PRINTED: 09/25/2020 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185141	B. WING		06/	03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	ey investigating Complaint	F 00	0		
	KY#00031775 and a Infection Control Sur- 06/01/2020 and comp Complaint KY#00031 with related deficience Scope and Severity of the facility had impler Centers for Disease	COVID-19 Focused vey was initiated on bleted on 06/03/2020. 775 was unsubstantiated ies cited at the highest of a "D". It was determined mented the CMS and Control and Prevention I practices to prepare for				
F 607 SS=D	Develop/Implement A CFR(s): 483.12(b)(1)	buse/Neglect Policies -(3)	F 60	7		
		icies and procedures that:				
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of re	ion of residents and				
	§483.12(b)(2) Establi to investigate any suc	sh policies and procedures ch allegations, and				
	§483.12(b)(3) Include paragraph §483.95,	e training as required at				
	by: Based on interview, the facility's policy, it failed to ensure its ab	record review, and review of was determined the facility buse policy and procedures lated to reporting and				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE

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

(X6) DATE

07/31/2020

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.

Facility ID: 100381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			06/03/2020	
	ROVIDER OR SUPPLIER	BEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CO 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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From paginvestigating allegat four (4) sampled reserves Resident #1 reporters someone threw liquing extremities, startling to yell out for help. In documented evident written abuse policy alleged violation to sconducting a thorout the allegation was in on 04/14/2020, Statt of the allegation untiresident reported the Office. Also, there we of staff interviews, in residents, or physical assessments conduite residents after the fallegation. (Refer to The findings include Review of the facility Misappropriation of reviewed and revise organization's policy Administration, or his reasonable investigation.	ge 1 ions of abuse for one (1) of sidents (Resident #1). d to staff on 04/14/2020, that id on his/her lower him/her and causing him/her dowever, there was no ce the facility implemented its related to reporting the State Agencies and gh investigation. Although nitially reported to the facility e Agencies were not notified il 05/26/2020, after the e allegation to the Corporate was no documented evidence interviews with interviewable al assessments/skin cted for non-interviewable acility learned of the F-609 and F-610) c: y's "Abuse, Neglect, and Property" Policy, last id 05/08/19, revealed "It is the or that the Facility is or her designee, will direct a lation of each such alleged	F 6	DEFICIENC			
	interested or is impli violation." Guideline Administrator will inv reports, grievances, could constitute "alle an unknown source, of crime." The inves						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		185141	B. WING _		_	06/03/2020)
	ROVIDER OR SUPPLIER	EORGETOWN	,	STREET ADDRESS, CITY, ST. 102 POCAHONTAS TRAIL GEORGETOWN, KY 403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		TION
F 607	applicable, the follow pertinent when conduinvestigation: The date and time of The nature and circuing the location of the in A description of any in the condition of any in the condition of any in the condition of the instance, transported the names of witness incident. The time and date of physician and family Other pertinent informathe name and title of documentation. Continued review of the of alleged resident at (DON) or his/her design or the entire facility, a conduct an appropriate residents who are not interviewed. The investigation should be appropriate investigation should be appropriate the resident of the determine the resident of the Administrator will determine the root cand will implement cowith the investigation eliminate any ongoing residents.	To the extent possible and ing information may be ucting a reasonable the incident mstances of the incident cident injury injured person (for to a hospital) sees and their accounts of the motification of the resident's mation if the person completing the indication of the resident's injured person (for to a hospital) sees and their accounts of the motification of the resident's indication of the resident's indication of the person completing the indication of the person completing the indication of the person the resident's unit, is appropriate; and shall the physical assessment of the capable of being instigation will review the resident records to int's history and condition. Includible documented on	F6	507			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185141 B. WIN				06/03/2020		
	ROVIDER OR SUPPLIER	GEORGETOWN		STREET ADDRESS, CITY, STATE 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 PREFI TAG	X (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE		
