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	185141	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF GEORGETOWN	102 POCAHONTAS TRAIL GEORGETOWN, KY 40324

(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#00031775 and a COVID-19 Focused Infection Control Survey was initiated on 06/01/2020 and completed on 06/03/2020. Complaint KY#00031775 was unsubstantiated with related deficiencies cited at the highest Scope and Severity 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 50.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §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, and review of the facility's policy, it was determined the facility failed to ensure its abuse policy and procedures were implemented related to reporting and	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/31/2020

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investigating allegations of abuse for one (1) of four (4) sampled residents (Resident #1).

Resident #1 reported to staff on 04/14/2020, that someone threw liquid on his/her lower extremities, startling him/her and causing him/her to yell out for help. However, there was no documented evidence the facility implemented its written abuse policy related to reporting the alleged violation to State Agencies and conducting a thorough investigation. Although the allegation was initially reported to the facility on 04/14/2020, State Agencies were not notified of the allegation until 05/26/2020, after the resident reported the allegation to the Corporate Office. Also, there was no documented evidence of staff interviews, interviews with interviewable residents, or physical assessments/skin assessments conducted for non-interviewable residents after the facility learned of the allegation. (Refer to F-609 and F-610)

The findings include:

Review of the facility's "Abuse, Neglect, and Misappropriation of Property" Policy, last reviewed and revised 05/08/19, revealed "It is the organization's policy that the Facility Administration, or his or her designee, will direct a reasonable investigation of each such alleged violation unless he or she has a conflict of interested or is implicated in the alleged violation." Guidelines revealed, "The Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute "allegations of abuse," injuries of an unknown source," "exploitation", or "suspicions of crime." The investigation should include interviews of persons who may have knowledge

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of the alleged event. To the extent possible and applicable, the following information may be pertinent when conducting a reasonable investigation:
The date and time of the incident
The nature and circumstances of the incident
The location of the incident
A description of any injury
The condition of any injured person
The disposition of the injured person (for instance, transported to a hospital)
The names of witnesses and their accounts of the incident
The time and date of notification of the resident's physician and family
Other pertinent information
The name and title of the person completing the documentation

Continued review of the Policy, revealed in cases of alleged resident abuse, the Director of Nursing (DON) or his/her designee will conduct interviews of interviewable residents on the resident's unit, or the entire facility, as appropriate; and shall conduct an appropriate physical assessment of residents who are not capable of being interviewed. The investigation will review the pertinent parts of the resident records to determine the resident's history and condition.
The investigation should be documented on company approved, designed forms.
The Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents.

Additional review of the Policy, revealed all

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alleged violations involving abuse, neglect, neglect, exploitation, or mistreatment are reported immediately, but no later than two (2) hours after the allegation is made. If a State reporting requirement establishes a longer reporting time for certain unusual incidents other than abuse or neglect, that reporting time applies only to such incidents. In other words, all allegations and incidents of abuse or neglect, as defined in this policy, will be reported "immediately", as defined in this paragraph. Any abuse allegation must be reported to State within two (2) hours from the time the allegation was received.

Review of Resident #1's clinical record revealed the facility admitted the resident on 02/06/2020 with multiple diagnoses to include Rhabdomyolysis, Unspecified Fall, Muscle Weakness, Need for assistance with Personal Care, Other Skin Changes, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Pulmonary Heart Disease, and Pressure Ulcer of Unspecified site.

Review of the "Complaint/Grievance Report", signed on 04/14/2020 by the Social Services Director (SSD), revealed Resident #1 complained his/her roommate or someone else threw water on his/her legs and this was communicated verbally to the Director of Nursing (DON).
The "Documentation of Investigation" Section of the Report, dated 04/18/2020, signed by the DON, revealed "see attached sheet of interview".
The "Results of Action Taken" Section of the Report, dated 04/18/2020, signed by the DON, revealed "investigated, {he/she} was insistent it was his/her roommate." Resident #1 then stated, "Well, someone threw it", but never stated who.

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Review of the "Resolution" Section of the Report, dated 04/18/2020, signed by the Social Services Director (SSD), revealed complaint/grievance resolved, and resident seemed satisfied.

