/she was confused and could not make his/her needs know. Continued interview revealed, on 06/30/2020 around lunch, she was walking through the North Unit and witnessed Resident #1 standing behind Resident #2 sliding his/her hands down Resident #2's chest and kissing him/her on the cheek. Additionally, HA #1 immediately separated the residents and told Resident #1 not to rub or kiss other residents. Per interview, she immediately reported what was witnessed to LPN #2 and assisted Resident #2 to the nurses' station. Further, later that day Resident #1 was moved to another unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

Interview with LPN #2, on 07/09/2020 at 12:30 PM, revealed on 06/30/2020 around lunch time, HA #1 came to the nurses' station with Resident #2 and reported she had witnessed Resident #1 slide his/her hands down Resident #2's chest and kiss his/her cheek. Additionally, she immediately notified the DON, the Physician, and resident representatives. Per interview, Resident #1 had been on fifteen (15) minute checks since the first incident on 06/24/2020. LPN #2 stated the staff were worn out from trying to keep Resident #1 and Resident #2 apart since then. Further, on 06/30/2020, the day of the second occurrence, Resident #1 had a room change to another unit to protect Resident #2.

Interview with LPN #2, on 07/09/2020 at 12:30 PM, revealed she had worked at the facility for seven (7) months and completed the Incident Report Investigation for Resident #2 on 06/25/2020. Per interview, Resident #1 and Resident #2 were both independent with mobility and resided on the same hallway at the time of the incident, only two (2) doors apart. Resident #1 roamed a lot and required constant redirection and supervision. Continued interview revealed Resident #1 understood others; however, Resident #2 was confused and usually could not understand others or follow direction. Per interview, on 06/24/2020 at 8:00 pm, SRNA #1 reported to RN #1, who reported to her that Resident #1 and Resident #2 were in the North television room, and SRNA #1 witnessed Resident #1 kiss Resident #2 on the neck and lick his/her ear. Additionally, the residents had been separated, and Resident #1 was placed on fifteen (15) minute checks. Further, LPN #2 stated she had never seen Resident #1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14	F 600		

Resident #2 interact inappropriately to one another.

Interview with LPN #3, on 07/09/2020 at 12:52 PM, revealed she had worked at the facility for four (4) months. Continued interview revealed Resident #1 and Resident #2 would sit by one another, prior to the incident on 06/30/2020, at the nurses' station; however, there were no inappropriate interactions between them. LPN #3 stated Resident #1 and Resident #2 required redirection related to poor safety awareness. Additionally, on 06/30/2020 after lunch, LPN #3 stated she accompanied the DON to provide re-education to Resident #1 on sexual behaviors. Per interview, the DON explained to Resident #1 he/she could not kiss Resident #2 because he/she was incapable of making decisions and was married. Further, after the second incident on 06/30/2020, Resident #1 was trying to find Resident #2, and she revealed she had to keep reminding Resident #1 he/she could not sit near Resident #2. LPN #3 stated Resident #1 was moved off the unit to protect Resident #2.

Interview with SS, on 07/09/2020 at 2:08 PM, revealed she had worked at the facility for seven (7) months. Per interview, she received a message the night of 06/24/2020 about Resident #1 kissing Resident #2's neck. Per message, staff could not keep the residents apart, but they were trying to redirect them. Additionally, on 06/25/2020, the Clinical Interdisciplinary Team (IDT) meeting, which included department heads and administrative staff, discussed the occurrence between Resident #1 and Resident #2 and how fifteen (15) minute checks were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

implemented and staff were to ensure the residents were apart. However, there was no discussion about further approaches to increase supervision for both residents. Continued interview revealed, on 06/25/2020, she interviewed Resident #1 who stated he/she missed his/her boy/girlfriend and the things they did together sexually. Further, there was discussion about self-pleasure and how to meet one's needs. Continued interview revealed rules on his/her behavior were explained to Resident #1 related to consent and how some residents do not have the mental capacity to give consent, or the other resident could be married. Resident #1 voiced understanding and stated he/she would not do it again. Continued interview with SS revealed it was important to maintain and protect the well-being of residents because healthcare workers were resident advocates and protectors. Further, it was her expectation residents would be free from abuse, and it was important for resident rights and the facility's abuse policy to be maintained to ensure quality of life, health, safety, psychosocial well-being, quality of care, dignity and respect for all residents.

Interview with the DON, on 07/09/2020 at 4:53 PM, revealed she had worked at the facility for one (1) year. Per interview, she was notified by RN #1, on 06/24/2020 at 10:15 PM via a telephone call, that SRNA #1 witnessed Resident #1 and Resident #2 sitting in a dark room, and Resident #1 was licking and kissing Resident #2's ear and neck. Continued interview revealed she drove to the facility to ensure the residents were separated. Additionally, she read the facility policy and regulation on sexual abuse. The DON stated, she called the Clinical Support Nurse to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

discuss the occurrence, and at that time, she did not feel kissing and licking was sexual abuse but an unusual occurrence, a behavior. Per interview, she thought she had twenty-four (24) hours to report the "Unusual Occurrence" and wanted to investigate the occurrence more thoroughly. Continued interview with the DON revealed she spoke with Resident #1 and SS about the incident with Resident #2 on 06/25/2020, the day after the alleged incident. She stated she provided education immediately regarding sexual behaviors and not engaging with other residents without consent. Per interview, Resident #1 voiced understanding and stated he/she would not do it again. Further interview with the DON, revealed the facility did not immediately identify the incident, on 06/24/2020 as reported by SRNA #1 between Resident #1 and Resident #2, as an allegation of abuse. She stated she felt it was an unusual occurrence. Per interview, the occurrence should have been reported within two (2) hours of the incident, on 06/24/2020, and the facility should have increased supervision for both residents in order to prevent further potential abuse to Resident #2 or other residents.