F 607	neglect, exploitation reported immediate hours after the alleg reporting requirement reporting time for cethan abuse or neglet only to such incider allegations and incidefined in this policillimmediately", as diabuse allegation mutwo (2) hours from the received. Review of Resident the facility admitted with multiple diagnor. Rhabdomyolysis, Uweakness, Need for Care, Other Skin Cl Disorder, Obsessive Pulmonary Heart Di Unspecified site. Review of the "Comsigned on 04/14/20. Director (SSD), revenis/her roommate on his/her legs and	volving abuse, neglect, a, or mistreatment are ly, but no later than two (2) gation is made. If a State ent establishes a longer ertain unusual incidents other ect, that reporting time applies ets. In other words, all dents of abuse or neglect, as effined in this paragraph. Any ust be reported effined in this paragraph within the time the allegation was #1's clinical record revealed the resident on 02/06/2020	F	507				
	the Report, dated 0 DON, revealed "see The "Results of Acti Report, dated 04/18 revealed "investigat was his/her roomma	n of Investigation" Section of 4/18/2020, signed by the e attached sheet of interview". on Taken" Section of the 8/2020, signed by the DON, ed, {he/she} was insistent it ate." Resident #1 then stated, ew it", but never stated who.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILE			ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185141	B. WING			06/	/03/2020	
	ROVIDER OR SUPPLIER RE HEALTHCARE OF GI	EORGETOWN	·	102	EET ADDRESS, CITY, STATE, ZIP CODE POCAHONTAS TRAIL ORGETOWN, KY 40324			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 607	607 Continued From page 4		F	607				
	dated 04/18/2020, sig	ution" Section of the Report, gned by the Social Services aled complaint/grievance nt seemed satisfied.						
	reported Resident #1 and investigate some him/her. The DON a Nursing (ADON) wer regarding the inciden accused his/her room him/her, at 4:30 AM tresident, there was nroommate could not at him/her from acrosstated, "Well, someomy bed was wet." The procedure was to not Administrator and no and DON looked at rextremities, and no second	by the DON, revealed it was called the police to come cone throwing acid on and Assistant Director of at to speak with the resident at. Resident #1 at first a mate of throwing acid on this morning. Explained to a o acid in facility and physically throw something as the room. Resident #1 are threw something on me, the DON explained the proper tify either the DON, or the to call the police. ADON esident's bilateral lower kin issues were noted other s currently being treated for						
	Reported Incident For by the Office of Insp 05/26/2020, revealed occurred on 04/14/20 Resident alleges that AM, someone enteresomething, either wahim/her. Resident #* the nurse (Licensed Resident #1 also alleges that all also alleges that all also alleges that also alleges that all all all all all alleges that all all all all all all all all all a	220 involving Resident #1. t on 04/14/2020 around 4:00 d his/her room and threw ter, or something else on 1 alleged it may have been Practical Nurse #2). ges he/she reported this to a letter, and he never came						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		185141	B. WING _	B. WING		06/03/2020	
	ROVIDER OR SUPPLIER	BEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CO 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	policy was implement abuse to the State Aconducting a thorout the allegation was in on 04/14/2020, State of the allegation unt no documented evicimplemented related investigation as there evidence of statement or any resident inter 04/14/2020 incident that occurred with Rewas no documented assessments/skin an non-interviewable residence of the state of t	mented evidence the facility nted related to reporting Agencies, and related to gh investigation. Although nitially reported to the facility e Agencies were not notified il 05/26/2020. Also, there was dence the facility's policy was do to conducting a thorough re was no documented ents obtained, staff interviews rviews related to the alleged of the than the conversation desident #1. Further, there do evidence of physical sessesments completed for esidents after the facility was ed incident on 04/14/2020.	F 6	07			
	06/01/2020 at 1:42 Resident #1 the more being notified the repolice to report som his/her lower extrem resident implied his/she explained to Rehave any acid in the revealed Resident # threw some kind of extremities, and also Licensed Practical News removed from Flonger worked at the Additional interview there was an allegation.	irector of Nursing (DON), on PM, revealed she visited rning of 04/14/2020, after sident had contacted the eone had thrown acid on nities. Per interview, the the roommate did this, and sident #1 the facility did not e building. Further interview the insisted that someone liquid on his/her lower to conveyed he/she did not like Nurse (LPN) #2 and this nurse Resident #1's care and no e facility. with the DON, revealed if tion of abuse, State Agencies imely as per facility policy.					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	185141	B. WING _			06/03/2020		
