STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY31768 and KY32136) and a COVID-19 focused infection control survey was initiated on 07/28/2020 and concluded on 08/04/2020. Both complaints were substantiated and deficient practice was identified with the highest scope and severity at "G" level. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The total census was 76. Resident #3 had a history of aggressive behavior toward other residents. The facility failed to implement interventions that protected Resident #2 and Resident #4 from abuse. On 07/16/2020 at 3:40 PM, Resident #4 wandered into Resident #3's room. Resident #3 struck Resident #4 on the face because Resident #4 did not leave the room immediately. Then on 07/25/2020, Resident #2 was wandering in the hallway outside of Resident #3's room. Resident #3 shoved Resident #2, causing Resident #2 to fall to the floor. Resident #2 sustained a non-displaced fracture of the pelvis as a result of the fall.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to	F 563		

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
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 563	Continued From page 1 a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and the facility's visitation policy, it was determined that the facility failed to ensure end of life visitation rights were honored one (1) of three (3) sampled residents (Resident #1). Review of the record for Resident #1 revealed the resident's health status had declined over a three (3) month period, with a significant mental/physical change assessment performed on 03/04/2020. Further review of the record revealed a significant decline in Resident #1's health status was noted on 05/12/2020 during which the family was notified. The family requested visitation; however, the family was not given the opportunity to visit at that time and Resident #1 expired on 05/14/2020 at	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 563	Continued From page 2 approximately 6:15 AM without receiving visitors. The findings include: The facility provided a copy of the Centers for Medicare and Medicaid Services (CMS) recommended guidelines that suggest limiting visitation in long-term care (LTC) facilities during the COVID-19 outbreak, which made allowances for residents with end of life concerns to receive visitation. Interview with the facility Administrator on 07/30/2020 at 2:00 PM revealed the facility was using the CMS guidance as well as recommendations from the Centers for Disease Control and Prevention (CDC) when considering visitors in the facility at this time. Record review revealed that Resident #1 was admitted to the facility on 12/29/2019 with diagnoses that include Type 2 Diabetes with long-term use of insulin, Heart Failure, Chronic Kidney Disease, Muscle Wasting, Pulmonary Fibrosis, Epilepsy, Supraventricular Tachycardia, Unspecified Osteoarthritis, Anxiety, and Vascular Dementia without behavioral disturbances. Review of the Minimum Data Set (MDS) assessment, dated 03/04/2020 and performed due to a "significant change" in Resident #1's health status, revealed Resident #1's cognition had moderate impairment with a brief interview for mental status (BIMS) score of 10. Further review of Resident #1's MDS assessment revealed that he/she listed the question, "How important is it to you to have your family or a close friend involved in discussions about your care?" as "1- Very Important." Further review of Resident #1's records revealed that a care plan meeting was held on 02/28/2020 at 2:07 PM to discuss Resident #1's mental and physical	F 563		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 563	Continued From page 3	F 563		

declines and change in health status, including that Resident #1 "has not rebounded from acute illnesses as it was thought they might."

Further review of the record for Resident #1 revealed a nursing progress note dated 05/12/2020 at 11:55 AM that stated the physician was notified due to a decline in the resident's status. The resident was unable to sit up and was holding food in his/her mouth and not wanting to swallow it. The note further revealed that the physician offered no new orders. Another nursing progress note dated 05/12/2020 at 9:19 PM revealed the resident did not meet his/her fluid need for the day because the resident was "declining." Nursing Progress notes for 05/13/2020 at 8:00 AM and 6:07 PM revealed Resident #1 was refusing to eat, breathing hard, not talking or responding when spoken to, and was weak. Review of a nursing progress note dated 05/14/2020 revealed that at 4:00 AM staff checked on the resident; the resident was resting and vital signs were obtained. Further review of the nursing progress notes for 05/14/2020 revealed at 5:51 AM, Resident #1 had labored breathing and the resident's skin was mottling (a condition where the heart is no longer able to pump blood effectively and the skin becomes discolored). The note also stated that the family was notified of the changes and was on their way to the facility. The progress notes for 05/14/2020 further revealed that at 6:15 AM, Resident #1 did not have a pulse or respirations and that the family arrived at approximately 6:30 AM.