Additional interview with the DON, on 07/09/2020 at 4:53 PM, revealed she was notified by LPN #2, on 06/30/2020 at 11:00 AM, that HA #1 witnessed Resident #1 and Resident #2 in the North Hallway, and Resident #1 walked up behind Resident #2 and rubbed his/her chest and kissed the side of his/her neck. Continued interview revealed she ensured the residents were separated. Additionally, she and LPN #3 went to Resident #1's room and talked to him/her about the re-occurrence with Resident #2. Per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17 interview, re-education was provided to Resident #1 on not engaging in sexual behaviors/desires with residents that could not give consent, and Resident #1 verbalized understanding. Further, Resident #1 and Resident #2 were placed on fifteen (15) minute checks, and a stop sign was placed across Resident #1's old room. Per interview, the facility made contact with outside resources to assist with placement at another facility per Resident #1's wishes. Further interview with the DON, revealed the facility did not identify the incident, on 06/30/2020, as reported by HA #1 between Resident #1 and Resident #2, as an allegation of abuse. She stated she felt it was an unusual occurrence. Per interview, the facility should have increased supervision for both residents in order to prevent the re-occurrence on 06/30/2020. Interview with the Administrator, on 07/09/2020 at 5:27 PM, revealed he had worked at the facility for eight (8) years. Additionally, he was in the hospital when the incident between Resident #1 and Resident #2 occurred and was not as involved with the investigation as he usually was. Per interview, the facility failed to identify the incidents as abuse, and residents had the right to be free from abuse with the facility ensuring this through policies, staff education, and regulation. Continued interview revealed all allegations of abuse should be reported within two (2) hours. Further, it was important to maintain a resident's right to be safe and free of abuse. Continued interview with the Administrator revealed the facility should provide adequate supervision to reduce risk factors that could be present to ensure resident safety.	F 600		
F 607	Develop/Implement Abuse/Neglect Policies	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607 SS=D	Continued From page 18 CFR(s): 483.12(b)(1)-(3)	F 607		

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of Kentucky Revised Statute (KRS) Chapter 209.030, and review of the facility's policy, it was determined the facility failed to ensure its abuse policy was implemented related to reporting allegations of abuse and protection from abuse for one (1) of three (3) sampled residents (Resident #2).

On 06/24/2020 at approximately 8:00 PM, State Registered Nurse Aide (SRNA) #1 witnessed Resident #1 standing close to and kneeling down beside Resident #2 in the North Hallway Dayroom. SRNA #1 walked closer to the residents and witnessed Resident #1 kiss Resident #2 on the neck. However, there was no documented evidence the facility implemented its written abuse policy related to reporting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 19	F 607		

alleged violation to State Agencies and protecting the resident throughout the investigation. Although the allegation was witnessed by SRNA #1 at 8:00 PM, the Director of Nursing (DON) was not notified of the allegation until 10:15 PM and the State Agencies were not notified of the allegation until 06/25/2020 at 1:36 PM; seventeen (17) hours and thirty-six (36) minutes later. Additionally, there was no documented evidence adequate supervision was provided to the residents after the facility learned of the allegation.

(Refer to F-600, F-609, F-656, and F-689)

The findings include:

Review of the facility's policy, "Alleged Abuse/Potential Neglect/Exploitation Reporting/Investigation," dated 06/01/2017, revealed the facility provided an environment that promoted dignity and respect for residents that prohibited abuse. Per the policy, allegations were to be reported to the supervisor and the resident's charge nurse. Persons receiving the report were to immediately inform the Administrator and if the Administrator was unavailable, it was to be reported to the Director of Nursing (DON). Per policy, interventions to protect residents should be taken to avoid potential harm during the investigation process. Further, allegations of abuse would be reported to the appropriate regulatory and investigative agencies in accordance with state requirements.

Review of KRS Chapter 209.030, revealed an oral or written report was to be made immediately to State Agencies upon knowledge of suspected abuse, neglect, or exploitation of an adult.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 20	F 607		

Review of the Long Term Care Facility-Self Reported Incident Form/ Initial Report, faxed to the Office of Inspector General (OIG), on 06/25/2020 at 1:36 PM, revealed a "resident to resident occurrence" happened on 06/24/2020. SRNA #1 witnessed Resident #1 kiss and lick the neck of Resident #2. Further review revealed residents were separated, and there were no signs or symptoms of injury noted.

There was no documented evidence the facility policy was implemented related to reporting abuse to the State Agencies in accordance to state requirements, or immediately. Although the allegation was initially reported to the facility, on 06/24/2020 at 8:00 PM, State Agencies were not notified of the allegation until 06/25/2020 at 1:36 PM.

Review of the Long Term Care Facility-Self Reported Incident Form/ Five (5) day/Follow up/Final Report revealed, on 06/25/2020, Social Services (SS) and the DON interviewed Resident #1 who stated he/she did kiss the Resident #2 because he/she was looking for a boy/girlfriend since he/she could not see his/her boy/girlfriend. Additional review revealed education was provided to Resident #1 related to appropriateness for finding an unmarried mate, ensuring consent was given by the other resident. Resident #1 voiced understanding and agreed not to engage in these activities with Resident #2.

There was no documented evidence the facility's policy was implemented related to protection of abuse throughout an investigation as there was no increased supervision for Resident #1 or Resident #2 other than fifteen (15) minute checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 21	F 607		

for Resident #1.

