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	185112	A. BUILDING _____ B. WING _____	C 06/12/2020

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NIM HENSON GERIATRIC CENTER	420 JETT DRIVE JACKSON, KY 41339

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 06/09/2020 and concluded on 06/12/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		
F 000	INITIAL COMMENTS An abbreviated standard survey (KY31820) and a COVID-19 focused infection control survey was initiated on 06/09/2020 and concluded on 06/12/2020. The complaint was substantiated and deficient practice was identified with the highest scope and severity at "G" level. The facility was found to be out of compliance with 42 CFR 483.80 Infection Control at "E" level. The total census was 61. On 05/30/2020, Resident #1 reported activating his/her call light to request staff assistance with toileting. Due to the long wait, the resident was incontinent of urine. When State Registered Nurse Aide (SRNA) #2 arrived to assist the resident (almost an hour after the call light was activated), the SRNA called the resident an "idiot" and placed an incontinence brief on the resident against the resident's wishes. The resident told the SRNA she was ready to cry and the SRNA told the resident if he/she cried then she (SRNA #2) would leave the resident's room. In addition, observation of the facility's security camera footage revealed on 05/30/2020, Licensed Practical Nurse (LPN) #1 was observed to enter Resident #1's room at 2:22 PM and exit at 2:23 PM. Per LPN #1, Resident #1 had asked for assistance with toileting and the LPN left the room to get assistance for the resident but left the	F 000		

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

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F 000	Continued From page 1 call light on. The LPN went to the Team 2 nurses' station and paged overhead for SRNAs to assist the resident. Further observation of the security camera footage revealed no staff entered Resident #1's room until 3:16 PM (fifty-four minutes later). Interview with Resident #1 on 06/10/2020 revealed the resident was still upset and tearful when asked about the incident stating, "It made me feel really bad and hurt my feelings."	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's investigation, and facility policy review, it was determined that the facility failed to ensure one (1) of five (5) sampled residents (Resident #1) was protected from	F 600		

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verbal/mental abuse. On 05/30/2020, Resident #1 reported activating his/her call light to request staff assistance with toileting. However, due to a long wait, the resident was incontinent of urine. When State Registered Nurse Aide (SRNA) #2 arrived to assist the resident (almost an hour after the call light was activated), the SRNA called the resident an "idiot" and placed an incontinence brief on the resident against the resident's wishes. The resident told the SRNA that she was going to cry and SRNA #2 responded that if the resident cried, she would leave the resident's room. Interview with Resident #1 on 06/10/2020 revealed the resident was still upset and tearful when asked about the incident stating the incident "made me feel really bad and hurt my feelings."

The findings include:

Review of the facility's policy titled, "Abuse Prohibition-Abuse, Neglect, and Misappropriation of Property," undated, revealed each resident had the right to be free from abuse and the facility did not condone abuse by anyone, including staff members. The facility defined abuse as "the willful infliction of injury...with resulting physical harm or pain or mental anguish...It includes verbal, sexual, physical & mental abuse..." Further review of the facility's policy revealed the facility defined mental abuse as "but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services." The policy defined verbal abuse as "any use of oral, written or gestured language that included disparaging and/or derogatory terms to residents or their families, within hearing distance, or to describe residents, regardless of their age or ability to comprehend or disability."

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Review of the medical record for Resident #1 revealed the facility admitted the resident on 03/13/2017, with diagnoses that included Cerebral Palsy, Anxiety, and Osteoarthritis. Review of the most recent annual Minimum Data Set (MDS) assessment dated 03/01/2020, revealed the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was interviewable. The MDS also revealed Resident #1 had been assessed to require the extensive assistance of two (2) staff members for bed mobility and toileting. The MDS revealed the resident was on a toileting program and was frequently incontinent of bladder and occasionally incontinent of bowel.

Review of Resident #1's restorative toileting care plan reviewed on 04/07/2020, and the resident's SRNA care plan dated May 2020, revealed two (2) staff members were required to assist the resident with toileting. Further review of the care plan revealed the resident was on a toileting plan and no interventions had been developed regarding the resident wearing an incontinence brief.