Review of the attached Statement dated 04/15/2020, written by the DON, revealed it was reported Resident #1 called the police to come and investigate someone throwing acid on him/her. The DON and Assistant Director of Nursing (ADON) went to speak with the resident regarding the incident. Resident #1 at first accused his/her roommate of throwing acid on him/her, at 4:30 AM this morning. Explained to resident, there was no acid in facility and roommate could not physically throw something at him/her from across the room. Resident #1 stated, "Well, someone threw something on me, my bed was wet." The DON explained the proper procedure was to notify either the DON, or the Administrator and not to call the police. ADON and DON looked at resident's bilateral lower extremities, and no skin issues were noted other than what he/she was currently being treated for by the Wound Physician.

Review of the Long Term Care Facility-Self Reported Incident Form-Initial Report, received by the Office of Inspector General (OIG) on 05/26/2020, revealed an alleged incident occurred on 04/14/2020 involving Resident #1. Resident alleges that on 04/14/2020 around 4:00 AM, someone entered his/her room and threw something, either water, or something else on him/her. Resident #1 alleged it may have been the nurse (Licensed Practical Nurse #2). Resident #1 also alleges he/she reported this to the Administrator via a letter, and he never came to his/her room to talk about the incident.

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There was no documented evidence the facility policy was implemented related to reporting abuse to the State Agencies, and related to conducting a thorough investigation. Although the allegation was initially reported to the facility on 04/14/2020, State Agencies were not notified of the allegation until 05/26/2020. Also, there was no documented evidence the facility's policy was implemented related to conducting a thorough investigation as there was no documented evidence of statements obtained, staff interviews or any resident interviews related to the alleged 04/14/2020 incident, other than the conversation that occurred with Resident #1. Further, there was no documented evidence of physical assessments/skin assessments completed for non-interviewable residents after the facility was notified of the alleged incident on 04/14/2020.

Interview with the Director of Nursing (DON), on 06/01/2020 at 1:42 PM, revealed she visited Resident #1 the morning of 04/14/2020, after being notified the resident had contacted the police to report someone had thrown acid on his/her lower extremities. Per interview, the resident implied his/her roommate did this, and she explained to Resident #1 the facility did not have any acid in the building. Further interview revealed Resident #1 insisted that someone threw some kind of liquid on his/her lower extremities, and also conveyed he/she did not like Licensed Practical Nurse (LPN) #2 and this nurse was removed from Resident #1's care and no longer worked at the facility.

Additional interview with the DON, revealed if there was an allegation of abuse, State Agencies were to be notified timely as per facility policy.

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However, she stated this allegation was not reported timely to State Agencies because the facility did not believe the incident occurred due to the resident's frequent paranoid and accusatory behavior. Per interview, after learning the resident reported the allegation to the Corporate Office on 05/26/2020, State Agencies were notified. Continued interview with the DON, revealed there was no documented evidence of a thorough investigation as per policy, to include staff interviews or any resident interviews related to the incident, other than the conversation that occurred with Resident #1. Further, there was no documented evidence of skin assessments completed for non-interviewable residents as part of the investigation.

Interview with the Administrator, on 06/01/2020 at 2:00 PM, revealed he was aware the night shift nurse informed the DON of Resident #1's allegation of someone throwing a liquid on him/her on 04/14/2020. Per interview, administrative staff did not identify this as an allegation of abuse, and thought maybe Resident #1 had awakened from a bad dream because he/she also reported he/she had called the police, but the police did not come to the facility. Further interview revealed he later learned that Resident #1 had contacted the Corporate Office on 05/26/2020 related to the alleged incident of 04/14/2020, and the facility notified State Agencies of the allegation on that date. Further interview revealed there was no documented evidence of statements obtained, staff interviews or any resident interviews related to the alleged 04/14/2020 incident, other than the conversation that occurred with Resident #1. Further, there was no documented evidence of physical assessments or skin assessments completed for

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F 607	Continued From page 7 non-interviewable residents after the facility was notified of the alleged incident on 04/14/2020. Continued interview revealed all allegations of abuse should be reported timely and thoroughly investigated as outlined in the Abuse policy.	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 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.	F 609		

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of the facility's policies, and review of the Kentucky Revised Statues (KRS), it was determined the facility failed to ensure all alleged violations involving abuse or neglect, were reported immediately, but no later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse to State Agencies for one (1) of four (4) sampled residents (Resident #1).