Further review of another Long Term Care Facility-Self Reported Incident Form/ Initial Report, faxed to the OIG, on 06/30/2020 at 1:26 PM, related to a "resident to resident occurrence" which happened on 06/30/2020. Hospitality Aide (HA) #1 witnessed Resident #1 kiss the neck of Resident #2. Additionally, skin assessments were completed, and there were no signs or symptoms of injury noted. Further, the report revealed Resident #1 was provided education and placed on fifteen (15) minute checks.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 06/10/19 with diagnoses including Sequelae of Cerebral Infarction, Depressive Disorder, Mild Intellectual Disability, Hypertension, Fibromyalgia, Homonymous Bilateral Field Defects (left), and Type II Diabetes Mellitus.

2. Review of Resident #2's medical record revealed the facility admitted the resident on 09/17/19 with diagnoses including Occlusion and Stenosis of Vertebral Artery, Heart Failure, Aphasia, Abnormalities of Gait and Mobility, Spondylosis, Adult Failure to Thrive, Sleep Apnea, Alzheimer's Disease, Dementia, Wandering in Disease, Atrial Fibrillation, Type II Diabetes Mellitus, Anxiety, and Insomnia.

Post Survey telephone interview with SRNA #1, on 07/13/ 2020 at 10:30 AM, revealed, on 06/24/2020 at approximately 8:00 PM, she witnessed Resident #1 in the North Dayroom with Resident #2; Resident #1 was ambulatory and Resident #2 was seated in a wheelchair. Continued interview revealed SRNA #1 thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 22	F 607		

Resident #1 was licking Resident #2, but as she approached the residents, she realized Resident #1 was kissing Resident #2 on the neck. Additionally, SRNA #1 immediately knew this behavior was unacceptable and stated to Resident #1 "you cannot be touching, kissing, hugging on residents; you have been told about this." She revealed Resident #1 stated "I just gave him/her a peck good night." Continued interview revealed SRNA #1 separated the residents, assisted Resident #2 to the nurses' station, directed Resident #1 to his/her room, and immediately reported the Abuse to RN #1. Further, SRNA #1 stated Resident #1 had the mindset of a younger girl and was known for touching, hugging, and kissing on other staff and residents. Per interview, staff provided ongoing redirection to Resident #1 not to touch, hug, or kiss others, and the resident would say "ok, ok" and walk away. Per interview, Resident #2 was confused with poor safety awareness. Further, Resident #2 would wander into other rooms, and staff constantly had to redirect him/her. Further interview with SRNA #1 revealed she felt fifteen (15) minute checks were effective for the night of 06/24/2020; however, there should have been additional interventions implemented on 06/25/2020 to protect the residents.

Interview with Licensed Practical Nurse (LPN) #2, on 07/09/2020 at 12:30 PM, revealed Resident #1 and Resident #2 were both independent with mobility and resided on the same hallway at the time of the incident, only two (2) doors apart. Additionally, Resident #1 roamed a lot and required constant redirection and supervision. Continued interview revealed Resident #1 understood others; however, Resident #2 was confused and usually could not understand others

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 23	F 607		

or follow direction. Further, on 06/24/2020 at 8:00 pm, Registered Nurse (RN) #1 reported to her that Resident #1 and Resident #2 were in the North television room when SRNA #1 witnessed Resident #1 kiss Resident #2 on the neck and lick his/her ear.

Interview with Social Services (SS), on 07/09/2020 at 2:08 PM, revealed she received a message the night of 06/24/2020 about Resident #1 kissing Resident #2's neck. Also, per message, staff could not keep the residents apart. Additionally, on 06/25/2020, the Clinical Interdisciplinary Team (IDT) meeting, which included department heads and administrative staff, discussed the occurrence between Resident #1 and Resident #2 and how fifteen (15) minute checks were implemented and staff were to ensure the residents were apart. However, there was no discussion about further approaches to increase supervision for both residents. Continued interview revealed, on 06/25/2020, she interviewed Resident #1 who stated he/she missed his/her boy/girlfriend and the things they did together sexually. Further, there was discussion about self-pleasure and how to meet one's needs. Continued interview revealed rules on his/her behavior were explained to Resident #1 related to consent and how some residents do not have the mental capacity to give consent, or the other resident could be married. Resident #1 voiced understanding and stated he/she would not do it again.

Interview with the DON, on 07/09/2020 at 4:53 PM, revealed she was notified by RN #1, on 06/24/2020 at 10:15 PM via a telephone call, that SRNA #1 witnessed Resident #1 and Resident #2 sitting in a dark room, and Resident #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 24 licking and kissing Resident #2's ear and neck. Additionally, she read the facility policy and regulation on sexual abuse. The DON stated she called the Clinical Support Nurse to discuss the occurrence, and at that time, she did not feel kissing and licking was sexual abuse but an unusual occurrence, a behavior. Per interview, she thought she had twenty-four (24) hours versus two (2) hours to report the "Unusual Occurrence" and wanted to investigate the occurrence more thoroughly. Further interview with the DON revealed, after the 06/24/2020 occurrence, the facility should have increased supervision for both residents in order to prevent further potential abuse to Resident #2 or other residents. Interview with the Administrator, on 07/09/2020 at 5:27 PM, revealed he was in the hospital when the incident between Resident #1 and Resident #2 occurred and was not as involved with the investigation as he usually was. Per interview, all allegations of abuse should be reported within two (2) hours. Further interview revealed the facility should provide adequate supervision to reduce risk factors that could be present to ensure resident safety. Per interview, it was his expectation that staff would follow the facility's policy and state regulations.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 25	F 609		

mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of Kentucky Revised Statutes (KRS), and review of the facility's policy, it was determined the facility failed to ensure all alleged violations involving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 26	F 609		

abuse or neglect, were reported immediately, but no later than two (2) hours after the allegation was made, to State Agencies for one (1) of three (3) sampled residents (Resident #2).

