PRINTED: 07/07/2020 FORM APPROVED OMB NO. 0938-0391

		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE : COMPL	
STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL.			185141	B. WING _				
CAN D SUMMARY STATEMENT OF DEFICIENCIES D PROVIDERS PLAN OF CORRECTION CAN PREFIX TAG PROVIDERS PLAN OF CORRECTION CAN CAN	NAME OF PR	ROVIDER OR SUPPLIER				ZIP CODE	00/	7012020
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/01/20/20 and concluded on 06/03/20/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). F 000 INITIAL COMMENTS An Abbreviated Survey investigating Complaint KY#00031775 and a COVID-19 Focused Infection Control Survey was initiated on 06/03/20/20. Complaint KY#00031775 was unsubstantiated with related deficiencies cited at the highest Scope and Severity of a 'D'. It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 50. F 607 SS=D F 607 CSR(s): 483.12(b)(1)-(3) §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	SIGNATUR	RE HEALTHCARE OF G	EORGETOWN					
A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/01/2020 and concluded on 06/03/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). F 000 An Abbreviated Survey investigating Complaint KY#00031775 and a COVID-19 Focused Infection Control Survey was initiated on 06/01/2020 and completed on 06/03/2020. Complaint KY#00031775 was unsubstantiated with related deficiencies cited at the highest Scope and Severity of a "D". It was determined the facility had implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 50. F 607 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED)	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
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§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607	An Abbreviated Surv KY#00031775 and a Infection Control Sur 06/01/2020 and com Complaint KY#0003 with related deficient Scope and Severity the facility had imple Centers for Disease (CDC) recommended COVID-19. Total cer Develop/Implement / CFR(s): 483.12(b)(1) §483.12(b) The facility	vey investigating Complaint COVID-19 Focused vey was initiated on pleted on 06/03/2020. 1775 was unsubstantiated cies cited at the highest of a "D". It was determined mented the CMS and Control and Prevention d practices to prepare for nsus 50. Abuse/Neglect Policies 0-(3)					
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		§483.12(b)(1) Prohibineglect, and exploita misappropriation of r §483.12(b)(2) Establito investigate any su §483.12(b)(3) Including paragraph §483.95,	it and prevent abuse, tion of residents and esident property, ish policies and procedures ch allegations, and e training as required at					

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

(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			C 06/03/2020	
	ROVIDER OR SUPPLIER	SEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 607	Continued From pa	ge 1	F 6	507			
	by: Based on interview the facility's policy, if failed to ensure its a were implemented r investigating allegat four (4) sampled resembles and resident #1 reporters someone threw liquextremities, startling to yell out for help. If documented eviden written abuse policy alleged violation to sconducting a thorough the allegation was in on 04/14/2020, State of the allegation untresident reported the Office. Also, there we of staff interviews, in residents, or physical assessments conducted and review of the facility Misappropriation of reviewed and revised organization's policy. Administration, or his reasonable investigation.	him/her and causing him/her However, 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 nterviews with interviewable al assessments/skin acted for non-interviewable acility learned of the F-609 and F-610) E: y's "Abuse, Neglect, and Property" Policy, last ad 05/08/19, revealed "It is the or that the Facility is or her designee, will direct a action of each such alleged or she has a conflict of					

AND DUAN OF CODDECTION DEPOSITION NUMBER.		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		185141	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	·	06/03/2020	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	reports, grievances, could constitute "allian unknown source of crime." The investinterviews of persor of the alleged event applicable, the follow pertinent when condinvestigation: The date and time of the investigation of the entire facility, conduct an approprince of the investigation of the investig	reservealed, "The vestigate all allegations, and incidents that potentially egations of abuse," injuries of "exploitation", or "suspicions stigation should include as who may have knowledge at To the extent possible and wing information may be ducting a reasonable of the incident aumstances of the incident aumstances of the incident arinjury of injured person (for ad to a hospital) assess and their accounts of the of notification of the resident's of the person completing the abuse, the Director of Nursing signee will conduct interviews idents on the resident's unit, as appropriate; and shall is appropriate; and shall is appropriate; and shall is appropriate; and shall is appropriate; and condition. Incould be documented on	F 6	07			