An interview conducted with Resident #1's family member on 08/04/2020 at 11:26 AM revealed she received a call on Sunday, 05/10/2020, from a nurse at the facility (did not remember who) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 563	Continued From page 4	F 563		

was told that Resident #1 was declining. She stated someone from the facility called again on 05/12/2020 and stated that the resident's condition was continuing to decline. She stated she asked the nurse if her family member was dying and was told that she was probably getting close to death. The family member stated that she reached out to the Director of Nursing (DON) on 05/13/2020 and requested a visit because it appeared that her family member was dying. She stated the DON told her that the Administrator would be calling regarding the visitation; however, she did not receive a phone call from the Administrator. She stated she received a call early in the morning on 05/14/2020 and was told she should come to the facility because Resident #1 was dying. The family member stated that she had not visited Resident #1 since the restrictions were put into place due to the pandemic and did not request to visit until she was told by nursing staff at the facility that they felt Resident #1 was getting close to death. The family member stated that Resident #1 died before the family arrived at the facility.

Interview with Registered Nurse (RN) #4 on 08/04/2020 at 10:49 AM revealed she remembered calling the family on a Sunday (she did not recall the exact date) and discussing with the family that the resident was not eating well and was declining. RN #4 stated the family did not request a visit at that time and she was not aware if they ever requested a visit. RN #4 stated the Administrator would make the decision during this time as to whether family could visit or not due to the restrictions related to the pandemic.

The DON resigned on 07/31/2020 and was unavailable for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 563	Continued From page 5 Interview with the Administrator on 08/04/2020 at 3:12 PM revealed that she and the previous Infection Preventionist had a meeting about Resident #1 on 05/12/2020 because the family had requested to visit with the resident and the facility was only allowing visits for end of life situations. The Administrator stated that the resident's health had fluctuated, but they told the family they would have a meeting to discuss whether they could visit and get back with them. The Administrator further stated that she could not remember all of the details but she thought the DON at the time had talked with the family as well. The Administrator stated the resident passed before they had a chance to decide if the family could visit.	F 563		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two (2) of four (4) sampled residents (Residents #2 and #4) were free from abuse. On 07/16/2020 at 3:40 PM, Resident #4 wandered into Resident #3's room. Resident #3 struck Resident #4 on the face because Resident #4 did not leave the room immediately. Then on 07/25/2020, Resident #2 was wandering in the hallway outside of Resident #3's room. Resident #3 shoved Resident #2, causing Resident #2 to fall to the floor. Resident #2 sustained a non-displaced fracture of the pelvis as a result of the fall. The findings include: Review of the facility policy titled, "Policy on Abuse," (undated) revealed the facility will actively promote the absence of abuse and the resident has the right to be free from abuse. The policy further defined abuse as the willful infliction of injury with resulting physical harm, pain, or mental anguish. The facility defined willful as the individual must have acted deliberately, not that the individual intended to inflict harm. Review of the medical record for Resident #3 revealed the facility admitted the resident on 07/01/2009 and the resident's diagnoses included Schizophrenia, Mental Retardation, and Anxiety Disorder. Further review of the record revealed the Minimum Data Set (MDS) assessment completed on 05/27/2020 was an annual assessment and documented that the resident did not exhibit behaviors. The MDS further noted that the resident's Brief Interview for Mental	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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		

Status (BIMS) score was six (6) which indicated severe cognitive impairment. Review of the progress notes for the resident revealed the resident displayed aggressive/combative behavior toward staff on 01/21/2020, and on 03/04/2020 Resident #3 threw coffee on another resident in the hallway and hit the resident on the back of the head when the resident was in Resident #3's way. Review of the facility investigation dated 03/06/2020 revealed the facility investigated the incident and determined that there were no injuries related to the incident.

Review of the comprehensive care plan revealed Resident #3 had a potential for alteration in mood/behavior that was initiated on 04/25/2017 and revised on 06/08/2020. The interventions included to assist the resident in getting snacks and coffee as requested, educate the resident to allow others plenty of time to move out of the way, and to get older staff members to do care when the resident will not allow others to help. Further review of the care plan revealed the resident did not like change and the resident had a history of hitting staff when staff removed coffee cups from his/her room and also that Resident #3 was reluctant to interact with others.