On 06/24/2020 at approximately 8:00 PM, State Registered Nurse Aide (SRNA) #1 witnessed Resident #1 standing close to and kneeling down beside Resident #2. Resident #1 kissed Resident #2 on the neck. Although the allegation was witnessed by SRNA #1 at 8:00 PM, the Director of Nursing (DON) was not notified of the allegation until 10:15 PM and the State Agencies were not notified of the allegation until 06/25/2020 at 1:36 PM; seventeen (17) hours and thirty-six (36) minutes later.

(Refer to F-600 and F-607)

The findings include:

Review of KRS Chapter 209.030, revealed an oral or written report was to be made immediately to State Agencies upon knowledge of suspected abuse, neglect, or exploitation of an adult.

Review of the facility's policy, "Alleged Abuse/Potential Neglect/Exploitation Reporting/Investigation," dated 06/01/2017, revealed allegations of abuse were to be reported to the supervisor and the resident's charge nurse. Per the policy, persons' receiving the report were to immediately inform the Administrator. Continued review revealed allegations of abuse would be reported to the appropriate regulatory and investigative agencies in accordance with state requirements.

Review of the Long Term Care Facility-Self

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 27	F 609		

Reported Incident Form/ Initial Report, faxed to the Office of Inspector General (OIG), on 06/25/2020 at 1:36 PM, revealed a "resident to resident occurrence" happened on 06/24/2020. SRNA #1 witnessed Resident #1 kiss and lick the neck of Resident #2. Further, the residents were separated, and there were no signs or symptoms of injury noted.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 06/10/19 with diagnoses including Sequelae of Cerebral Infarction, Depressive Disorder, Mild Intellectual Disability, Hypertension, Fibromyalgia, Homonymous Bilateral Field Defects (left), and Type II Diabetes Mellitus.

Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 06/17/2020, revealed the facility assessed the resident had clear speech, made self-understood, and had the ability to understand others. Continued review revealed the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating intact cognition. Additional review of the Annual MDS Assessment, Section E - Behavior, revealed the facility assessed behavior not exhibited for Resident #1. Further, the facility assessed the resident required supervision of one (1) for transfers and ambulation, but Resident #1 was independent with setup with locomotion on and off the unit.

Review of the facility's Incident Report (IR) for Resident #1, dated 06/25/2020 at 12:05 AM, signed by RN #1, revealed SRNA #1 alerted RN #1 she witnessed Resident #1 sucking on Resident #2's neck 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	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 28	F 609		

educated. Additionally, Resident #1 had no injuries observed at the time of the incident and was alert to person, place, time, and situation. Per the IR, Nursing Administration was in the facility, and an investigation was underway. In addition, fifteen (15) minute checks and labs were immediately done on Resident #1. Further review revealed Resident #1 stated he/she was not sucking or licking on Resident #2; he/she gave Resident #2 a kiss on the cheek because he/she was looking for a boy/girlfriend to take care of him/her before the resident representative passed away.

Observation of Resident #1, on 07/08/2020 at 3:00 PM, revealed the resident sitting in a wheelchair in his/her room holding a cell phone.

Interview with Resident #1, on 07/08/2020 at 3:00 PM revealed the resident stated "hello and come in" when the State Inspector knocked on the door. Additionally, Resident #1 stated he/she did not recall any incident with another resident involving a kiss or touching the other resident's chest. Further, the resident did not recall Social Services (SS) or the Director of Nursing (DON) talking with him/her about sexual behaviors/desires or discharging from the facility.

2. Review of Resident #2's medical record revealed the facility admitted the resident on 09/17/19 with diagnoses including Occlusion and Stenosis of Vertebral Artery, Heart Failure, Aphasia, Abnormalities of Gait and Mobility, Spondylosis, Adult Failure to Thrive, Sleep Apnea, Alzheimer's Disease, Dementia, Wandering in Disease, Atrial Fibrillation, Type II Diabetes Mellitus, Anxiety, and Insomnia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 29	F 609		

Review of Resident #2's Quarterly MDS Assessment, dated 05/27/2020, revealed the facility assessed the resident had clear speech, sometimes made self-understood, and sometimes had the ability to understand others. Continued review revealed the facility assessed the resident had a BIMS score of zero (0) out of fifteen (15), indicating severe cognitive impairment. Additional review of the MDS assessment revealed the resident had signs and symptoms delirium/inattention present and fluctuating. Further, the facility assessed the resident required extensive assistance of two (2) for transfers and ambulation, supervision of one (1) with locomotion on the unit, and was independent with setup with locomotion off the unit.

Review of the facility's IR for Resident #2, dated 06/25/2020 at 12:05 AM and revised on 06/25/2020 at 3:36 PM, signed by LPN #2, revealed an SRNA alerted LPN #2 that Resident #2 was found with Resident #1 sucking on his/her neck and licking his/her ear. Additionally, the patients were separated and educated. Further, Resident #2 had no injuries observed at the time of the incident and was alert to person only.

Post Survey telephone interview with SRNA #1, on 07/13/ 2020 at 10:30 AM, revealed, on 06/24/2020 at approximately 8:00 PM, she witnessed Resident #1 in the North Dayroom with Resident #2; Resident #1 was ambulatory, and Resident #2 was seated in a wheelchair. Resident #1 was bent over along the side of Resident #2. Continued interview revealed SRNA #1 thought Resident #1 was licking Resident #2, but as she approached the residents, she realized Resident #1 was kissing Resident #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 30	F 609		

the neck. Additionally, SRNA #1 immediately knew this behavior was unacceptable and stated to Resident #1 "you cannot be touching, kissing, hugging on residents; you have been told about this." She revealed Resident #1 stated "I just gave him/her a peck good night." Further interview revealed SRNA #1 separated the residents, assisted Resident #2 to the nurses' station, directed Resident #1 to his/her room, and immediately reported the abuse to RN #1.