Observation and interview conducted with Resident #1 on 06/10/2020 at 9:40 AM, revealed on 05/30/2020 it had taken staff over one (1) hour to answer his/her call light. The resident stated, "I had to wait too long and went [urinated] on myself." Resident #1 stated when SRNA #2 came into his/her room, she stated, "Why did you do that, you idiot?". Resident #1 told SRNA #2 it was because it had taken so long for someone to answer the call light. The resident with tears in his/her eyes stated, "It made me feel really bad and hurt my feelings." The resident stated SRNA

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#2 changed the resident's clothes and sheets and proceeded to put an incontinence brief on the resident. Resident #1 stated he/she told the SRNA that he/she did not want a brief, but the SRNA put it on anyway and stated, "You have to keep from having another accident." The resident stated he/she then cried because it hurt his/her feelings, and SRNA #2 threatened to leave the resident's room if he/she cried. The resident stated he/she waited until LPN #2 came on duty to report the incident because the resident felt more comfortable talking to her.

Review of a Resident Abuse Investigation Report Form dated 05/30/2020, revealed the facility conducted an investigation of Resident #1's allegations. Review of the facility's report revealed the resident's initial allegation to the facility was the same recollection of events that the resident reported to the surveyor during his/her interview on 06/10/2020. The report stated that Resident #1 reported to Licensed Practical Nurse (LPN) #2 on 05/30/2020 that he/she had activated his/her call light because the resident needed to use the restroom. The resident stated he/she waited for approximately one (1) hour before staff arrived to assist him/her with toileting and was incontinent of urine while waiting for assistance. The investigation revealed when SRNA #2 entered the resident's room to assist the resident, the SRNA stated, "Why did you do that, you idiot?". Resident #1 was about to cry and the SRNA stated, "If you do that [cry], I will leave the room." Further review revealed SRNA #2 placed an incontinence brief on the resident, even though the resident told the SRNA that he/she did not want to wear a brief. According to the facility's investigation, the resident's "feelings" were hurt.

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Interview with Licensed Practical Nurse (LPN) #2 on 06/11/2020 at 12:15 PM, revealed she was asked to go to Resident #1's room at approximately 10:00 PM on 05/30/2020, when Resident #1 reported the allegation. The LPN stated the resident was very upset when he/she reported the allegations regarding the SRNA's treatment of the resident.

A review of a progress note written by Advanced Practice Registered Nurse (APRN) #1 dated 06/02/2020 revealed on 05/30/2020, Resident #1 reported to the APRN "negative verbal speech from SRNA during an episode of urinary incontinence. [Resident #1] stated [he/she] was okay now but that it did hurt [his/her] feelings."

Review of SRNA #2's statement dated 06/02/2020, revealed she entered Resident #1's room and provided incontinence care for Resident #1 alone (even though the resident required the assistance of two staff members) after 2:00 PM on 05/30/2020. The SRNA stated that she did not place an incontinence brief on the resident and did not call the resident an idiot, but did tell the resident that she would leave the room if the resident cried, because she would cry too. According to SRNA #2's statement, she had asked other staff to let her know if any of the residents' call lights were ringing because she was in another resident's room and could not hear the call light.

Interview conducted with SRNA #2 on 06/10/2020 at 10:10 AM, revealed after she left the facility on 05/30/2020, facility staff notified her that she was suspended due to an allegation involving Resident #1. She stated that prior to the phone

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call, she was not aware of any problems with Resident #1. According to SRNA #2, on 05/30/2020 at approximately 10:00 AM, Resident #1 was about to cry because he/she had an incontinence episode. The SRNA admitted that she told the resident if he/she cried, she would leave the room. However, the SRNA stated she made the statement because she was emotional that day and would have cried if she had seen the resident crying. SRNA #2 stated she probably should not have told Resident #1 that she would leave the room. The SRNA also admitted that she placed an incontinence brief under the resident to prevent future accidents. SRNA #2 stated she provided incontinence care for the resident again at approximately 2:00 PM on 05/30/2020; however, the SRNA denied putting an incontinence brief on Resident #1 at 2:00 PM on 05/30/2020, and stated she would not have placed a brief on the resident against his/her will. Further interview with SRNA #2 revealed the SRNA denied calling the resident an idiot. In addition, SRNA #2 denied knowing that the resident's call light had sounded for approximately one hour before receiving assistance. She stated she had asked other staff to notify her if the residents on the unit where Resident #1 resided needed assistance because she was responsible for caring for residents on a different hallway and could not hear Resident #1's call light from there.