	GEORGETOWN	•	STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE		
owever, she stated ported timely to Scility did not believe resident's frequency frequ	d this allegation was not tate Agencies because the ve the incident occurred due to ent paranoid and accusatory iew, after learning the resident ion to the Corporate Office on agencies were notified. I with the DON, revealed there is devidence of a thorough policy, to include staff sident interviews related to man the conversation that lent #1. Further, there was no ce of skin assessments interviewable residents as part in the was aware the night shift DON of Resident #1's in throwing a liquid on 120. Per interview, did not identify this as an and thought maybe Resident from a bad dream because in the later learned that Resident in the later learned that Resident in the Corporate Office on to the alleged incident of a facility notified State gation on that date. Further there was no documented ents obtained, staff interviews related to the alleged incident #1. Further, there	F	607				
	SUMMARY S (EACH DEFICIENT REGULATORY OF REGU	IDENTIFICATION NUMBER: 185141 VIDER OR SUPPLIER HEALTHCARE OF GEORGETOWN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	IDENTIFICATION NUMBER: A. BUILDIN INDER OR SUPPLIER HEALTHCARE OF GEORGETOWN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 6 owever, she stated this allegation was not uported timely to State Agencies because the cility did not believe the incident occurred due to e resident's frequent paranoid and accusatory shavior. Per interview, after learning the resident uported the allegation to the Corporate Office on 5/26/2020, State Agencies were notified. Ontinued interview with the DON, revealed there as no documented evidence of a thorough vestigation as per policy, to include staff terviews or any resident interviews related to e incident, other than the conversation that courred with Resident #1. Further, there was no occumented evidence of skin assessments ompleted for non-interviewable residents as part the investigation. Iterview with the Administrator, on 06/01/2020 at 00 PM, revealed he was aware the night shift urse informed the DON of Resident #1's legation of someone throwing a liquid on mylher on 04/14/2020. Per interview, diministrative staff did not identify this as an legation of abuse, and thought maybe Resident 1 had awakened from a bad dream because selshe also reported he/she had called the police, at the police did not come to the facility. Further terview revealed he later learned that Resident 1 had contacted the Corporate Office on 5/26/2020 related to the allegad incident of 4/14/2020, and the facility notified State gencies of the allegation on that date. Further terview revealed there was no documented vidence of statements obtained, staff interviews any resident interviews related to the alleged 4/14/2020 incident, other than the conversation at occurred with Resident #1. Further, there as no documented evidence of physical	IDENTIFICATION NUMBER: 188141 BUILDING 188141 BUILDING BUINDS STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 6 Owever, she stated this allegation was not ported timely to State Agencies because the cility did not believe the incident occurred due to e resident's frequent paranoid and accusatory ehavior. Per interview, after learning the resident ported the allegation to the Corporate Office on 5/26/2020, State Agencies were notified. Ontinued interview with the DON, revealed there as no documented evidence of a thorough vestigation as per policy, to include staff terviews or any resident interviews related to e incident, other than the conversation that courred with Resident #1. Further, there was no commented evidence of skin assessments ampleted for non-interviewable residents as part it he investigation. To PM, revealed he was aware the night shift use informed the DON of Resident #1's legation of someone throwing a liquid on minher on 04/14/2020. Per interview, ministrative staff did not identify this as an legation of abuse, and thought maybe Resident 1 had awakened from a bad dream because s/she also reported he/she had called the police, at the police did not come to the facility, Further terview revealed he later learned that Resident 1 had awakened from a bad dream because of the allegation of the facility notified State gencies of the allegation on that date. Further terview revealed there was no documented vidence of statements obtained, staff interviews any resident interviews are not courred with Resident #1. Further, there as no documented evidence of physical	IDER OR SUPPLIER ### HEALTHCARE OF GEORGETOWN SUMMARY STATEMENT OF DEFICIENCIES GEORGETOWN, KY 40324 PROVIDENS PLAN OF CORRECTION (GEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDENS PLAN OF CORRECTION (GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 607 TO THE VIEW OF THE VIEW APPROPRIATE DEFICIENCY F 607 F 60		