On 04/14/2020, Resident #1 reported either his/her roommate or someone else threw liquid on his/her legs while in bed, and startled the resident causing him/her to scream out for help. However, the facility did not identify this as an allegation of abuse and did not report the allegation to State Agencies as per Policy. The abuse allegation was not reported to State Agencies until 05/26/2020, after Resident #1 reported the allegation to the Corporate Office. (Refer to F-607 and F-610)

The findings include:

Review of the facility's "Abuse, Neglect, and Misappropriation of Property" Policy, last reviewed and revised 05/08/19, revealed all

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alleged violations involving abuse, neglect, neglect, exploitation, or mistreatment are reported immediately, but no later than two (2) hours after the allegation is made. If a State reporting requirement establishes a longer reporting time for certain unusual incidents other than abuse or neglect, that reporting time applies only to such incidents. In other words, all allegations and incidents of abuse or neglect, as defined in this policy, will be reported "immediately", as defined in this paragraph. Any abuse allegation must be reported to State within two (2) hours from the time the allegation was received.

Review of KRS Chapter 209.020, revealed an oral or written report was to be made immediately to the State Agencies upon knowledge of suspected abuse, neglect, or exploitation of an adult.

Review of Resident #1's medical record revealed the facility admitted the resident on 02/06/2020 with diagnoses to include Rhabdomyolysis, Unspecified Fall, Muscle Weakness, Need for assistance with Personal Care, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Pulmonary Heart Disease, and Pressure Ulcer of Unspecified site.

Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 02/13/2020, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating intact cognition. Further review of the MDS Assessment, revealed the facility assessed Resident #1 as exhibiting no physical, verbal, or other behavioral symptoms.

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Review of the "Complaint/Grievance Report", signed 04/14/2020 by the Social Services Director (SSD), revealed Resident #1 complained either his/her roommate or someone else threw water on his/her legs and this was communicated verbally to the Director of Nursing (DON).

Review of the attached Statement, dated 04/15/2020, written by the DON, revealed it was reported Resident #1 called the police to come and investigate someone throwing acid on him/her. The DON and Assistant Director of Nursing (ADON) spoke with the resident regarding the incident. Resident #1 first accused his/her roommate of throwing acid on him/her at 4:30 AM this morning and the DON explained there was no acid in the facility and the roommate could not physically throw something at him/her from across the room. Resident #1 then stated, "Well, someone threw something on me, my bed was wet."

Review of the Long Term Care Facility-Self Reported Incident Form-Initial Report, received by the Office of Inspector General (OIG) on 05/26/2020, revealed an alleged incident occurred on 04/14/2020 which involved Resident #1. Resident alleged on 04/14/2020 around 4:00 AM, someone entered his/her room and threw something, either water, or something else on him/her. Resident #1 then alleged it may have been the nurse, (Licensed Practical Nurse (LPN) #2). Resident #1 also alleged he/she reported this to the Administrator via a letter, but the Administrator never came to his/her room to talk about the incident.

Interview with Resident #1, on 06/01/2020 at

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11:30 AM, revealed on April 14th at at 4:30 AM, someone threw something on his/her lower extremities and this alarmed him/her so much, he/she screamed out for help. Resident #1 stated State Registered Nurse Aide (SRNA) #4 entered his/her room and he/she reported this to her. Per interview, SRNA #4 had to change his/her bed as it was wet. Additional interview revealed the DON came to his/her room the following morning and instructed him/her never to call the police, but to call the staff when needing help. Resident #1 further stated he/she then requested to speak to the Administrator, but the Administrator never came to talk to him/her. Additional interview revealed Resident #1 called the Ombudsman, who told him/her visitation restrictions prohibited him from coming to the facility. Resident #1 stated he/she then formulated a letter for the Ombudsman, sealed it, and asked the Administrator to give it to the Ombudsman. Resident #1 stated he/she wanted to let someone know what was going on at the facility.