An interview with SRNA #4 on 06/11/2020 at 12:30 PM revealed on 05/30/2020 at 3:16 PM she and SRNA #5 entered Resident #1's room because the resident's call light was on. According to SRNA #4, the resident did not normally wear incontinence briefs unless he/she was out of bed, but was wearing one on

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05/30/2020, and was wet.

Interview conducted with SRNA #5 on 06/11/2020 at 12:50 PM, confirmed that she and SRNA #4 assisted Resident #1 on 05/30/2020 because the call light was on. She also stated that the resident only wore an incontinence brief per the resident's request. However, SRNA #5 stated she could not remember if Resident #1 was wearing a brief on 05/30/2020.

Interview conducted with the Director of Nursing (DON) on 06/11/2020 at 12:20 PM, revealed she made rounds several times daily to ensure residents were free from abuse and neglect. The DON stated if a resident did not want something it was their right and the staff should not force them. The DON stated Resident #1 should not have had to wear a brief had he/she not wanted to. The DON further acknowledged that approximately one hour was too long to wait for a call light to be answered and stated that SRNA #2 should not have threatened to leave Resident #1's room, nor should any staff member call a resident an idiot.

Interview with APRN #1 on 06/10/2020 at 9:25 AM, revealed she assessed Resident #1 on 05/31/2020, the day after the incident. She stated the resident was very upset and told her that the day before, the resident needed to use the restroom, but no one answered the call light and the resident was incontinent. According to the APRN, at the time of the incident, Resident #1 had a Urinary Tract Infection, which caused the resident to urinate frequently. Further interview revealed the resident also told the APRN that SRNA #2 gave the resident a "hard time" because the resident had "peed" on

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F 600	Continued From page 8 himself/herself. According to the APRN, Resident #1 was alert and oriented and she believed the incident occurred as stated by the resident because the resident was so upset and the resident's interviews had remained consistent.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §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 observation, interview, record review,	F 610		

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and facility policy review, it was determined that the facility failed to ensure an allegation of abuse was thoroughly investigated per the facility's policy for one (1) of five (5) sampled residents (Resident #1). The facility received an allegation of abuse on 05/30/2020, which alleged State Registered Nurse Aide (SRNA) #2 called Resident #1 an "idiot" after the resident was incontinent due to waiting for approximately one hour for assistance with toileting. In addition, SRNA #2 told the resident that she would leave the room if the resident cried, and then placed an incontinence brief on the resident against the resident's wishes. The facility conducted an investigation, determined that abuse did not occur, and recommended that SRNA #2 be allowed to return to work with no contact with Resident #1. However, the facility's investigation only consisted of an interview with the alleged perpetrator and an assessment and statement from Resident #1. The facility failed to thoroughly investigate Resident #1's allegation in accordance with facility policy/procedure.

The findings include:

A review of the facility's policy titled, "Abuse Prohibition-Abuse, Neglect, and Misappropriation of Property," undated, revealed each resident had the right to be free from abuse and the facility did not condone abuse by anyone, including staff members. The policy revealed the facility would obtain detailed witness statements from staff working at the time the incident occurred and would submit the witness statements with the incident report. According to the policy, the Administrator was responsible for ensuring all investigations were investigated and policy and procedures were followed. The policy did not

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address interviewing/assessing other residents. However, interview with the Administrator on 06/10/2020 at 12:15 PM, revealed it was the facility's procedure to interview all "interviewable" residents and assess all "non-interviewable" residents to ensure they had not been abused or neglected.

A review of Resident #1's medical record revealed the facility admitted Resident #1 on 03/13/2017, with diagnoses that included Cerebral Palsy, Anxiety, and Osteoarthritis. Review of the resident's most recent annual Minimum Data Set (MDS) assessment dated 03/01/2020, revealed the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was interviewable.

