STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. BUILDING _____ B. WING _____	C 06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKCASTLE HEALTH AND REHABILITATION CENTER	371 WEST MAIN STREET BRODHEAD, KY 40409

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F 000	INITIAL COMMENTS An abbreviated standard survey (KY31883) and a COVID-19 focused infection control survey was initiated on 06/24/2020 and concluded on 06/29/2020. The complaint was substantiated and deficient practice was identified with the highest scope and severity at "D" level. The facility was found to be in compliance with 42 CFR 483.80 Infection Control and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The total census was 92.	F 000		
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 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.	F 609		

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.

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F 609	Continued From page 1 §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, and a review of the facility abuse/neglect policy, it was determined the facility failed to ensure that three (3) allegations of abuse/neglect for one (1) of three (3) sampled residents (Resident #1) were reported to facility Administration and the required state agencies. On 03/27/2020, 05/07/2020, and 06/22/2020, Resident #1's family member reported concerns regarding the resident's care to the facility (left in urine, an untreated cough, and/or not shaved/long fingernails). The facility failed to report the allegations to facility Administration and to state agencies. The findings include: A review of the facility's "Abuse, Neglect and Misappropriation of Property" policy, revised 05/08/2019, revealed all alleged violations of	F 609		

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F 609	Continued From page 2 neglect were required to be reported immediately to the Facility Administrator and appropriate state agencies in accordance with federal law. Further review of the policy revealed the Facility Administrator was the abuse coordinator and would direct the reporting of allegations and findings to required agencies. A review of the medical record for Resident #1 revealed the facility admitted the resident on 04/12/2019 with diagnoses that included Diabetes Mellitus Type II, Dementia, and Depression. A review of Resident #1's Brief Interview for Mental Status (BIMS) score of 15, dated 11/04/2019, indicated the resident had no cognition impairments. Further review revealed on 06/27/2020 the resident's BIMS score was 11, indicating the resident had impaired cognition but was able to be interviewed. An interview with Resident #1's family member on 06/23/2020 at 3:34 PM revealed the resident called the family member when facility staff were not caring for the resident appropriately (due to COVID-19, the family member was not permitted to visit inside the facility). She stated Resident #1 called in March and May 2020 because he/she was lying in urine and could not get staff to assist him/her. The family member also stated the resident had a cough in May and she requested that the resident go to the hospital. Further interview revealed that in May 2020, Licensed Practical Nurse (LPN) #1 threatened Resident #1 during incontinence care and stated she would not give the resident coffee. Further interview with Resident #1's family member revealed she visited the facility on 06/22/2020 and talked with the resident through the facility glass door. She stated the resident had not been assisted with	F 609		

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F 609	Continued From page 3 grooming, he/she had not been shaven, hair was dirty, and fingernails were long. She stated a staff member (last name unknown) was going into the facility while she was visiting and she told the staff member that she "was tired" of the facility neglecting to care for Resident #1. 1. Review of Resident #1's nurse's notes revealed on 03/27/2020 at approximately 3:30 AM, Resident #1's family member called Licensed Practical Nurse (LPN) #1 because the resident was lying in urine. According to the nurse's note, staff went to the resident's room and "changed" the resident. An interview conducted with Resident #1 on 06/24/2020 at 10:16 AM and on 06/25/2020 at 12:05 PM, revealed staff would not check on the resident at night and would let the resident lie in urine. The resident could not recall specific dates that this occurred, but stated he/she contacted his/her family member when the incidents occurred. An interview with LPN #1 on 06/25/2020 at 9:20 AM confirmed that Resident #1's family member called her (could not recall the exact date) and stated that the resident was lying in urine. She stated she and SRNA #3 checked on the resident and provided care. LPN #1 stated the resident did not normally have incontinence episodes, but often spilled urine from his/her urinal. LPN #1 stated she documented the family member's call/concern in the nursing notes, but did not report the allegation to the Administrator because she did not consider that it was an allegation of neglect. 2. Further review of Resident #1's nurse's notes	F 609		

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F 609	Continued From page 4 revealed on 05/07/2020 at 3:47 AM, Resident #1's family member contacted LPN #1 because the resident had called the family member and told her that he/she was coughing and staff were not doing anything. According to the note, the family member was upset and was going to notify Social Services. Continued interview with Resident #1's family member on 06/23/2020 at 3:34 PM revealed she was upset after the call on 05/07/2020 because LPN #1 hung up on her when she told the nurse that someone needed to check on the resident. The family member stated that Resident #1 also told her afterward that when LPN #1 was assisting him/her with incontinence care, the LPN threatened the resident and told him/her that she would not give the resident coffee because she had to clean the resident. The family member stated she reported the allegation to the social worker the next morning and the social worker and Administrator told her that LPN #1 would no longer provide care for Resident #1. Continued interview with Resident #1 on 06/24/2020 at 10:16 AM and on 06/25/2020 at 12:05 PM, revealed the resident had called Family Member #1 and told her that LPN #1 would not let the resident have coffee at night. He/she stated he/she sometimes woke up early in the morning and wanted coffee. He/she stated the other nurse would get coffee for the resident; however, LPN #1 would not get coffee for the resident. The resident stated he/she felt like the LPN tried to "bully" the resident, but the resident was not afraid of the LPN. Continued interview with LPN #1 on 06/25/2020 at 9:20 AM revealed the LPN had received calls	F 609		