PLIER RE OF GEORGETOWN MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) rom page 7 vable residents after the facility was a alleged incident on 04/14/2020.	10	TREET ADDRESS, CITY, STATE, ZIP CODE 02 POCAHONTAS TRAIL GEORGETOWN, KY 40324 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.
MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) from page 7 vable residents after the facility was	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) From page 7 vable residents after the facility was	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLETION
vable residents after the facility was	F 607		
terview revealed all allegations of d be reported timely and thoroughly as outlined in the Abuse policy.			
Alleged Violations 12(c)(1)(4) n response to allegations of abuse, oitation, or mistreatment, the facility	F 609		
) Ensure that all alleged violations use, neglect, exploitation or t, including injuries of unknown hisappropriation of resident property, immediately, but not later than 2 he allegation is made, if the events he allegation involve abuse or result in y injury, or not later than 24 hours if hat cause the allegation do not involve to not result in serious bodily injury, to reator of the facility and to other auding to the State Survey Agency and hive services where state law provides in in long-term care facilities) in with State law through established 1) Report the results of all is to the administrator or his or her epresentative and to other officials in with State law, including to the State lay, within 5 working days of the			
	Alleged Violations 12(c)(1)(4) In response to allegations of abuse, oitation, or mistreatment, the facility It is including injuries of unknown in isappropriation of resident property, immediately, but not later than 2 in eallegation is made, if the events in eallegation involve abuse or result in any injury, or not later than 24 hours if in at cause the allegation do not involve in ont result in serious bodily injury, to reator of the facility and to other auding to the State Survey Agency and inverse services where state law provides in in long-term care facilities) in with State law through established In Report the results of all is to the administrator or his or her expresentative and to other officials in with State law, including to the State	Alleged Violations 12(c)(1)(4) In response to allegations of abuse, oitation, or mistreatment, the facility It is to the administrator or his or her epresentative and to other uffer alleged violation or to the allegation of the allegation of the allegation of the state cy, within 5 working days of the if the alleged violation or to the allegation in the allegation in the allegation of the state of the administrator or his or her epresentative and to other officials in with State law, including to the State cy, within 5 working days of the if the alleged violation is verified	Alleged Violations 12(c)(1)(4) In response to allegations of abuse, oitation, or mistreatment, the facility I) Ensure that all alleged violations use, neglect, exploitation or to the including injuries of unknown insappropriation of resident property, immediately, but not later than 2 use allegation is made, if the events use allegation involve abuse or result in y injury, or not later than 24 hours if use tause the allegation do not involve to not result in serious bodily injury, to eator of the facility and to other use use the state Survey Agency and the services where state law provides in long-term care facilities) in with State law through established I) Report the results of all use to the administrator or his or her epresentative and to other officials in with State law, including to the State cy, within 5 working days of the if the alleged violation is verified