Continued interview with Resident #1, revealed a nurse on night shift was mean to him/her and everyone down the hall. Resident #1 identified LPN #2 by name. Resident #1 stated he/she had a funny feeling it might have been LPN #2 who threw the liquid on him/her, but since he/she did not see this nurse do it, he/she did not want to falsely accuse the nurse. Per interview, Resident #1 was afraid of this nurse. He/she stated, what happened to him/her on 04/14/2020 at 4:30 AM was abuse.

Phone interview with SRNA #4, on 06/02/2020 at 5:05 PM, revealed she was working on 04/14/2020 at 04:30 AM, at the time of the alleged event, and heard Resident #1 yelling and

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went to check on him/her. Per interview, Resident #1 said someone spilled something on his/her bed, and he/she was awakened and startled by this. SRNA #4 confirmed Resident #1's sheet and bed coverings were wet to the touch with what appeared to be water toward the foot of the bed. She stated she tried to reassure Resident #1 by telling him/her it was "just water", and the bed linens were changed. SRNA #4 stated she thought perhaps Resident #1 had kicked over his/her water pitcher, but she could not recall if she observed the water pitcher turned over, Further interview revealed SRNA #4 reported this incident to LPN #2, who was the nurse on duty, as she felt this was an allegation of abuse.

LPN #2 no longer worked at the facility and was unable to be reached for interview.

Interview with the Director of Nursing (DON), on 06/01/2020 at 1:42 PM, revealed she visited Resident #1 the morning of 04/14/2020, after being informed the resident had contacted the police to report someone had thrown acid on his/her lower extremities. Per interview, the resident implied his/her roommate did this, and she explained to Resident #1 the facility did not have any acid in the building. Further, Resident #1 insisted that someone threw some kind of liquid on his/her lower extremities. Continued interview revealed Resident #1 conveyed he/she did not like LPN #2 and this nurse was removed from Resident #1's care and no longer worked at the facility.

Additional interview with the DON, revealed if there was an allegation of abuse, it was her expectation State Agencies were notified timely

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(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 13 as per facility policy. When questioned if what Resident #1 reported the morning of 04/14/2020 at 4:30 AM would be considered abuse, the DON replied, "The resident never said {he/she} was abused." She stated this allegation was not reported timely to State Agencies because the facility did not believe the incident occurred due to the resident's frequent paranoid and accusatory behavior. Per interview, after learning the resident reported the allegation to the Corporate Office on 05/26/2020, State Agencies were notified of the allegation. Interview with the Administrator, on 06/01/2020 at 2:00 PM, revealed the night shift nurse informed the DON of Resident #1's allegation of someone throwing a liquid on him/her on 04/14/2020. Per interview, administrative staff did not identify this as an allegation of abuse, and thought perhaps Resident #1 had awakened from a bad dream because he/she also reported he/she had called the police, who did not come to the facility. He further stated he later learned Resident #1 had contacted the Corporate Office on 05/26/2020, alleging on 04/14/2020 around 4:00 AM, someone entered his/her room and threw something, either water, or something else on him/her. Resident #1 alleged it may have been the nurse (LPN #2). Per interview, it was his responsibility to ensure all allegations of abuse were reported to State Agencies in a timely manner. He stated, although the facility learned of the allegation of abuse on 04/14/2020, the allegation was not reported to State Agencies until 05/26/2020, after the resident reported the allegation to Corporate.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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F 610	Continued From page 14 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 review of the facility's policy, it was determined the facility failed to have evidence that all alleged violations of abuse, or mistreatment are thoroughly investigated for one (1) of four (4) sampled residents (Resident #1). Resident #1 alleged on 04/14/2020, someone threw liquid on his/her lower extremities, startling	F 610		

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him/her and causing her to yell out for help. However, there was no documented evidence a thorough investigation was conducted related to the allegation. (Refer to F-607 and F-609).