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F 609	Continued From page 5 from Resident #1's family member regarding allegations made by Resident #1. The LPN could not recall the dates, but stated she documented the calls in the nurse's notes. According to the LPN, on 05/07/2020 the family member called because the resident called and told her that staff were not taking care of him/her and that he/she wanted to go to the hospital. LPN #1 stated she assessed the resident and gave the resident some cough medication, but did not feel that the resident needed to go to the hospital. The LPN stated she did tell the resident that he/she could not have coffee. She stated she did not give any resident coffee at night because "they [residents] are supposed to be sleeping." According to LPN #1, she notified the West Wing Unit Manager that the family member was upset because she thought the LPN hung up on her, but did not consider the resident/family member's concerns as an allegation of neglect and did not report the allegations to the Administrator. Interview with the West Wing Unit Manager on 06/25/2020 at 11:04 AM confirmed that LPN #1 notified her that she had a disagreement with Resident #1's family member on the phone. The Unit Manager stated she was not sure what was discussed between them, but was not aware any allegations of neglect were made. Interview with the Social Worker on 06/25/2020 at 11:30 AM revealed she talked to Resident #1's family member on 05/07/2020 and she was upset that LPN #1 hung up on her and asked that the LPN not care for Resident #1 anymore. The Social Worker stated she was not aware of an allegation that LPN #1 denied the resident coffee or that the resident had not received care for a cough.	F 609		

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F 609	Continued From page 6 An interview with the Administrator on 06/29/2020 at 10:03 AM revealed the social worker reported that Resident #1 and LPN #1 had a "conflict" and she arranged it so that the LPN did not provide care for the resident any longer. The Administrator stated she was not notified nor aware that any allegations of neglect/abuse had been made regarding Resident #1. 3. An interview with State Registered Nurse Aide (SRNA) #1 on 06/25/2020 at 7:58 AM revealed she was at the facility for a COVID-19 Lab test (exact date unknown). The SRNA stated FM #1 was visiting Resident #1 outside the facility door and the family member informed her that she was tired of the facility neglecting the resident. The family member reported the facility was not shaving and grooming the resident. According to the SRNA, she immediately informed the West Wing Unit Manager of the allegation made by the resident's family member. Interview with the West Wing Unit Manager on 06/25/2020 at 11:04 AM revealed she was aware that Resident #1's family member visited the resident that week and recalled the family member saying the resident did not look clean. The Unit Manager stated she explained to the family member that the resident refused showers and shaving, but did not consider it an allegation of neglect. Further interview revealed the Unit Manager denied that SRNA #1 reported that the family member alleged the resident was being neglected. An interview with the Administrator on 06/29/2020 at 10:03 AM revealed she had not been informed of any allegations of neglect/abuse related to	F 609		

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F 609	Continued From page 7 Resident #1. The Administrator stated the allegations should have been reported to her immediately.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility policy for nail grooming it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) received the necessary services to maintain grooming. Resident #1 was observed with long toenails and fingernails, which had not been trimmed. The findings include: A review of the facility policy titled "Nail Grooming," with a revision date of 05/18/18 revealed nursing staff would provide observation and care of nails for all residents daily and as necessary. Interview with the West Wing Unit Manager on 06/25/2020 at 11:04 AM revealed nurses were responsible to trim residents' nails during weekly skin assessments. A review of the medical record for Resident #1 revealed the facility admitted the resident on 04/12/2019 with diagnoses that included Diabetes Mellitus Type II, Muscle Weakness, and Lack of	F 677		

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F 677	Continued From page 8 Coordination. A review of the most recent Minimum Data Set (MDS) Assessment completed for Resident #1 dated 04/19/2020 revealed the resident was assessed to require the extensive assistance of two staff members for personal hygiene. Further review of the assessment revealed the resident's Brief Interview for Mental Status score was not listed because the resident refused to participate in the assessment. A review of the BIMS assessment completed on 06/25/2020 revealed the resident was moderately impaired for cognition with a score of eleven (11). An interview with Family Member #1 on 06/23/2020 at 3:34 PM revealed the Family Member had visited Resident #1 on 06/22/2020 and had complained to faculty staff that Resident #1 had not been groomed. A review of a skin assessment dated 06/21/2020 revealed the assessment did not address the resident's nails nor nail care. Review of the nurse's notes dated 06/21/2020 revealed no evidence that Resident #1 refused nail care. Observation of photographs of Resident #1 taken by Family Member #1 on 06/22/2020 revealed the resident's fingernails were long and not trimmed. Observation of Resident #1's fingernails and toenails during a skin assessment conducted on 06/24/2020 at 10:50 AM revealed the resident's toenails and fingernails were long and had not been trimmed. Interview with Resident #1 on 06/24/2020 at 10:16 AM revealed the resident had not been offered nail care nor had he/she refused nail care.	F 677		

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F 677	Continued From page 9 The resident stated, "I wish they would cut my nails." Interview with Registered Nurse (RN) #1 on 06/29/2020 at 9:10 AM, revealed RN #1 had conducted the skin assessments on Resident #1 on 06/21/2020 and on 06/24/2020. According to RN #1, she had not noticed the resident's nails being long or in need of trimming. Continued interview with the West Wing Unit Manager on 06/25/2020 at 11:04 AM revealed she made rounds daily to ensure residents received adequate grooming/nail care and had not noticed Resident #1's nails were untrimmed.	F 677		

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 06/24/2020 and concluded on 06/29/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		

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N 000	Initial Comments A complaint investigation (KY31883) and a COVID-19 focused infection control survey was initiated on 06/24/2020 and concluded on 06/29/2020. 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		

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