A review of a progress note written by Advanced Practice Registered Nurse (APRN) #1 dated 06/02/2020, revealed on 05/30/2020, Resident #1 had reported to the APRN "negative verbal speech from SRNA during an episode of urinary incontinence. [Resident #1] stated [he/she] was okay now but that it did hurt [his/her] feelings."

An interview with Resident #1 on 06/10/2020 at 9:40 AM, revealed on 05/30/2020, he/she waited for approximately one (1) hour for staff to answer his/her call light, and he/she was incontinent of urine due to the long wait time. Resident #1 stated when SRNA #2 finally responded to the resident's call light and found the resident was incontinent, the SRNA stated to the resident, "Why did you do that, you idiot?". Resident #1 stated he/she told SRNA #2 that he/she was incontinent because it had taken so long to answer the call light. The resident with tears in

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his/her eyes stated, "It made me feel really bad and hurt my feelings." Resident #1 stated that SRNA #2 changed the urine-soaked items and proceeded to put an incontinence brief on the resident. Resident #1 stated he/she told the SRNA that he/she did not want a brief; however, the SRNA contained to put a brief on the resident and stated, "You have to keep from having another accident." The resident stated he/she then cried because it hurt his/her feelings. According to Resident #1, SRNA #2 threatened to leave the resident's room if he/she cried.

Interview with Licensed Practical Nurse (LPN) #2 on 06/11/2020 at 12:15 PM, revealed Resident #1 requested the LPN to come to his/her room at approximately 10:00 PM, shortly after her shift began at the facility on 05/30/2020. The LPN stated Resident #1 reported the abuse/neglect allegation, which had happened on the previous shift at approximately 3:00 PM. The LPN stated SRNA #2 had already completed her shift and had gone home, and she immediately notified the Administrator and the Social Worker (SW), who came to the facility. LPN #2 stated she and the SW interviewed Resident #1 and the resident's story was the same. The LPN stated the SW called SRNA #2 for an interview and placed her on suspension; however, no one had asked her (LPN #2) for a statement, nor interviewed her regarding the resident's allegations.

An interview conducted with SRNA #2 on 06/10/2020 at 10:10 AM, revealed she provided care for Resident #1 on 05/30/2020 from 7:00 AM until 3:00 PM. She stated she assisted the resident with incontinence care/toileting approximately every two hours. The SRNA stated at approximately 10:00 AM on 05/30/2020, the

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resident had an incontinence episode and was about to cry. The SRNA stated she was emotional that day and told the resident if he/she cried, she would leave the room. The SRNA acknowledged that she probably should not have told Resident #1 that she would leave the room. The SRNA stated the resident had also been incontinent when she checked on the resident at 2:00 PM. According to SNRA #2, she put an incontinence brief under the resident at 10:00 AM, without fastening the brief. However, she stated she did not place the brief against the resident's will and denied calling the resident an idiot. Further, SRNA #2 acknowledged that she was aware that Resident #2 required two staff members for assistance with incontinence care/toileting, but other staff members were busy and she did not ask for assistance. Continued interview with SRNA #2 revealed she was not aware that the resident's call light rang for one (1) hour on 05/30/2020. She stated she was working with other residents on another unit and could not hear/see the resident's call light. According to SRNA #2, she was not aware that the resident had any concerns when she left for the day at approximately 3:00 PM on 05/30/2020, but the facility called her after she went home and suspended her employment due to Resident #1's allegations.

An interview conducted with SRNA #4 on 06/11/2020 at 12:30 PM, and with SRNA #5 on 06/11/2020 at 12:50 PM revealed they responded to Resident #1's call light on 05/30/2020 at 3:16 PM, just after their shift started. According to SRNA #4, the resident was in bed and wearing an incontinence brief that was wet. SRNA #5 stated she could not remember whether the resident was wearing a brief. Both SRNAs stated the

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resident did not normally wear a brief while in bed and only wore one per the resident's request when out of bed. SRNA #4 and SRNA #5 stated the facility did not interview them, nor obtain their statement regarding Resident #1.