Interview with RN #1, on 07/09/2020 at 3:30 PM, revealed on 06/24/2020 around 10:00 PM, SRNA #1 reported she witnessed Resident #1 kiss and lick Resident #2's ear and neck and ask him/her if he/she liked it. Additionally, the residents were separated at that time and fifteen (15) minute checks were initiated for both residents. Further interview revealed RN #1 immediately called the DON to notify her of the Abuse, and the DON came into building.

Interview with the DON, on 07/09/2020 at 4:53 PM, revealed she was notified by RN #1, on 06/24/2020 at 10:15 PM via a telephone call, that SRNA #1 witnessed Resident #1 and Resident #2 sitting in a dark room, and Resident #1 was licking and kissing Resident #2's ear and neck. Continued interview revealed she drove to the facility to ensure the residents were separated. Additionally, she read the facility policy and regulation on sexual abuse. The DON stated she called the Clinical Support Nurse to discuss the occurrence, and at that time, she did not feel kissing and licking was sexual abuse but it was an unusual occurrence, a behavior. Per interview, she thought she had twenty-four (24) hours to report the "Unusual Occurrence" and wanted to investigate it more thoroughly. Further,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 31 if there was an allegation of abuse, it was her expectation State Agencies were to be notified timely as per facility policy. Per interview, the occurrence should have been reported within two (2) hours on 06/24/2020. Interview with the Administrator, on 07/09/2020 at 5:27 PM, revealed he had worked at the facility for eight (8) years. Additionally, he was in the hospital when the incident between Resident #1 and Resident #2 occurred and was not as involved with the investigation as he usually was. Per interview, the facility failed to identify the incidents as abuse, and residents had the right to be free from abuse with the facility ensuring this through policies, staff education, and regulation. Continued interview revealed all allegations of abuse should be reported within two (2) hours.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 32	F 656		

provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS), "Resident Assessment Instrument (RAI) Manual 3.0," it was determined the facility failed to develop and implement a comprehensive person-centered care plan related to supervision for one (1) of three (3) sampled residents (Resident #1).

On 06/24/2020 at approximately 8:00 PM, State

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 33	F 656		

Registered Nurse Aide (SRNA) #1 witnessed Resident #1 kiss Resident #2 on the neck. Additionally, on 06/30/2020 at approximately 11:00 AM, Hospitality Aide (HA) #1 witnessed Resident #1 rub his/her hands down the front of Resident #2's chest and kiss Resident #2 on the cheek.

The facility failed to develop and implement the Comprehensive Care Plan (CCP), on 06/24/2020, with additional interventions to address Resident #1's problems and risks, to ensure each resident was provided adequate supervision and remained free from abuse. Therefore, abuse reoccurred on 06/30/2020.

(Refer to F-600, F-607, and F-689)

The findings include:

Review of CMS, "Resident Assessment Instrument (RAI) Manual 3.0," dated October 2016, revealed the CCP was an interdisciplinary communication tool which must include measurable objectives and time frames and must describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Additionally, the CCP should identify and implement interventions and treatments to address the individual's physical, functional, psychosocial needs, concerns, problems, and risks. Further, the care plan was driven by effective clinical decision making and identified resident needs to ensure quality of care and quality of life needs of individual residents were met.

Review of Resident #1's medical record revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 34	F 656		

the facility admitted the resident on 06/10/19 with diagnoses including Sequelae of Cerebral Infarction, Depressive Disorder, Mild Intellectual Disability, Hypertension, Fibromyalgia, Homonymous Bilateral Field Defects (left), and Type II Diabetes Mellitus.

Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 06/17/2020, revealed the facility assessed the resident had clear speech, made self-understood, and had the ability to understand others. Continued review revealed the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating intact cognition. Additional review of the Annual MDS Assessment, Section E - Behavior, revealed the facility assessed behavior not exhibited for Resident #1. Further, the facility assessed the resident required supervision of one (1) for transfers and ambulation, but the resident was independent with setup with locomotion on and off the unit.

Review of Resident #1's CCP, initiated on 06/26/2020, revealed a problem of "sexually active: resident experiencing sexual desires and expresses interest in other residents." The CCP was revised on 06/30/2020 to include "resident declined vibrator." The goal stated the resident would voice understanding of what inappropriate sexual behaviors were toward other residents and would be provided time alone as needed for self-pleasure. The CCP interventions included: 06/25/2020, place on fifteen (15) minute checks; assist with private time to self-pleasure; educate resident on the definition of consent and inappropriate sexual behaviors toward others; provide information and offer vibrator; and observe for changes in psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 35	F 656		

However, there was no further documented evidence the facility identified the need to develop and implement additional interventions and treatments to address the increased need for supervision of Resident #1 to protect other residents throughout the investigation except for the fifteen (15) minutes checks initiated on 06/25/2020.

Review of Fifteen (15) Minute Checks for Resident #1, on 06/30/2020, revealed the resident was in the bathroom from 10:45 AM until 12:00 PM. However, HA #1 witnessed Resident #1 on the North Hallway at approximately 11:00 AM rubbing his/her hands down the front of Resident #2's chest and kissing Resident #2 on the cheek.

Interview with HA #1, on 07/09/2020 at 1:02 PM, revealed she used the CCP to know what care each resident needed. Further, it was important for the CCP to include approaches the staff could use to ensure residents were provided adequate supervision to keep them safe.

Post Survey telephone interview with SRNA #1, on 07/13/ 2020 at 10:30 AM, revealed she used the CCP to know how to provide care to each resident. Additionally, if residents required increased supervision, the CCP would note the specific intervention for the resident, such as fifteen (15) minute checks or one (1) on one (1) care for residents with behaviors that would affect others. Further, she stated it was important for the CCP to be developed and implemented for increased supervision of residents with behaviors to ensure safety for all residents.