Interviews with staff that worked with Resident #3 including the Social Services Director on 07/29/2020 at 2:55 PM, State Registered Nursing Assistant (SRNA) #1 on 07/30/2020 at 4:26 PM, and SRNA #2 on 07/30/2020 at 4:34 PM, revealed Resident #3 was "territorial" and did not like "to be bothered", would get agitated easily, and did not like for people to be in his/her way.

1. Review of the medical record for Resident #4 revealed the resident was admitted on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 09/09/2019 with diagnoses that include Dementia Alzheimer's Disease, Anxiety Disorder, and Chronic Obstructive Pulmonary Disease (COPD). Review of the quarterly MDS assessment completed on 05/06/2020 revealed the resident displayed wandering behavior one (1) to three (3) days during the lookback period. Further review of the MDS revealed Resident #4's BIMS score was one (1) indicating severe cognitive impairment and that the resident was not interviewable. Review of the care plan revealed interventions for the wandering behavior initiated on 03/03/2020 which included redirecting the resident from wandering by offering diversional activities such as food or a doll. Review of a facility investigation dated 07/16/2020 revealed at 3:40 PM, Resident #4 wandered into Resident #3's room. The investigation stated that Resident #3 asked Resident #4 to leave the room; however, Resident #4 did not understand the request. Resident #3 then became aggressive toward Resident #4 and hit Resident #4 on the left side of the face with his/her fist. The investigation further revealed a State Registered Nursing Assistant (SRNA) heard screaming and went to the room to separate the residents, but "it was over." Resident #3's roommate reported that he/she saw the event as it was reported. Resident #4 was removed from the room and was noted to have redness to the left side of the face/cheek and the left hand, and Resident #4 complained of pain to the left hand. The investigation further revealed that x-rays were ordered and completed of Resident #4's face and hand with no fractures or dislocations noted. Interview with Licensed Practical Nurse (LPN) #1	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 on 7/31/2020 at 10:22 AM revealed she worked on the East Wing where Resident #4 and Resident #3 resided. LPN #1 stated she was not working when the incident occurred between the residents, but had been told about the incident. LPN #1 stated that she was not aware of any changes made to Resident #3's care plan or Resident #4's care plan after the incident. The LPN further stated that they "just tried" to keep Resident #4 out of that area after the incident and no further interventions were put into place to prevent wandering residents from entering Resident #3's room. Interviews with SRNA #3 on 07/31/2020 at 10:31 AM and with SRNA #4 on 08/01/2020 at 9:03 AM revealed that they worked on the East Wing where Resident #3 and Resident #4 resided. Both of the SRNAs stated they were not working when the incident occurred between Resident #3 and Resident #4 and were not aware of the incident. In addition, both stated they were not aware of any changes that had been made to the care plans for the residents. Interview with Resident #9 on 07/30/2020 at 12:20 PM revealed he/she was Resident #3's roommate before the resident was moved on 07/25/2020. Resident #9 stated that when the incident occurred between Resident #3 and Resident #4, he/she was coming out of the bathroom and saw Resident #3 hit Resident #4 in the face. Resident #9 stated he called for help and staff came and took Resident #4 out of the room. Resident #9 did not know if Resident #4 sustained injuries from the incident. Review of the record for Resident #9 revealed the resident's BIMS score was fifteen (15) indicating that the resident was cognitively intact.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 Review of the Care Plan for Resident #3 revealed it was revised on 07/16/2020 with an intervention for the resident to be seen by telehealth psychiatric services. Further review of the record revealed Resident #3 had routine telehealth psychiatric visits every four (4) weeks and had previously been seen on 06/25/2020. Resident #3 was seen on 07/23/2020 by telehealth for the routine visit. The psychiatric nurse practitioner recommended an increase in the resident's Risperdal (anti-psychotic medication) which was approved and initiated on 07/25/2020. There was no evidence of any other interventions initiated for Resident #3 related to the incident. Interview with the Social Services Director on 08/04/2020 at 1:40 PM revealed she investigated the incident between Resident #3 and Resident #4. She stated that Resident #4 did wander in the facility, but did not usually go down the hallway where Resident #3 resided. She stated the only interventions they put into place after the incident was the psychiatric consultation for Resident #3, and to redirect Resident #4 when wandering. 2. Review of the medical record for Resident #2 revealed the resident was admitted to the facility on 02/25/2020 with diagnoses that included Alzheimer's Dementia and COPD. Review of the quarterly MDS assessment with a reference date of 05/20/2020 revealed the resident had wandering behavior one (1) to three (3) days during the reference period. Further review of the MDS revealed the resident's BIMS score was two (2) indicating severe cognitive impairment and that the resident was not interviewable. Review of the Comprehensive Care Plan with an initiation	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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		