The findings include:

Review of the facility's "Abuse, Neglect, and Misappropriation of Property" Policy, last reviewed and revised 05/08/19, revealed "It is the organization's policy that the Facility Administration, or his or her designee, will direct a reasonable investigation of each such alleged violation unless he or she has a conflict of interested or is implicated in the alleged violation." Guidelines revealed, "The Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute "allegations of abuse," injuries of an unknown source," "exploitation", or "suspicions of crime." The investigation should include interviews of persons who may have knowledge of the alleged event. To the extent possible and applicable, the following information may be pertinent when conducting a reasonable investigation:
The date and time of the incident
The nature and circumstances of the incident
The location of the incident
A description of any injury
The condition of any injured person
The disposition of the injured person (for instance, transported to a hospital)
The names of witnesses and their accounts of the incident
The time and date of notification of the resident's physician and family
Other pertinent information
The name and title of the person completing the

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documentation

Continued review of the Policy, revealed in cases of alleged resident abuse, the Director of Nursing (DON) or his/her designee will conduct interviews of interviewable residents on the resident's unit, or the entire facility, as appropriate; and shall conduct an appropriate physical assessment of residents who are not capable of being interviewed. The investigation will review the pertinent parts of the resident records to determine the resident's history and condition. The investigation should be documented on company approved, designed forms.
The Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents.

Review of the facility's "Resident Rights" Policy, last reviewed and revised on 08/16/2020, revealed all residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility. All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life. Additionally, residents have the right to voice grievances and have the facility respond to those grievances.

Review of Resident #1's clinical record revealed the facility admitted the resident on 02/06/2020 with multiple diagnoses to include Rhabdomyolysis, Unspecified Fall, Muscle Weakness, Need for assistance with Personal Care, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Pulmonary

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Heart Disease, and Pressure Ulcer of Unspecified site.

Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 02/13/2020, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating intact cognition. Continued review revealed the facility assessed Resident #1 as exhibiting no physical, verbal, or other behavioral symptoms.

Review of Resident #1's Comprehensive Care Plan, dated 03/19/2020, revealed a focus of verbal behavioral symptoms directed toward others; tendency to be manipulative, and fabricates. The goal stated the resident would have fewer than two (2) episodes a week of threatening, screaming or cursing. There were several approaches including avoid over stimulation such as noise, crowding; maintain a calm environment, and two (2) staff members to care for the resident at all times.

Review of the "Complaint/Grievance Report", signed 04/14/2020 by the Social Services Director (SSD), revealed Resident #1 complained his/her roommate or someone else threw water on his/her legs and this was communicated verbally to the Director of Nursing (DON).
The "Documentation of Investigation" Section of the Report, dated 04/18/2020, signed by the DON, revealed "See attached sheet of interview".
The "Results of Action Taken" Section of the Report, dated 04/18/2020, signed by the DON, revealed "investigated, {he/she} was insistent it was {his/her} roommate." Resident #1 then stated, "Well, someone threw it", but never stated who. Review of the "Resolution" Section of the

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Report, dated 04/18/2020, signed by the SSD, revealed complaint/grievance resolved, and resident seemed satisfied.

Review of the attached Statement, dated 04/15/2020, written by the DON, revealed it was reported Resident #1 called the police to come and investigate someone throwing acid on him/her. The DON and Assistant Director of Nursing (ADON) went to speak with the resident regarding the incident. Resident #1 first accused his/her roommate of throwing acid on him/her, at 4:30 AM this morning. Explained to resident there was no acid in facility and roommate could not physically throw something at him/her from across the room. Resident #1 stated, "Well, someone threw something on me, my bed was wet." The DON explained the proper procedure was to notify either the DON, or the Administrator and not to call the police. The ADON and DON looked at the resident's bilateral lower extremities, and no skin issues were noted other than what he/she was currently being treated for by the Wound Physician.

However, further review of the Investigation, revealed there was no documented evidence of statements obtained, staff interviews, or resident interviews related to the incident, other than the conversation that occurred with Resident #1. In addition, there was no documented evidence of physical assessments/skin assessments for non-interviewable residents.

Review of Resident #1's Progress Notes, dated 04/14/2020, revealed no documentation depicting details of the incident which allegedly occurred at 04:30 AM.