Interview with Social Services (SS), on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 36	F 656		

07/09/2020 at 2:08 PM, revealed the CCP should be developed and implemented to ensure continuity of care and meet each resident's needs. Additionally, it was important for staff to provide adequate supervision to all residents to ensure their safety. Further, it was the facility's responsibility to identify, develop, and implement interventions to address the individual resident's needs, concerns, problems, and risks to ensure quality of care and to protect the well-being of residents.

Interview with RN #1, on 07/09/2020 at 3:30 PM, revealed the CCP was utilized by the Interdisciplinary Team (IDT) as a communication tool on how to provide adequate care to each resident. Additionally, the CCP should include interventions to meet ongoing changes with residents. Further, it was important to ensure residents with behaviors received adequate supervision to ensure the safety and well-being of all residents and to decrease the risk for negative outcomes.

Interview with MDS Coordinator, on 07/09/2020 at 4:43 PM, revealed she had worked at the facility for five (5) years. Additionally, the IDT worked collaboratively to identify, develop, and implement the CCP for each individual resident per the RAI Guidelines. Per interview, it was important for individual needs and specific care needs and approaches to be included on the CCP to ensure quality of care. Further, safety and supervision interventions ensured residents were provided a safe environment and minimized the risk for adverse effects.

Interview with the Director of Nursing (DON), on 07/09/2020 at 4:53 PM, revealed at the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 37 the occurrence, on 06/24/2020, she did not feel kissing and licking was sexual abuse but a behavior. Additionally, she did not think Resident #1 would have the same behaviors again toward Resident #2 because in discussion with Resident #1, on 06/25/2020, the resident verbalized he/she would not kiss Resident #2 again. Therefore she felt fifteen (15) minute checks for Resident #1 was an effective intervention to ensure resident safety. However, she stated the facility should have implemented increased supervision for both residents in order to prevent further potential abuse to Resident #2 or other residents after the 06/24/2020 occurrence. Further, the DON revealed it was important to develop and implement the CCP to ensure residents were provided adequate supervision to protect them from any type of abuse. Interview with the Administrator, on 07/09/2020 at 5:27 PM, revealed he expected the IDT to identify problems and risks for residents. Additionally, he expected the IDT to develop and implement the CCP to include approaches to minimize risk factors that might be present. Further, it was important to identify, develop, and implement the CCP to ensure quality care and resident safety.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38	F 689		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident receives adequate supervision for one (1) of three (3) sampled residents (Resident #2).

On 06/24/2020 at approximately 8:00 PM, State Registered Nurse Aide (SRNA) #1 witnessed Resident #1 kiss Resident #2 on the neck. Additionally, on 06/30/2020 at approximately 11:00 AM, Hospitality Aide (HA) #1 witnessed Resident #1 rub his/her hands down the front of Resident #2's chest and kiss Resident #2 on the cheek. Further, the facility failed to provide residents adequate supervision to ensure each resident remained free from abuse, and abuse reoccurred, on 06/30/2020 at approximately 11:00 AM.

(Refer to F-600, F-607, and F-656)

The findings include:

Review of the facility's policy, "Safety and Supervision of Residents," revised July 2017, revealed it was the facility's priority to make the environment free from accident hazards to ensure resident safety, supervision, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39	F 689		

assistance to prevent accidents. Continued review revealed the facility used a dual approach to safety, facility oriented and individualized resident centered, which were used together to implement a systems approach to safety. Additionally, resident supervision was a core component of the systems approach to safety. Per policy, the type and frequency of resident supervision was determined by the individual resident's assessed needs and identified hazards in the environment. Further, the type of frequency of resident supervision could vary among residents and over time for the same resident. Per policy, supervision might need to be increased for temporary hazards or change in a resident's condition. Additional review of the policy revealed facility oriented approaches included identifying accident hazards through ongoing monitoring and reporting processes. Per policy, individualized resident centered approaches included analyzing information obtained from assessments and observations to identify specific hazards or risks for individual residents. Further, the care team targeted interventions to reduce individualized risks related to hazards in the environment, including adequate supervision. Continued review of the policy revealed implementing interventions to reduce accident hazards would include: communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions; providing necessary training; ensuring interventions were implemented; and documenting interventions. Additionally, monitoring the effectiveness of interventions included: ensuring interventions were implemented correctly and consistently; evaluating the effectiveness of interventions; modifying or replacing interventions as needed;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40	F 689		

and evaluating the effectiveness of new or revised interventions.

Review of the Long Term Care Facility-Self Reported Incident Form/ Initial Report, faxed to the Office of Inspector General (OIG), on 06/25/2020 at 1:36 PM, revealed a "resident to resident occurrence" happened on 06/24/2020. Continued review revealed SRNA #1 witnessed Resident #1 kiss and lick the neck of Resident #2. Per report, the Physician, POA, Administration, OIG, Adult Protective Services (APS), the Attorney General, and the Department for Community Based Services (DCBS) were notified. Additionally, there were no signs or symptoms of injury noted. Further, this incident occurred seventeen (17) hours and thirty-six (36) minutes prior to the Initial Report and notifications.