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185141	B. WING _			06/03/2020	
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODI 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	E		
(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 COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	Continued From pag	ne 8	F 6	09			
	by: Based on interview, facility's policies, and Revised Statues (KF facility failed to ensu involving abuse or no immediately, but no the allegation is mad the allegation involve	record review, review of the dreview of the Kentucky RS), it was determined the re all alleged violations eglect, were reported later than two (2) hours after le, if the events that cause e abuse to State Agencies for impled residents (Resident					
	his/her roommate or on his/her legs while resident causing him However, the facility allegation of abuse a allegation to State A abuse allegation was Agencies until 05/26	ident #1 reported either someone else threw liquid in bed, and startled the n/her to scream out for help. did not identify this as an and did not report the gencies as per Policy. The sonot reported to State 1/2020, after Resident #1 on to the Corporate Office.					
	Misappropriation of I	's "Abuse, Neglect, and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		185141	B. WING _			06/03/2020	
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CO 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 (((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 609	neglect, exploitation, reported immediately hours after the allegare porting requirement reporting time for cethan abuse or neglet only to such incident allegations and incide defined in this policy "immediately", as deabuse allegation mutwo (2) hours from the received. Review of KRS Chaporal or written report to the State Agencie	volving abuse, neglect, or mistreatment are y, but no later than two (2) ation is made. If a State at establishes a longer retain unusual incidents other ct, that reporting time applies s. In other words, all ents of abuse or neglect, as	Fé	609			
	the facility admitted to with diagnoses to incurrence unspecified Fall, Mulassistance with Pers Anxiety Disorder, Obdisorder, Pulmonary Pressure Ulcer of Urressure Ulcer of Urressure (MDS) Assisted the facility of the property of the facility of the faci	#1's Admission Minimum essment, dated 02/13/2020, assessed the resident as few for Mental Status (BIMS) but of fifteen (15), indicating her review of the MDS ed the facility assessed biting no physical, verbal, or					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185141	B. WING			06/	03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		10	TREET ADDRESS, CITY, STATE, ZIP CODE D2 POCAHONTAS TRAIL SEORGETOWN, KY 40324		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pag	e 10	F	609			
	signed 04/14/2020 b (SSD), revealed Reshis/her roommate or on his/her legs and the verbally to the Direct Review of the attach 04/15/2020, written be reported Resident #1 and investigate some him/her. The DON a Nursing (ADON) sporegarding the incider his/her roommate of 4:30 AM this morning there was no acid in could not physically a from across the room "Well, someone three was wet." Review of the Long Reported Incident For by the Office of Inspective O5/26/2020, revealed occurred on 04/14/20 #1. Resident alleged AM, someone enteressomething, either was him/her. Resident #1 als this to the Administration.	ed Statement, dated by the DON, revealed it was called the police to come eone throwing acid on and Assistant Director of ke with the resident at. Resident #1 first accused throwing acid on him/her at and the DON explained the facility and the roommate throw something at him/her a. Resident #1 then stated, w something on me, my bed Ferm Care Facility-Self form-Initial Report, received ector General (OIG) on					
	Interview with Reside	ent #1, on 06/01/2020 at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185141	B. WING			06/	03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 02 POCAHONTAS TRAIL GEORGETOWN, KY 40324	1 00,	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	someone threw some extremities and this a he/she screamed ou State Registered Nurhis/her room and he/interview, SRNA #4 It was wet. Additional came to his/her room instructed him/her ned call the staff when ned further stated he/she the Administrator, but came to talk to him/her visithim from coming to the stated he/she then for the composition of the stated he/she then for the stated he/she the stated	ething on his/her lower alarmed him/her so much, to for help. Resident #1 stated rese Aide (SRNA) #4 entered she reported this to her. Per mad to change his/her bed as I interview revealed the DON in the following morning and ever to call the police, but to reding help. Resident #1 then requested to speak to the Administrator never er. Additional interview I called the Ombudsman, tation restrictions prohibited the facility. Resident #1 formulated a letter for the lit, and asked the lit to the Ombudsman. e/she wanted to let someone go on at the facility. With Resident #1, revealed a was mean to him/her and hall. Resident #1 identified esident #1 stated he/she had hit have been LPN #2 who m/her, but since he/she did to it, he/she did not want to himse. Per interview, Resident nurse. Per interview, Resident nurse. He/she stated, what on 04/14/2020 at 4:30 AM	F	609			
		ne was working on AM, at the time of the eard Resident #1 velling and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			06/03/2020	
	ROVIDER OR SUPPLIER	GEORGETOWN	•	STREET ADDRESS, CITY, STATE, ZIP CO 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	Resident #1 said so his/her bed, and he/ startled by this. SRN sheet and bed cove with what appeared the bed. She stated Resident #1 by tellir and the bed linens with stated she thought pkicked over his/her not recall if she obsover, Further intervireported this incider nurse on duty, as shabuse. LPN #2 no longer with unable to be reached linterview with the Dimension of the long informed the police to report som his/her lower extrem resident implied his/ she explained to Rehave any acid in the #1 insisted that som	m/her. Per interview, meone spilled something on //she was awakened and NA #4 confirmed Resident #1's rings were wet to the touch to be water toward the foot of she tried to reassure ng him/her it was "just water", were changed. SRNA #4 perhaps Resident #1 had water pitcher, but she could erved the water pitcher turned ew revealed SRNA #4 nt to LPN #2, who was the ne felt this was an allegation of	F 6	09			