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Review of the Long Term Care Facility-Self Reported Incident Form-Initial Report, received by the Office of Inspector General (OIG) on 05/26/2020, revealed an alleged incident occurred on 04/14/2020 involving Resident #1. Resident #1 alleges that on 04/14/2020 around 4:00 AM, someone entered his/her room and threw something, either water, or something else on him/her. Resident #1 alleged it may have been the nurse (Licensed Practical Nurse #2). Resident #1 also alleges he/she reported this to the Administrator via a letter, and he never came to his/her room to talk about the incident.

Interview with Resident #1, on 06/01/2020 at 11:30 AM, revealed he/she was admitted to the facility about three (3) months ago, and was receiving rehabilitation after falling at home. Per interview, on April 14th at at 4:30 AM, someone threw something on his/her lower extremities and this alarmed him/her so much, he/she screamed out for help. Resident #1 stated State Registered Nurse Aide (SRNA) #4 came into his/her room and she reported this to her as he/she was very frightened. He/she stated SRNA #4 had to change his/her bed as it was wet. Further interview revealed the DON entered his/her room the following morning and instructed him/her never to call the police, but call the staff when needing help. Resident #1 stated he/she then requested to speak to the Administrator, but the Administrator never came to talk to him/her. Continued interview revealed Resident #1 called the Ombudsman, who told him/her visitation restrictions prohibited him from coming to the facility. Resident #1 stated he/she then formulated a letter for the Ombudsman, sealed it, and asked the Administrator to give it to the Ombudsman, which he did. Per interview, he/she

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wanted to let someone know what was going on at the facility.

Additional interview with Resident #1, revealed a nurse on night shift was mean to him/her and everyone down the hall. Resident #1 identified the nurse by name, Licensed Practical Nurse (LPN) #2. Resident #1 stated he/she had a funny feeling it might have been LPN #2 who threw the liquid on him/her, but since he/she did not see this nurse do it, he/she did not want to falsely accuse. Resident #1 stated she overheard LPN #2 saying, "she probably threw it on {himself/herself}." Per interview, Resident #1 was afraid of this nurse. Further interview revealed he/she felt what happened to him/her on the night of 04/14/2020 at 4:30 AM was abuse.

Phone interview with SRNA #4, on 06/02/2020 at 5:05 PM, revealed she was working on 04/14/2020 at 04:30 AM, the night of the alleged event, and was assigned to Resident #1. She stated she heard Resident #1 yelling and went to check on him/her. Per interview, Resident #1 said someone spilled something on his/her bed, and he/she was awakened and startled. SRNA #4 stated Resident #1's sheet and bed covering were wet to the touch with what appeared to be water toward the foot of the bed. She stated she tried to reassure Resident #1 by telling him/her it was "just water", and the bed linens were changed. SRNA #4 stated she thought perhaps Resident #1 had kicked over his/her water pitcher. When questioned if she observed the water pitcher turned over, SRNA #4 stated she could not recall. Further interview revealed SRNA #4 reported this incident to LPN #2 who was the nurse on duty, as she felt this was an allegation of abuse. Per interview, LPN #2 entered the

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resident's room and observed the wet sheets. SRNA #4 stated Resident #1 did not mention the incident to her again, and no one at the facility interviewed her related to the incident.

Interview with the Social Service Director (SSD), on 06/01/2020 at 12:30 PM, revealed she initially reviewed complaints/grievances, then depending on the nature of the complaint, directed the investigation and followed-up with the appropriate department. The SSD stated she met with Resident #1 on 04/14/2020 and was informed the resident's roommate threw water on his/her legs while he/she was sleeping. The SSD further stated Resident #1 explained this startled him/her and woke him/her up and he/she screamed out. Per interview, Resident #1 was insistent at first it was his/her roommate that did this, but then stated,"Well, someone threw it", but was unable to say for sure who did this. The SSD stated Resident #4 denied throwing anything on Resident #1. Continued interview revealed weeks later, Resident #1 suspected it might be a nurse who threw something on him/her. Further interview revealed there was no documented staff interviews or any documented interviews related to the incident, other than the conversation that occurred with Resident #1. The SSD stated she thought Resident #1 seemed satisfied with the follow-up, and the investigation and follow up was given to the DON.

LPN #2 no longer worked at the facility and could not be reached for interview.