Review of the Long Term Care Facility-Self Reported Incident Form/ Five (5) day/Follow up/Final Report, faxed to OIG, on 07/01/2020 at 11:30 PM, (six (6) days after the initial report), revealed there was a "resident to resident occurrence" on 06/24/2020. Continued review revealed SRNA #1 witnessed Resident #1 kiss and lick the neck of Resident #2. Additionally, the residents were immediately separated, and no signs or symptoms of injury were noted. Further review revealed, on 06/25/2020, SS and the DON interviewed Resident #1 who stated he/she did kiss the resident because he/she was looking for a boy/girlfriend since he/she could not see his/her boy/girlfriend. Additional review revealed education was provided to Resident #1 related to appropriateness for finding a mate, ensuring consent and ensuring the person was not married. Resident #1 voiced understanding and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41	F 689		

agreed not to engage in these activities with Resident #2. Per the report, the facility unsubstantiated abuse or any harm based on their investigation and determined the Root Cause of the incident was related to Resident #1 having the mindset of a teenager and trying to satisfy his/her basic needs of companionship. Per report, Resident #2 had no injuries or signs and/or symptoms of any harm occurring from the incident; remained on fifteen (15) minute checks; and continued monitoring for any other psychological needs would be done by SS.

Review of the Long Term Care Facility-Self Reported Incident Form/ Initial Report, faxed to the OIG, on 06/30/2020 at 1:26 PM, revealed a "resident to resident occurrence" happened on 06/30/2020. Continued review revealed HA #1 witnessed Resident #1 kiss the neck of Resident #2. Per report, the Physician, POA, Administration, OIG, APS, the Attorney General, and DCBS were notified. Additionally, skin assessments were completed, and there were no signs or symptoms of injury noted. Further, Resident #1 was provided education and placed on fifteen (15) minute checks.

Review of the Long Term Care Facility-Self Reported Incident Form/ Five (5) day/Follow up/Final Report, faxed to OIG, on 07/07/2020 at 8:43 PM (seven (7) days after OIG received the Initial Report), revealed there was a "resident to resident occurrence" on 06/30/2020. Continued review revealed HA #1 witnessed Resident #1 kiss the neck of Resident #2. Additionally, the residents were immediately separated, and no signs or symptoms of injury were noted. Further review of the report revealed, on 06/30/2020, SS and the DON interviewed Resident #1. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42	F 689		

#1 stated he/she did kiss Resident #2 and did it again because he/she wanted to move out of the facility. Continued review revealed the facility discussed discharge planning. Additional review revealed re-education was provided to Resident #1, and he/she voiced understanding and agreed not to engage in these activities with Resident #2. Per the report, the facility unsubstantiated abuse or any harm based on their investigation and determined the Root Cause of the incident was related to Resident #1 trying to find companionship and wanting to move out of the facility. Per report, Resident #2 had no injuries or signs and/or symptoms of any harm occurring from the incident, and he/she remained on fifteen (15) minute checks with a stop sign placed across Resident #1's old room. Further, SS would continue to monitor for any other psychological needs.

Review of Resident #1's medical record revealed the facility admitted the resident on 06/10/19 with diagnoses including Sequelae of Cerebral Infarction, Depressive Disorder, Mild Intellectual Disability, Hypertension, Fibromyalgia, Homonymous Bilateral Field Defects (left), and Type II Diabetes Mellitus.

Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/17/2020, revealed the facility assessed the resident had clear speech, made self-understood, and had the ability to understand others. Continued review revealed the facility assessed the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating intact cognition. Additional review of the Annual MDS Assessment, Section E - Behavior, revealed the facility assessed behavior not exhibited for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 43	F 689		

Resident #1. Further, the facility assessed the resident required supervision of one (1) for transfers and ambulation, but Resident #1 was independent with setup with locomotion on and off the unit.

Review of Resident #1's Comprehensive Care Plan (CCP), initiated on 06/26/2020, revealed a problem of "sexually active: resident experiencing sexual desires and expresses interest in other residents." The CCP was revised on 06/30/2020 to include "resident declined vibrator." The goal stated the resident would voice understanding of what inappropriate sexual behaviors were toward other residents and would be provided time alone as needed for self-pleasure. The CCP interventions included: 06/25/2020, place on fifteen (15) minute checks; assist with private time to self-pleasure; educate resident on the definition of consent and inappropriate sexual behaviors toward others; provide information and offer vibrator; and observe for changes in psychosocial well-being, dated 06/26/2020. However, there was no further documented evidence the facility identified the need to develop and implement additional interventions and treatments to address the increased need for supervision of Resident #1 to protect other residents throughout the investigation except for the fifteen (15) minutes checks initiated on 06/25/2020.

Review of Fifteen (15) Minute Checks for Resident #1, on 06/30/2020, revealed the resident was in the bathroom from 10:45 AM until 12:00 PM. However, HA #1 witnessed Resident #1 on the North Hallway at approximately 11:00 AM rubbing his/her hands down the front of Resident #2's chest and kissing Resident #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44	F 689		

the cheek. Additional review of Fifteen (15) Minute Checks revealed no documented evidence of who completed them. The monitoring form was not developed to include the signature or title of staff completing each check.

Observation of Resident #1, on 07/08/2020 at 3:00 PM, revealed the resident was sitting in a wheel chair in his/her room holding a cell phone.

Interview with Resident #1, on 07/08/2020 at 3:00 PM, revealed the resident said "hello and come in" when the State Inspector knocked on the door. Additionally, Resident #1 stated he/she did not recall any incident with another resident involving a kiss or touching the other resident's chest. Further, the resident did not recall Social Services or the DON talking with him/her about sexual behaviors or discharging from the facility.

Review of Resident #2's medical record revealed the facility admitted the resident on 09/17/19 with diagnoses including Occlusion and Stenosis of Vertebral Artery, Heart Failure, Aphasia, Abnormalities of Gait and Mobility, Spondylosis, Adult Failure to Thrive, Sleep Apnea, Alzheimer's Disease, Dementia, Wandering in Disease, Atrial Fibrillation, Type II Diabetes Mellitus, Anxiety, and Insomnia.