Interview with APRN #1 on 06/10/2020 at 9:25 AM, revealed she assessed Resident #1 on 05/31/2020, the day after the incident, and the resident told her about the incident. The APRN revealed the resident's story remained consistent that he/she was incontinent because no one answered his/her call light. The resident also told the APRN that SRNA #2 gave the resident a "hard time" because the resident had "peed" on himself/herself and the resident was very upset about the incident. According to the APRN, Resident #1 was alert and oriented and she believed the incident occurred as stated by the resident because the resident was so upset and the resident's interviews had remained consistent. APRN #1 stated she was aware that the facility was investigating the matter because the facility had notified her of the incident on 05/30/2020; however, the facility did not interview her and she had not spoken with anyone at the facility about the incident.

A review of a Resident Abuse Investigation Report Form dated 05/30/2020, revealed the facility investigated Resident #1's allegations and determined the resident was not abused and would allow SRNA #2 to return to work, but not care for Resident #1. Review of the facility's investigation revealed the facility's determination was based on no concerns with the resident's skin assessment, no witnesses to confirm the incident, and after the resident spoke with the APRN he/she was okay. Further review revealed

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the facility only obtained a statement from SRNA #2 and interviewed Resident #1. There was no documented evidence that the facility obtained statements from staff who worked at the time the incident occurred as required by the facility policy or from the APRN who assessed the resident and documented that the resident's feelings were hurt. Further, there was no evidence the facility assessed/interviewed other residents to determine if they were affected as required by the Administrator. The investigation report was signed by both the SW and the Administrator.

An interview conducted with the Social Worker (SW) on 06/11/2020 at 1:00 PM, revealed she was responsible for completing all abuse investigations. The SW revealed staff notified her on 05/30/2020 at approximately 10:00 PM of Resident #1's allegations of abuse and immediately went to the facility to initiate an investigation. She stated she notified SNRA #2 at home that she was suspended and conducted an interview with the SRNA. She further stated that she and LPN #2 interviewed Resident #1. According to the SW, she also interviewed one other resident, Resident A, but did not document the interview, nor did she interview any other residents regarding their care/treatment. In addition, the SW stated she had interviewed staff from another unit, but did not document the interviews, and did not interview staff that worked with SRNA #2 on the unit where Resident #1 resided. The SW stated she had given her report to the Administrator to review prior to sending the final report to state agencies because she only had two (2) days of orientation and this was her first investigation. According to the SW, she was "flying by the seat of my pants."

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F 610	Continued From page 15 Interview with the Administrator on 06/10/2020 at 12:15 PM, revealed he reviewed the SW's final report related to Resident #1. He stated he instructed the SW to interview other interviewable residents, but did not follow up and was not aware that only one (1) resident had been interviewed, nor that the SW had not documented the interview. The Administrator stated because he had only reviewed the SW's final written report, and not all documented evidence, he did not identify that the investigation was not thorough and had agreed with the Social Worker that the allegation was unsubstantiated.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, it was determined the facility failed to implement the plan of care for one (1) of five (5) sampled residents (Resident #1). Resident #1's comprehensive care plan required two (2) staff members to provide extensive assistance with toileting and bed mobility. However, interview with State Registered Nursing Assistant (SRNA) #2 revealed she provided incontinence care for Resident #1 on 05/30/2020 at approximately 10:00 AM and 2:10 PM unassisted. In addition, review of Resident #1's toileting care plan, updated 04/07/2020, revealed the resident was to be toileted by staff daily at 9:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 7:00 PM,

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9:00 PM, and as needed. However, review of the resident's Restorative Voiding Sheet dated 05/01/2020 through 06/04/2020, revealed the facility failed to toilet the resident as planned sixty (60) times.

The findings include:

Review of the facility's "Purpose of Nursing Care Plans" policy, dated September 2017, revealed care plans provide for consistency of care and to allow the nursing team to customize its interventions for each resident. The policy also directed SRNAs to refer to the care plans at the start of their shift and at any time there was a question about a resident's care. According to the policy, staff could utilize more staff than a care plan called for, but may not use less staff than required by the care plan.