Interview with LPN #1 on 06/01/2020 at 12:52 PM; SRNA #3 at 4:40 PM; and SRNA #2 at 4:47 PM, revealed they were working on 04/14/2020 at 04:30 AM. However, they were never interviewed

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related to the alleged incident involving Resident #1, nor were they aware of the allegation.

Interview with the Assistant Director of Nursing (ADON), on 06/02/2020 at 4:31 PM, revealed she received information from the DON regarding the alleged 04/14/2020 incident related to Resident #1. She stated she was told by the DON that Resident #1 insinuated his/her roommate (Resident #4) had thrown something on him/her. Per interview, she accompanied the DON to Resident #1's room the morning after the alleged incident and noted the two (2)residents' beds were separated by a curtain. The ADON stated the curtain usually remained pulled and Resident #4 was not able to get out of bed. Per interview, Resident #1 could not name any staff who could have done this to him/ her. The ADON stated Resident #1 alleged he/she had called the police, but the police did not come to the facility. She stated a skin assessment was performed on Resident #1 with no negative findings. The ADON agreed abuse allegations should be thoroughly investigated; however, was unaware of statements obtained, staff interviews or any interviews related to the incident, other than the conversation that occurred with Resident #1.

Interview with the Director of Nursing (DON), on 06/01/2020 at 1:42 PM, revealed she visited Resident #1 the morning of 04/14/2020, after being told the resident had contacted the police by calling 911 to report someone had thrown acid on his/her lower extremities. Per interview, the resident implied his/her roommate did this, and she told Resident #1 the facility did not have any acid in the building. Further, eventually Resident #1 got off the issue of acid, but insisted that someone threw some kind of liquid on his/her

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lower extremities. Continued interview revealed skin assessments were performed on Resident #1 with negative findings. Also, Resident #1 conveyed he/she did not like LPN #2 and this nurse was removed from Resident #1's care and no longer worked at the facility.

Additional interview with the DON, revealed if there was an allegation of abuse, it was her expectation the resident was assured safety, and a full investigation was conducted with subsequent follow up as the facility had zero-tolerance for abuse. When questioned if what Resident #1 reported the morning of 04/14/2020 at 4:30 AM would be considered abuse, the DON replied, "The resident never said {he/she} was abused." The DON verified there was no documented evidence of a thorough investigation to include staff interviews or any resident interviews related to the incident, other than the conversation that occurred with Resident #1. She stated this was because the facility did not believe the incident occurred due to the resident's frequent paranoid and accusatory behavior.

Interview with the Administrator, on 06/01/2020 at 2:00 PM, revealed the night shift nurse informed the DON of Resident #1's allegation of someone throwing a liquid on him/her on 04/14/2020. Per interview, staff thought perhaps Resident #1 had awakened from a bad dream because he/she also reported he/she had called the police. He stated the police did not come to the facility and he did not know for sure if they were called. Further interview revealed Resident #1 had requested to speak with him on 05/11/2020 and when he entered his/her room, he/she was asleep. He stated he later had a conversation

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F 610	Continued From page 24 with the resident on 05/12/2020, and learned Resident #1 contacted the Ombudsman and asked him to come to the facility and get a sealed envelope containing information he/she wanted him to read. The Administrator stated he gave the letter to the Ombudsman, but was not aware of the content. He stated he later learned Resident #1 had contacted the Corporate Office on 05/26/2020 related to the alleged incident of 04/14/2020. Continued interview revealed all allegations of abuse should be thoroughly investigated as outlined in the Abuse policy. However, he stated there was no documented evidence of statements obtained, staff interviews or any resident interviews related to the alleged 04/14/2020 incident, other than the conversation that occurred with Resident #1. Further, there was no documented evidence of physical assessments and skin assessments completed for non-interviewable residents after the facility was notified of the alleged incident on 04/14/2020.	F 610		

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/01/2020 and concluded on 06/03/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

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

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N 000	Initial Comments A Complaint Survey investigating Complaint KY#00031775 and a COVID-19 Focused Infection Control Survey was initiated on 06/01/2020 and completed on 06/03/2020. Complaint KY#00031775 was unsubstantiated with related deficiencies. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/29/20