Review of Resident #2's Quarterly MDS Assessment, dated 05/27/2020, revealed the facility assessed the resident had clear speech, sometimes made self-understood, and sometimes had the ability to understand others. Continued review revealed the facility assessed the resident as having a BIMS score of zero (0) out of fifteen (15), indicating severe cognitive impairment. Additional review of the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45	F 689		

assessment revealed the resident had signs and symptoms delirium/ inattention present and fluctuating. Further, the facility assessed the resident required extensive assistance of two (2) for transfers and ambulation and required supervision of one (1) with locomotion on the unit. Also, per assessment, the resident was independent with setup with locomotion off the unit.

Review of Resident #2's CCP, initiated on 09/18/2019, revealed a problem of an elopement risk/wanderer related to disorientation to place and impaired safety awareness. On 03/30/2020, a problem was revealed of a communication deficit related to difficulty expressing and processing information/thoughts due to Dementia. On 06/30/2020, the CCP was revised to include resident had tendencies to migrate toward other female rooms. The goals stated basic needs would be met, and the resident would not leave the facility unattended. Interventions, dated 09/18/2019, included distract the resident from wandering by offering pleasant diversions and wander guard to left ankle. On 03/30/2020, added interventions included speak facing the resident; use short phrases when communicating and allow time to respond; observe for non-verbal communication; and ask yes or no questions. On 06/30/2020, added interventions were fifteen (15) minute checks and provide a stop sign to rooms he/she tended to go into.

Observation of Resident #2, on 07/08/2020 at 2:30 PM, revealed the resident sitting in a wheelchair in his/her room at the bedside. The call light was on above the door, and staff were assisting the resident. However, he/she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 46	F 689		

unable to state why the call light was on or what the need was when staff inquired. Further, the resident would not speak to the State Inspector. He/she would only make eye contact when the State Inspector attempted to talk with him/her.

Post Survey telephone interview with SRNA #1, on 07/13/ 2020 at 10:30 AM, revealed Resident #1 had the mindset of a younger girl and was known for touching, hugging, and kissing on others, staff and residents. Per interview, staff provided ongoing redirection not to touch, hug or kiss others to Resident #1, and the resident would say "ok, ok" and walk away. Per interview, Resident #2 was confused with poor safety awareness; he/she would wander into other rooms, and staff constantly had to redirect him/her. Additional interview with SRNA #1 revealed she felt fifteen (15) minute checks were effective for the night of 06/24/2020; however, there should have been additional interventions implemented on 06/25/2020 to protect residents. Further, it was important for residents with behaviors to have increased supervision to ensure all residents remained safe.

Interview with Licensed Practical Nurse (LPN) #2, on 07/09/2020 at 12:30 PM, revealed Resident #1 and Resident #2 were both independent with mobility and resided on the same hallway at the time of the incident, only two (2) doors apart until 06/30/2020. Additionally, Resident #1 roamed a lot and required constant redirection and supervision. Continued interview revealed Resident #1 understood others; however, Resident #2 was confused and usually could not understand others or follow direction. Further, LPN #2 stated staff should provide approaches/interventions to meet the ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 47	F 689		

changes with residents, and it was important to ensure residents with behaviors received adequate supervision to ensure the safety and well-being of all residents and to decrease the risk for negative outcomes.

Interview with Social Services (SS), on 07/09/2020 at 2:08 PM, revealed on 06/25/2020, the Clinical Interdisciplinary Team (IDT) meeting, which included department heads and administrative staff, discussed the occurrence between Resident #1 and Resident #2 and how fifteen (15) minute checks was the approach implemented to ensure the residents were apart. However, there was no discussion about modifying the approach or implementing further approaches to increase supervision for both residents until the second occurrence of abuse, on 06/30/2020. Additionally, she stated she interviewed Resident #1, on 06/25/2020, who stated he/she missed his/her boy/girlfriend and the things they did together sexually and that was why he/she kissed Resident #2. Per interview, there was discussion about self-pleasure and rules related to sexual desires to which Resident #1 voiced understanding and stated he/she would not do it again. However, after speaking with Resident #1, she did not identify the need for increased supervision beyond fifteen (15) minute checks. Further, she revealed it was the facility's responsibility to identify approaches/interventions to address the individual resident's risks to ensure quality of care, to protect from harm, and to ensure his/her well-being.

Interview with the Director of Nursing (DON), on 07/09/2020 at 4:53 PM, revealed she was notified on 06/24/2020 at 10:15 PM via a telephone call, that SRNA #1 witnessed Resident #1 licking and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 48	F 689		

kissing Resident #2's ear and neck. Additionally, on 06/24/2020, she read the facility policy and regulation on sexual abuse. The DON stated she called the Clinical Support Nurse to discuss the occurrence, and at that time, she did not feel kissing and licking was sexual abuse but it was an unusual occurrence, a behavior. Per interview, she did not think Resident #1 would have the same behaviors again toward Resident #2 because in discussion with Resident #1, on 06/25/2020, the resident verbalized he/she would not kiss Resident #2 again. Therefore, she felt fifteen (15) minute checks for Resident #1 was an effective approach/intervention to ensure resident safety. However, the facility did not identify the need to modify or increase supervision, to prevent further potential abuse to Resident #2 or other residents, until after the 06/30/2020 occurrence. Further, the DON stated it was important to ensure residents were provided adequate supervision to protect them from any type of abuse.

Interview with the Administrator, on 07/09/2020 at 5:27 PM, revealed he was in the hospital when the incident between Resident #1 and Resident #2 occurred and was not as involved with the investigation as he usually was. Per interview, the facility should identify and provide adequate supervision to reduce risk factors that may be present to ensure resident safety. Further, he stated adequate supervision was important to ensure quality care and resident safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 07/08/2020 and concluded on 07/09/2020. It was determined there were no concerns with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

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

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

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100355	A. BUILDING: _____ B. WING _____	C 07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments 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.	N 000		

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