date of 02/25/2020 and revision date of 05/21/2020 revealed Resident #2 was at risk for elopement due to wandering behavior and the interventions for the wandering behavior included to redirect the resident to the lounge when he/she was wandering toward the exits or to other residents' rooms.

Review of the facility's final investigation dated 07/29/2020 revealed on 07/25/2020 at approximately 6:00 PM, Resident #2 wandered down the hallway where Resident #3 resided. The investigation further stated that Resident #3 came out of his/her room and Resident #2 was in Resident #3's pathway and Resident #3 then pushed/shoved Resident #2 out of his/her way. Resident #2 "fell/sat" down on the floor as a result of the push and Resident #2 complained of pain to the lower back and buttocks. The investigation further stated that x-rays were performed and a CT (computerized tomography) scan was completed and Resident #2 had a non-displaced fracture of the right inferior pubic ramus (pelvis).

Interview with Resident #9 on 07/30/2020 at 12:20 PM revealed he/she was in the bathroom when the incident occurred between Resident #2 and Resident #3. Resident #9 stated when he/she came out of the bathroom, Resident #2 was on the floor and he heard yelling. Resident #9 stated that staff responded quickly to the incident.

Interview with Resident #10 on 07/30/2020 at 12:15 PM revealed he/she witnessed the incident with Resident #2 and Resident #3 on 07/25/2020. Resident #10 stated he/she was in his/her room and the incident happened in the hallway just outside of his/her room, which was directly across

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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		

the hallway from Resident #3's room. Resident #10 stated that Resident #2 was walking in the hallway and Resident #3 "pushed" Resident #2 causing Resident #2 to fall. Resident #10 stated that Resident #2 "wasn't doing anything" when Resident #3 pushed him/her. Resident #10 stated that he/she called out for help and staff responded "right away" to take care of Resident #2. Review of the list of residents with their BIMS scores provided by the facility revealed the BIMS score for Resident #10 was fifteen (15) indicating Resident #10 was cognitively intact.

Interview with SRNA #3 on 07/31/2020 at 10:31 AM revealed she was working on 07/25/2020 when the incident occurred between Resident #2 and Resident #3. She stated she was in the dining room when the incident occurred. SRNA #3 further stated that Resident #2 "wanders all over East Wing" and the resident is easily redirected. SRNA #3 stated she was unaware of Resident #3 being aggressive toward other residents prior to this incident.

Interview with SRNA #5 on 07/29/2020 at 2:10 PM revealed she was working on 07/25/2020 when the incident occurred between Resident #2 and Resident #3. She stated she heard another resident yell that Resident #3 pushed Resident #2. She stated that Resident #2 was on the floor and the nurses came and assessed the resident and assisted the resident to his/her room. SRNA #5 stated that Resident #3 can be aggressive and has been aggressive toward staff and other residents in the past.

Interview with Registered Nurse (RN) #1 on 07/29/2020 at 2:30 PM revealed she was working on 07/25/2020 when the incident occurred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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		

between Resident #2 and Resident #3. She stated that another resident called out and when they arrived Resident #2 was on the floor and complained that his/her "back and bottom" were hurting. RN #1 stated the other nurse that was working assessed Resident #2 and she assessed Resident #3. She stated Resident #3 had no injuries and that when Resident #3 was asked about the incident, he/she stated, "[he/she] was in my way."

Interview with RN #2 on 07/29/2020 at 2:03 PM revealed she was working on 07/25/2020 when the incident occurred. She stated she is the Quality Assurance (QA) Nurse for the facility and was in the building assisting the nurses. RN #2 stated that she saw Resident #2 sitting on the floor and complaining of pain in his/her back. RN #2 stated she assessed Resident #2 for injuries and called the doctor and got an order for an x-ray. She stated Resident #2 was able to ambulate back to his her room, but did so slower than usual. RN #2 stated that Resident #2 was known to wander on East Wing hall and often went into other residents' rooms. She stated that they would try to redirect the resident and some of the residents would notify staff when Resident #2 was going into other residents' rooms. RN #2 stated staff had a difficult time "keeping up with" Resident #2. Further interview with RN #2 revealed that she talked to Resident #3 after the incident with Resident #2 and Resident #3 admitted to pushing Resident #2.