A review of Resident #1's medical record revealed the facility admitted the resident on 03/13/2017, with diagnoses that included Anxiety, Cerebral Palsy, and Osteoarthritis. Review of the most recent annual Minimum Data Set (MDS) assessment dated 03/01/2020, revealed Resident #1's Brief Interview for Mental Status (BIMS) score was thirteen (13) which indicated the resident was interviewable. The MDS also revealed Resident #1 had been assessed to require the extensive assistance of two (2) staff members for bed mobility and toileting.

1. According to Resident #1's SRNA care plan, dated May 2020, the resident required the extensive assistance of two (2) persons for toileting and the resident was continent of both bowel and bladder.

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Interview conducted with SRNA #2 on 06/10/2020 at 10:10 AM, revealed she was aware that Resident #1 required the extensive assistance of two (2) staff persons for toileting and bed mobility. However, on 05/30/2020, the SRNA provided incontinence care while the resident was in bed at 10:00 AM, and between 2:10 PM and 2:15 PM, alone, and did not have another staff member assist with the resident's care. According to SRNA #2, all other SRNAs were busy and she did not ask a nurse for assistance.

2. Review of Resident #1's comprehensive care plan, restorative toileting care plan, updated 04/07/2020, revealed staff were required to toilet the resident daily at 9:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 7:00 PM, 9:00 PM, and as needed.

Review of a Restorative Voiding Sheet dated 05/01/2020 through 06/04/2020, revealed Resident #1 had not been toileted as required by the resident's care plan on 60 occasions from 05/01/2020 through 06/04/2020.

Interview conducted with SRNA #6 on 06/10/2020 at 9:45 AM, revealed she was required to review the care plan for residents at the beginning of every shift, and stated she was aware that the resident was on a toileting program and that she was required to toilet the resident at specific times and as needed. According to the SRNA, she was unaware Resident #1 was not being toileted at the times directed by the care plan.

An interview with SRNA #7 on 06/10/2020 at 10:00 AM, revealed she was also aware that staff were required to check residents' care plans at the beginning of every shift. The SRNA confirmed that Resident #1 was on a toileting

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F 656	Continued From page 19 plan and stated that she thought she had been toileting Resident #1 as directed. Interview with Licensed Practical Nurse (LPN) #2 conducted on 06/11/2020 at 12:10 PM, revealed she had developed the toileting care plan for Resident #1 and staff were required to review resident care plans at the beginning of every shift. The LPN further stated that the resident required the extensive assistance of two (2) persons for toileting and incontinence care. The LPN stated she reviewed the Restorative Voiding Sheets monthly to ensure staff were completing the forms as directed and had not identified that staff were not toileting Resident #1 as directed by the care plan. Interview conducted with the Director of Nursing (DON) on 06/11/2020 at 12:20 PM, revealed she made rounds several times daily to ensure residents were receiving care as directed by the residents' care plans. The DON stated she had not identified any concerns with residents not receiving the care as directed by their care plans.	F 656		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 835		

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by:
Based on interview, record review, review of a facility investigation, and review of the Administrator's job description, it was determined that the facility failed to be administered in a manner that enabled it to attain or maintain the highest practicable physical well-being of each resident. According to the Administrator's job description and the abuse policy, he was responsible for the competence of the workforce and was responsible to ensure all abuse/neglect investigations were investigated and policy and procedures followed. However, the Administrator designated the Social Worker to complete resident abuse/neglect investigations without ensuring she was competent to do so. Subsequently, the Social Worker failed to thoroughly investigate Resident #1's allegation of abuse/neglect on 05/30/2020.

The findings include:

Review of the Administrator's job description, not dated, revealed the primary purpose of the Administrator's job was to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to provide excellent care to residents. The job description also revealed the Administrator would review and frequently check the competence of the workforce.

A review of the facility's policy titled, "Abuse Prohibition-Abuse, Neglect, and Misappropriation of Property," undated, revealed each resident had the right to be free from abuse and the facility did not condone abuse by anyone, including staff members. The policy revealed the facility would

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obtain detailed witness statements from staff working at the time the incident occurred and would submit the witness statements with the incident report. Further review revealed the policy did not address interviewing/assessing other residents when conducting an investigation. However, interview with the Administrator on 06/10/2020 at 12:15 PM, revealed it was the facility's procedure to interview all "interviewable" residents and assess all "non-interviewable" residents to ensure they had not been abused or neglected. Further review of the abuse policy revealed the Administrator or his designee would investigate all alleged incidents of abuse. However, the policy revealed it was ultimately the Administrator who was responsible to ensure all investigations were investigated and policy and procedures followed.