	interview revealed F did not like LPN #2 from Resident #1's of the facility. Additional interview there was an allega	Resident #1 conveyed he/she and this nurse was removed care and no longer worked at with the DON, revealed if tion of abuse, it was her gencies were notified timely					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185141	B. WING			06/	03/2020
	ROVIDER OR SUPPLIER RE HEALTHCARE OF GE	EORGETOWN	,	1	STREET ADDRESS, CITY, STATE, ZIP CODE 02 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Resident #1 reported at 4:30 AM would be replied, "The resident abused." She stated reported timely to Stafacility did not believe the resident's frequer behavior. Per intervier reported the allegatio 05/26/2020, State Agallegation. Interview with the Adr 2:00 PM, revealed the the DON of Resident throwing a liquid on hinterview, administrates an allegation of ab Resident #1 had awa because he/she also the police, who did not further stated he later	when questioned if what the morning of 04/14/2020 considered abuse, the DON an ever said {he/she} was this allegation was not atte Agencies because the the incident occurred due to at paranoid and accusatory aw, after learning the resident in to the Corporate Office on encies were notified of the ministrator, on 06/01/2020 at an enight shift nurse informed #1's allegation of someone im/her on 04/14/2020. Per ive staff did not identify this buse, and thought perhaps kened from a bad dream reported he/she had called of come to the facility. He relearned Resident #1 had atte Office on 05/26/2020,	F	609			
F 610 SS=D	him/her. Resident #1 the nurse (LPN #2). responsibility to ensu were reported to Stat manner. He stated, a of the allegation was not rejuntil 05/26/2020, afte allegation to Corpora	/her room and threw ter, or something else on alleged it may have been Per interview, it was his re all allegations of abuse e Agencies in a timely although the facility learned buse on 04/14/2020, the corted to State Agencies r the resident reported the te. Correct Alleged Violation	F	610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185141	B. WING		06/03/2020	
	ROVIDER OR SUPPLIER	GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 610	Continued From pa	age 14	F 61	0		
		onse to allegations of abuse, on, or mistreatment, the facility				
		e evidence that all alleged oughly investigated.				
		vent further potential abuse, on, or mistreatment while the progress.				
	investigations to the designated represe accordance with S Survey Agency, wi incident, and if the	ort the results of all the administrator or his or her tentative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken.				
	by: Based on interview the facility's policy, failed to have evide of abuse, or mistre	NT is not met as evidenced w, record review, and review of it was determined the facility ence that all alleged violations eatment are thoroughly e (1) of four (4) sampled at #1).				
		d on 04/14/2020, someone her lower extremities, startling				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			06/	03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		102	EET ADDRESS, CITY, STATE, ZIP CODE POCAHONTAS TRAIL ORGETOWN, KY 40324		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From pag	e 15	F	310			
	However, there was thorough investigation	her to yell out for help. no documented evidence a on was conducted related to r to F-607 and F-609).					
	The findings include:						
	Misappropriation of Freviewed and revised organization's policy Administration, or his reasonable investigation unless he organization. Guidelines Administrator will inverse and constitute "alle an unknown source," of crime." The invest interviews of persons of the alleged event. applicable, the follow pertinent when condinvestigation: The date and time of the interview of the interview of the investigation: The date and time of the interview of the interview of the interview of the investigation: The date and time of the interview of the investigation of the investigation of the interview o	d 05/08/19, revealed "It is the that the Facility sor her designee, will direct a tion of each such alleged reshe has a conflict of cated in the alleged so revealed, "The estigate all allegations, and incidents that potentially gations of abuse," injuries of "exploitation", or "suspicions igation should include so who may have knowledge. To the extent possible and ving information may be sucting a reasonable. If the incident instances of the incident injury injured person the injured person (for display and their accounts of the incification of the resident's injured person (for display and their accounts of the incification of the resident's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185141	B. WING		06/03/2020	
	NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH: CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 610	of alleged resident a (DON) or his/her de of interviewable res or the entire facility, conduct an appropriate residents who are no interviewed. The investigation should be a company approved, and will implement of with the investigation eliminate any ongoinesidents. Review of the facility last reviewed and revealed all residents will be treatenized in the promoted and protesidents will be treatenized in the promoted and protesidents will be treatenized in the promoted and protesidents have the residents have the residents have the residents appropriate interviewed and protesidents have the residents have the residents have the residents have the residents appropriate interviewed and protesidents have the residents have the residents have the residents will be treatenized in the residents have the residents will be treatenized in the residents have the residents have the residents will be treatenized in the residents have the residents have the residents will be treatenized in the residents will	f the Policy, revealed in cases abuse, the Director of Nursing signee will conduct interviews idents on the resident's unit, as appropriate; and shall late physical assessment of ot capable of being vestigation will review the eresident records to ent's history and condition.	F 61	,		
	the facility admitted with multiple diagno Rhabdomyolysis, U Weakness, Need fo Care, Generalized A	nspecified Fall, Muscle r assistance with Personal				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			06/	03/2020	