Interview with the Social Services Director on 07/29/2020 at 2:55 PM and on 08/04/2020 at 1:40 PM revealed she does the abuse investigations for the facility and investigated the incidents with Resident #2, Resident #3, and Resident #4. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 stated that Residents #2 and #4 were known to wander on the East Wing of the facility and Resident #3 was known to be "territorial" and did not like to be bothered. She stated that the facility decided to move Resident #3 to a different wing of the facility after the incident with Resident #2 because there were fewer residents who wander on the West Wing. The Social Services Director stated that they did not implement any further interventions after the incident on 07/16/2020 with Resident #4 because Resident #4 did not usually wander on the hallway where Resident #3 resided, and they did not consider concerns with other residents who wandered. Interview with the Administrator on 08/04/2020 at 3:12 PM revealed that any time there is an allegation of abuse, she is notified. She stated that the investigation did reveal that Resident #3 pushed Resident #2 and the decision was made to move Resident #3 to a different wing. The Administrator stated she was unaware of interventions that were put into place after the incident on 07/16/2020 with Resident #3 and Resident #4 and that the former Director of Nursing (DON) would know more about the incident; however, the former DON was unavailable to be interviewed at that time.	F 600		
F 657 SS=G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 657	Continued From page 15 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the care plan for one (1) of four (4) sampled residents (Resident #3) was reviewed and revised related to aggressive behaviors. Resident #3 had a history of aggressive behavior toward other residents. On 03/04/2020, Resident #3 hit Resident #6 on the back of the head and "dashed cold coffee" on Resident #6 after Resident #6 accidently bumped into Resident #3. On 07/16/2020, Resident #4 wandered into Resident #3's room and Resident #3 hit Resident #4 in the face with his/her fist. However, the facility failed to revise Resident #3's	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 657	Continued From page 16	F 657		

care plan to address the resident's aggression toward other residents. On 07/25/2020, Resident #2 was wandering in the hallway near Resident #3's room when Resident #3 pushed Resident #2 causing Resident #2 to fall to the floor. Resident #2 sustained a non-displaced fracture of the pelvis as a result of the fall.

The findings include:

Review of the facility policy titled, "Behavior Management Policy," dated 11/01/2019, revealed residents "will be monitored at least quarterly and PRN [as needed] for care plan effectiveness and revisions as indicated."

Review of the medical record for Resident #3 revealed the resident was admitted to the facility on 07/01/2009 with diagnoses that included Schizophrenia, Mental Retardation, and Anxiety Disorder. Further review of the record revealed the Minimum Data Set (MDS) assessment completed 05/27/2020 was an annual assessment and documented that the resident did not exhibit behaviors. The MDS further noted that the resident's Brief Interview for Mental Status (BIMS) score was six (6) which indicates severe cognitive impairment.

Review of the progress notes for Resident #3 revealed the resident displayed aggressive/combative behavior toward staff on 01/21/2020. The progress note revealed that Resident #3 hit a State Registered Nursing Assistant (SRNA) in the face during care.

Review of the comprehensive care plan revealed Resident #3 had a potential for alteration in mood/behavior that was initiated on 04/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 657	Continued From page 17	F 657		

and revised on 06/08/2020. The interventions included to assist the resident in getting snacks and coffee as requested, educate the resident to allow others plenty of time to move out of the way, and to get older staff members to do care when the resident will not allow others to help. Further review of the care plan revealed that Resident #3 did not like change, had a history of hitting staff when staff removed coffee cups from his/her room, and was reluctant to interact with others. The care plan did not include person-centered interventions related to Resident #3's aggressive behaviors toward other residents.

Review of facility investigations revealed that Resident #3 was involved in resident-to-resident altercations on 07/24/2019, 03/04/2020, 07/16/2020, and 07/25/2020.