Interview with the Administrator on 06/10/2020 at 12:15 PM, revealed he had designated the facility Social Worker to complete facility abuse/neglect investigations and the Social Worker had investigated an allegation made by Resident #1.

Review of the Social Worker's employee file revealed the facility hired the Social Worker (SW) on 09/16/2019. However, there was no documented evidence in the employee's file that the SW had been trained on how to conduct an abuse/neglect allegation. The surveyor requested that the Administrator provide a copy of the SW's education on 06/12/2020 at 10:50 AM; however, the facility provided no training evidence.

Review of a Resident Abuse Investigation Report Form dated 05/30/2020, revealed the facility Social Worker investigated an allegation that

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SRNA #2 called Resident #1 an "idiot" when the resident was incontinent after waiting for approximately one hour for staff to respond to his/her call light; that SRNA #2 placed an incontinence brief on Resident #1 against his/her will; and that SRNA #2 told the resident that if he/she cried, the SRNA would leave the room. According to the investigation, the SW interviewed SRNA #2 and Resident #1, and an assessment of Resident #1 was completed. Review of the facility's final investigative report revealed the facility determined that SNRA #2 did not abuse Resident #1 and planned to allow SRNA #2 to return to work with no contact with Resident #1. According to the report, the decision was based upon no witnesses being found to confirm the incident; however, there was no documented evidence that staff who worked during the incident, or any staff, was interviewed in accordance with facility policy. Further review revealed the facility's decision to unsubstantiate was based upon no concerns being identified with Resident #1's skin assessment, and that the resident was okay after he/she spoke with APRN #1. However, there was no evidence that the facility interviewed the APRN or considered that the APRN documented that the resident's "feelings were hurt." (Refer to F610.) The report was signed by the SW and the Administrator.

Interview with the Social Worker (SW) on 06/10/2020 at 11:30 AM, revealed the investigation involving Resident #1 was the first investigation that she had completed since her employment at the facility. The SW stated she only received two (2) days of orientation when she was hired and was "flying by the seat of my pants" when she conducted the investigation. According to the SW, she asked the

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F 835	Continued From page 23 Administrator to review the investigation before submitting the documentation to state agencies to ensure the investigation was complete and accurate; however, he only advised her to interview another resident (no documented evidence that it was completed). Interview with the Administrator on 06/10/2020 at 12:15 PM, confirmed that he was ultimately responsible for ensuring abuse allegations were investigated thoroughly. The Administrator also confirmed that the social worker asked for assistance with the investigation and he had instructed the SW to interview interviewable residents. However, he did not follow up and stated he was not aware that the SW only interviewed one resident, nor that the interview was not documented. According to the Administrator, the SW had received two (2) weeks of training with the previous SW and he was not aware that she did not feel comfortable conducting investigations. Further interview revealed the Administrator was not aware that this was the SW's first investigation, and he only read the SW's final report and did not review witness statements or any other documentation. Subsequently, the Administrator did not identify that the SW did not interview other staff and residents and document the interviews, nor that all non-interviewable residents were not assessed to ensure they had not been abused or neglected. The Administrator stated that based on the final report, he agreed with the SW that the allegation was unsubstantiated, but was not aware at the time that the investigation was not thorough.	F 835		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 24 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of facility policy, and review of the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) guidance, it was determined that the facility failed to properly prevent the possible spread of COVID-19. On 06/09/2020, two (2) Licensed Physical Therapy Assistants (PTAs), one (1) State Registered Nurse Aide (SRNA), two (2) Dietary Aides (DAs), two (2) Cooks, and the Dietary Manager (DM) were all observed not wearing a

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	185112	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIM HENSON GERIATRIC CENTER	420 JETT DRIVE JACKSON, KY 41339

(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
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face mask appropriately in accordance with facility policy and CMS and CDC Guidance.