	ROVIDER OR SUPPLIER	GEORGETOWN	•	STREET ADDRESS, CI 102 POCAHONTAS I GEORGETOWN, K	TRAIL	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 610	Data Set (MDS) Ass revealed the facility a Brief Interview for of fifteen (15) out of cognition. Continue assessed Resident verbal, or other beh Review of Resident Plan, dated 03/19/2 verbal behavioral sy others; tendency to fabricates. The goa have fewer than two threatening, scream several approaches stimulation such as calm environment, a care for the resident Review of the "Comsigned 04/14/2020 I (SSD), revealed Reroommate or some of his/her legs and this to the Director of Nu The "Documentation the Report, dated 04/18 revealed "investigat was {his/her} roommate or some of the resident revealed "investigat was {his/her} roommate or some of the resident revealed "investigat was {his/her} roommate or some of the revealed "investigat was	#1's Admission Minimum sessment, dated 02/13/2020, assessed the resident to have Mental Status (BIMS) score iffiteen (15), indicating intact d review revealed the facility #1 as exhibiting no physical, avioral symptoms. #1's Comprehensive Care 020, revealed a focus of /mptoms directed toward be manipulative, and al stated the resident would to (2) episodes a week of hing or cursing. There were including avoid over noise, crowding; maintain a and two (2) staff members to t at all times. Inplaint/Grievance Report", by the Social Services Director sident #1 complained his/her one else threw water on s was communicated verbally	F	10				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185141	B. WING		0	6/03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	revealed complaint/g resident seemed satistics. Review of the attach 04/15/2020, written be reported Resident #1 and investigate some him/her. The DON a Nursing (ADON) wer regarding the incider his/her roommate of 4:30 AM this morning there was no acid in not physically throw across the room. Resomeone threw some wet." The DON explayas to notify either thand not to call the polooked at the resider extremities, and no set than what he/she was by the Wound Physically throwever, further reverseded there was restatements obtained interviews related to	2020, signed by the SSD, rievance resolved, and sfied. ed Statement, dated by the DON, revealed it was called the police to come ence throwing acid on and Assistant Director of the to speak with the resident at. Resident #1 first accused throwing acid on him/her, at g. Explained to resident facility and roommate could something at him/her from esident #1 stated, "Well, ething on me, my bed was alined the proper procedure the DON, or the Administrator dice. The ADON and DON the side of the proper bed other is currently being treated for	F 6 ⁻²	,		
	physical assessment non-interviewable res Review of Resident # 04/14/2020, revealed	o documented evidence of s/skin assessments for sidents. †1's Progress Notes, dated I no documentation depicting t which allegedly occurred at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185141	B. WING			06/03/2020	
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, Z 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	IP CODE	33/33/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE TO THE APPROPRIA		
F 610	Reported Incident Foby the Office of Inspectors of Inspect	Term Care Facility-Self orm-Initial Report, received ector General (OIG) on d an alleged incident 020 involving Resident #1. that on 04/14/2020 around entered his/her room and her water, or something else at #1 alleged it may have ensed Practical Nurse #2). Eges he/she reported this to a letter, and he never came lik about the incident. Lent #1, on 06/01/2020 at he/she was admitted to the B) months ago, and was on after falling at home. Per that at 4:30 AM, someone his/her lower extremities and a so much, he/she screamed at #1 stated State Registered #4 came into his/her room as to her as he/she was very stated SRNA #4 had to as it was wet. Further the DON entered his/her room and instructed him/her coe, but call the staff when ent #1 stated he/she then to the Administrator, but the came to talk to him/her. The revealed Resident #1 called no told him/her visitation did him from coming to the	F	610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		185141	B. WING		0	6/03/2020	
	ROVIDER OR SUPPLIER	EORGETOWN	•	STREET ADDRESS, CITY, STATE, ZIP COI 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	<u> </u>	3.03.2320	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 610	Continued From pag wanted to let someo	e 20 ne know what was going on	F 6	10			
	nurse on night shift veveryone down the hurse by name, Licel #2. Resident #1 state feeling it might have liquid on him/her, but this nurse do it, he/slaccuse. Resident #1 #2 saying, "she prob {himself/herself}." Pafraid of this nurse. he/she felt what happ of 04/14/2020 at 4:30. Phone interview with 5:05 PM, revealed slo4/14/2020 at 04:30 event, and was assig stated she heard Rescheck on him/her. Psaid someone spilled and he/she was awa stated Resident #1's were wet to the touch water toward the footried to reassure Reswas "just water", and changed. SRNA #4 Resident #1 had kick pitcher. When questi water pitcher turned could not recall. Furt	er interview, Resident #1 was Further interview revealed bened to him/her on the night D AM was abuse. SRNA #4, on 06/02/2020 at the was working on AM, the night of the alleged gned to Resident #1. She sident #1 yelling and went to the interview, Resident #1 I something on his/her bed, kened and startled. SRNA #4 sheet and bed covering the with what appeared to be the of the bed. She stated she sident #1 by telling him/her it					
		e felt this was an allegation of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			6/03/2020	
	ROVIDER OR SUPPLIER	GEORGETOWN	•	STREET ADDRESS, CITY, STATE, 2 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	•		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 610	SRNA #4 stated Fincident to her aga	rage 21 and observed the wet sheets. Resident #1 did not mention the ain, and no one at the facility lated to the incident.	F	610			
	on 06/01/2020 at reviewed complai on the nature of the investigation and department. The State of the investigation and department. The State of the investigation and department. The State of the investigation and versident's roomman while he/she was stated Resident # and woke him/her Per interview, Reswas his/her roomman stated, "Well, som to say for sure who interview for sure who threw somether interview revealed interviews or any to the incident, of occurred with Resident follow-up, and the given to the DON.						
	Interview with LPI PM; SRNA#3 at 4 PM, revealed they	worked at the facility and could r interview. N #1 on 06/01/2020 at 12:52 I:40 PM; and SRNA #2 at 4:47 were working on 04/14/2020 at er, they were never interviewed					