Review of the facility investigation dated 07/26/2019 revealed on 07/24/2019 at approximately 4:45 PM, Resident #3 was in the dining room sitting at a table with Resident #5, and Resident #3 "dashed" Resident #5 with cold coffee. The investigation further noted that there were no injuries and the resident's care plans were updated. Review of the comprehensive care plan for Resident #3 revealed an intervention initiated on 07/24/2019 related to the resident-to-resident altercation to encourage the resident to ask for assistance with coffee and not to dash it on others. Other interventions were to observe for mood changes and report to the physician and do a pharmacy review as needed.

Review of the facility investigation dated 03/06/2020 revealed that on 03/04/2020 at approximately 12:40 PM, Resident #6 was propelling his/herself in a wheelchair in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 657	Continued From page 18	F 657		

hallway and accidentally bumped into Resident #3. Resident #3 hit Resident #6 on the back of the head and "dashed cold coffee" on Resident #6. The investigation noted that Resident #6 did not sustain any injury related to the incident and Resident #6 was moved to a different room (the residents were roommates at the time). Further review of the investigation revealed that the actions taken to protect residents included an update of the care plan. However, review of Resident #3's care plan revealed no new interventions after the 03/04/2020 incident.

Review of the facility investigation dated 07/20/2020 revealed on 07/16/2020 at approximately 3:40 PM, Resident #4 "walked/wandered" into Resident #3's room. The investigation stated that Resident #3 asked Resident #4 to leave the room, but Resident #4 did not understand so Resident #3 "became aggressive" and hit Resident #4 on the left side of the face with his/her fist. The investigation further stated that the actions taken to protect residents were that the care plans were updated. Review of the care plan revealed that the interventions that were put into place after the incident on 07/16/2020 were to follow up with psychiatric services at the next visit and to do a medication review to see if the resident's medication "needs adjusting for behaviors." Further review of the care plan revealed no other interventions to address the resident's aggression toward other residents.

Review of the facility investigation dated 07/29/2020 revealed on 07/25/2020 at approximately 6:00 PM, Resident #2 wandered down the hallway where Resident #3 resided. Resident #3 came out of his/her room and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 657	Continued From page 19	F 657		

Resident #2 was in his/her pathway and Resident #3 "pushed/shoved" Resident #2 and Resident #2 "fell/sat" down on the floor. The investigation further revealed that Resident #2 sustained a fracture of the pubic ramus (pelvis) as a result of the incident.

Interview with State Registered Nursing Assistant (SRNA) #2 on 07/30/2020 at 4:34 PM revealed that Resident #3 was independent with most of his/her activities of daily living and did not like it when others "get in [his/her] way."

Interview with SRNA #3 on 07/31/2020 at 10:31 AM revealed Resident #3 could get aggressive at times, but it was usually with staff. She stated the resident was "protective" of his/her belongings and did not like others to bother his/her belongings.

Interview with Licensed Practical Nurse (LPN) #2 on 07/30/2020 at 4:11 PM revealed she was the MDS (Minimum Data Set) Nurse for the East Wing of the facility. She further stated that she did not do the section of the MDS related to behaviors. Per the LPN, the Social Services Director (SSD) did that section of the MDS and the behavior care plan as well, and then the Interdisciplinary Team (IDT) reviewed the care plan.

Interview with the SSD on 08/04/2020 at 1:40 PM revealed she does the behavior section on the MDS and develops the care plan with the IDT. She stated that the facility has a "behavior meeting" monthly and reviews incidents of behaviors in the morning meetings. The SSD further stated the monthly behavior meeting focused on review of the psychotropic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 657	Continued From page 20 medications and the morning clinical meeting focused more on behaviors. She stated that she does not "necessarily have the documents of the behaviors" to review and that the staff "just know the residents" and their behaviors. The SSD stated she can make revisions to the behavior care plan when necessary and that the team tried to put interventions in place for Resident #3 to prevent the aggressive behavior.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 07/28/2020 and concluded on 08/04/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		

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
	100526	A. BUILDING: _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	20 COUNTY BARN ROAD BOONEVILLE, KY 41314

(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 investigation (KY31768 and KY32136) and a COVID-19 focused infection control survey was initiated on 07/28/2020 and concluded on 08/04/2020. The complaint was substantiated and deficient practice was identified pursuant to 42 CFR 483.10-483.95. No deficient practice was identified related to the infection control survey.	N 000		

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