The findings include:

A review of COVID-19 Long-Term Care Facility Guidance from CMS dated 04/02/2020 and review of the facility's policy, "Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)" with a revision date of 04/13/2020, revealed all staff should wear a face mask while they are in the facility.

According to CDC guidance for "Using PPE," updated on 06/09/2020, when applying a face mask, the nose piece (if the mask has one), "should be fitted to the nose with both hands" and "should be extended under [the] chin." The guidance stated both the "mouth and nose should be protected." The guidance also stated that face masks should not be pulled below the chin.

1. Observation during the initial tour on 06/09/2020 at 10:35 AM revealed PTA #1 and PTA #2 were observed in the dining room with their face masks below their noses, leaving their nose exposed. Six (6) residents were observed in the dining room.

Interview with PTA #1 on 06/09/2020 at 10:40 AM, revealed he had been trained how to wear his face mask and should have covered his nose with the mask.

Interview with PTA #2 on 06/09/2020 at 10:45 AM, revealed he had been trained how to properly wear his face mask and should have had it pulled over his nose. The PTA stated his face mask had slipped down.

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2. Observation during initial tour at the Team 2 Unit nurses' station on 06/09/2020 at 10:50 AM, revealed SRNA #1 was observed to be wearing a face mask that was not covering her nose. Two (2) residents were observed in front of the nurses' station.

Interview with SRNA #1 on 06/09/2020 at 10:55 AM, revealed she had been trained how to properly don a face mask and was required to wear her face mask while at work. The SRNA stated her mask kept falling down.

3. Observation during initial tour on 06/09/2020 at 10:58 AM, revealed DA #1 and DA #2 were observed walking toward the Team 2 nurses' station. DA #1 was observed to have her face mask under her chin and not covering her nose or her mouth. In addition, DA #2 was observed to have her face mask down below her nose. Two (2) residents were observed at the Team 2 Unit nurses' station.

Interview with DA #1 on 06/09/2020 at 11:10 AM, revealed she had been trained how to appropriately don a face mask and was aware that she was required to wear it while she was in the facility. The DA stated she had pushed her face mask down to get a breath of fresh air.

Interview with DA #2 on 06/09/2020 at 11:15 AM, revealed her face mask had slipped down and needed to be tightened.

4. Observation during initial tour of the kitchen on 06/09/2020 at 11:05 AM, revealed Cook #1 and Cook #2 were in the kitchen with their face masks not covering their noses. The cooks were in the

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process of preparing lunch, and food was observed on the preparation table. In addition, the DM was observed to walk through the kitchen with her face mask hanging on her left ear and not covering her nose or her mouth.

Interview conducted with the DM on 06/09/2020 at 1:55 PM, revealed she had removed her face mask to talk on a telephone, and failed to put her mask back on after the phone call.

Interview with Cook #1 on 06/09/2020 at 1:58 PM, revealed her face mask kept falling down and she should have had ensured it was covering her nose.

Interview with Cook #2 on 06/09/2020 at 2:05 PM, revealed her mask needed to be tightened and she should have ensured that her mask was pulled up.

An interview with the Director of Nursing (DON) on 06/09/2020 at 2:30 PM, revealed all staff were required to wear a face mask at all times when in the building to help prevent the spread of the Coronavirus. She stated CMS's guidance was initiated on 04/03/2020 and all staff were trained. According to the DON, she made rounds to monitor to ensure staff were following the policy and she was providing on-the-spot education if needed. The DON stated she had not identified any concerns with staff not appropriately donning face masks.

An interview with the Administrator on 06/09/2020 at 2:35 PM revealed the Administrator was aware of the CMS Guidance, had revised the facility policy, and implemented the guidance on 04/03/2020. According to the Administrator, all

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F 880	Continued From page 29 staff were required to wear a face mask when inside the building in accordance with the facility policy to help prevent the spread of the Coronavirus.	F 880		

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N 000	Initial Comments A complaint investigation (KY31820) and a COVID-19 focused infection control survey was initiated on 06/09/2020 and concluded on 06/12/2020. The complaint was substantiated and deficient practice was identified pursuant to 42 CFR 483.10-483.95. Deficient practice was also identified related to the infection control survey.	N 000		

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