	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	185141	B. WING			06/03/2020	
	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP COE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		30,00,2020	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
to the alleger were they average with the As N, on 06/02/2 and information do 04/14/2020 and the ent #1 insinual ent #4) had the erview, she are the ent #1's room and noted the eparated by a stain usually resonant and noted the eparated by a stain usually resonant #1 could note this to him the ent #1 alleged a skin assessent #1 with note as a skin as a s	d incident involving Resident ware of the allegation. sisistant Director of Nursing 020 at 4:31 PM, revealed she infrom the DON regarding the incident related to Resident was told by the DON that ted his/her roommate incompanied the DON to the morning after the alleged the two (2)residents' beds a curtain. The ADON stated emained pulled and Resident let out of bed. Per interview, ot name any staff who could m/ her. The ADON stated he/she had called the police, at come to the facility. She sement was performed on negative findings. The ADON stations should be thoroughly er, was unaware of I, staff interviews or any the incident, other than the scurred with Resident #1. Frector of Nursing (DON), on PM, revealed she visited ming of 04/14/2020, after that contacted the police ort someone had thrown acid remities. Per interview, the her roommate did this, and I the facility did not have any	F 6				
the second of th	SUMMARY S (EACH DEFICIEN REGULATORY OF AUGUST AUGUS	TION IDENTIFICATION NUMBER:	THON IDENTIFICATION NUMBER: A. BUILDING B. WING	THOM IBST411 B. WING	THOM 185141 B. WING 102 POCAHONTAS TRAIL. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIPACE OF THE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIPACE OF THE ALL OR OR OF THE ALL OR OF THE A	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		185141	B. WING _			06/03/2020		
	ROVIDER OR SUPPLIER	EORGETOWN	1	STREET ADDRESS, CITY, STATE, ZIF 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 610	skin assessments w #1 with negative find conveyed he/she did nurse was removed no longer worked at Additional interview there was an allegat expectation the resid a full investigation w subsequent follow u zero-tolerance for al what Resident #1 re 04/14/2020 at 4:30 // abuse, the DON rep {he/she} was abuse was no documented investigation to inclu- resident interviews r than the conversation #1. She stated this not believe the incid resident's frequent p behavior. Interview with the Ad 2:00 PM, revealed the DON of Resident throwing a liquid on interview, staff thoug awakened from a be-	ontinued interview revealed ere performed on Resident dings. Also, Resident #1 do not like LPN #2 and this from Resident #1's care and the facility. With the DON, revealed if ion of abuse, it was her dent was assured safety, and as conducted with	F6	510				
	he did not know for a Further interview rev requested to speak when he entered his	not come to the facility and sure if they were called. yealed Resident #1 had with him on 05/11/2020 and higher room, he/she was a later had a conversation						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			06/03/2020	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN				STREET ADDRESS, CITY, STATE, 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					N
F 610	Resident #1 contacte asked him to come to envelope containing i him to read. The Adm letter to the Ombudsr the content. He stated #1 had contacted the 05/26/2020 related to 04/14/2020. Continue allegations of abuses investigated as outlin However, he stated the vidence of statement or any resident interv 04/14/2020 incident, of that occurred with Rewas no documented assessments and skill	d the Ombudsman and the facility and get a sealed information he/she wanted inistrator stated he gave the man, but was not aware of the later learned Resident Corporate Office on the alleged incident of ad interview revealed all should be thoroughly ed in the Abuse policy. There was no documented its obtained, staff interviews itews related to the alleged other than the conversation sident #1. Further, there evidence of physical in assessments completed residents after the facility	F	510			

PRINTED: 07/06/2020 **FORM APPROVED**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED	
185141			B. WING		ne ne	C 06/03/2020		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN				1021	EET ADDRESS, CITY, STATE, ZIP COD POCAHONTAS TRAIL DRGETOWN, KY 40324	DE	310012020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTT TAG CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPR		HOULD BE	ULD BE COMPLÉTION		
E 000	A COVID-19 Focus Survey was initiated concluded on 06/03	ed Emergency Preparedness I on 06/01/2020 and /2020. The facility was found with 42 CFR §483.73 related	EC	000				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE	

06/29/2020

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.

PRINTED: 07/06/2020 **FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ 100381 B. WING 06/03/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **102 POCAHONTAS TRAIL** SIGNATURE HEALTHCARE OF GEORGETOWN **GEORGETOWN, KY 40324** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#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.

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

TITLE

(X6) DATE

06/29/20