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		C 06/03	/2020
	ROVIDER OR SUPPLIER	ORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		72020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	7 Continued From page 3		F 60	07		
	and will implement co with the investigation eliminate any ongoing residents.	use of the alleged violation prective action consistent findings and take steps to g danger to the resident or				
	alleged violations involved in the second of	or mistreatment are , but no later than two (2) tion is made. If a State t establishes a longer tain unusual incidents other t, that reporting time applies s. In other words, all ents of abuse or neglect, as				
	the facility admitted the with multiple diagnose. Rhabdomyolysis, Unsure Weakness, Need for Care, Other Skin Chabisorder, Obsessive-					
	signed on 04/14/2020 Director (SSD), reveathis/her roommate or son his/her legs and the verbally to the Director	laint/Grievance Report", by the Social Services led Resident #1 complained someone else threw water lis was communicated by of Nursing (DON). of Investigation" Section of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		185141	B. WING _			C 06/03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		00/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	DON, revealed "see The "Results of Actin Report, dated 04/18 revealed "investigate was his/her roomma" "Well, someone three Review of the "Rescondated 04/18/2020, someone three Director (SSD), reversolved, and resided Review of the attact 04/15/2020, written reported Resident # and investigate some him/her. The DON Nursing (ADON) were garding the incide accused his/her room him/her, at 4:30 AM resident, there was roommate could not at him/her from acrostated, "Well, someone my bed was wet." The procedure was to not Administrator and not and DON looked at extremities, and not than what he/she was by the Wound Physical Review of the Long.	A/18/2020, signed by the attached sheet of interview". On Taken" Section of the //2020, signed by the DON, ed, {he/she} was insistent it it. "Resident #1 then stated, ew it", but never stated who. Solution" Section of the Report, igned by the Social Services ealed complaint/grievance ent seemed satisfied. Tend Statement dated by the DON, revealed it was 1 called the police to come eone throwing acid on and Assistant Director of ent to speak with the resident ent. Resident #1 at first ent to speak with the resident ent. Resident #1 at first ent ent for throwing acid on this morning. Explained to eno acid in facility and physically throw something ess the room. Resident #1 ene threw something on me, ene DON explained the proper of the to call the police. ADON resident's bilateral lower eskin issues were noted other as currently being treated for cian. Term Care Facility-Self	F	607		
	Reported Incident F by the Office of Insp 05/26/2020, reveale occurred on 04/14/2	orm-Initial Report, received bector General (OIG) on d an alleged incident 020 involving Resident #1. at on 04/14/2020 around 4:00				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		185141	B. WING			C 06/03/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		10/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	something, either within/her. Resident # the nurse (Licensed Resident #1 also allithe Administrator via to his/her room to ta There was no docur policy was implement abuse to the State A conducting a thorouthe allegation was in on 04/14/2020, State of the allegation untino documented evicimplemented related investigation as there evidence of statement or any resident inter 04/14/2020 incident that occurred with R was no documented	ed his/her room and threw ater, or something else on at alleged it may have been	F 6			
	non-interviewable renotified of the allege Interview with the Di 06/01/2020 at 1:42 I 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 I	esidents after the facility was ad incident on 04/14/2020. Frector of Nursing (DON), on PM, revealed she visited raing of 04/14/2020, after sident had contacted the eone had thrown acid on uities. Per interview, the her roommate did this, and sident #1 the facility did not building. Further interview 1 insisted that someone iquid on his/her lower oconveyed he/she did not like				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185141	B. WING				03/2020
	ROVIDER OR SUPPLIER	EORGETOWN	1	10	TREET ADDRESS, CITY, STATE, ZIP CODE D2 POCAHONTAS TRAIL EORGETOWN, 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 607	was removed from R longer worked at the Additional interview withere was an allegation were to be notified tir. However, she stated reported timely to Stafacility did not believe the resident's frequer behavior. Per intervier reported the allegation 05/26/2020, State Ag Continued interview was no documented investigation as per printerviews or any resist incident, other that occurred with Reside documented evidence completed for non-intof the investigation.	esident #1's care and no facility. with the DON, revealed if on of abuse, State Agencies nely as per facility policy. This allegation was not ate Agencies because the encident occurred due to at paranoid and accusatory ew, after learning the resident on to the Corporate Office on encies were notified. With the DON, revealed there evidence of a thorough colicy, to include staff dent interviews related to an the conversation that ant #1. Further, there was no erof skin assessments derviewable residents as part		607			
	2:00 PM, revealed he nurse informed the D allegation of someon him/her on 04/14/202 administrative staff di allegation of abuse, a #1 had awakened fro he/she also reported but the police did not interview revealed he #1 had contacted the 05/26/2020 related to 04/14/2020, and the	e throwing a liquid on 20. Per interview, d not identify this as an and thought maybe Resident m a bad dream because he/she had called the police, come to the facility. Further e later learned that Resident Corporate Office on the alleged incident of					

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185141	B. WING				C 03/2020
NAME OF PROVIDER	R OR SUPPLIER ALTHCARE OF GE	CORGETOWN		10	TREET ADDRESS, CITY, STATE, ZIP CODE 02 POCAHONTAS TRAIL BEORGETOWN, KY 40324		00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
intervevide or an 04/14 that of was rasses non-inotific Continabuse inves F 609 SS=D CFR(S483 involves that of serior the earth ours that of serior the earth of serio	ence of statement by resident interview 4/2020 incident, of the cocurred with Reno documented assents or skin interviewable resided of the alleged inued interview reshould be reporting of Alleged (s): 483.12(c)(1)(c).12(c) In response to, exploitation, and misapproper the allegation of the allegatio	ere was no documented the obtained, staff interviews fiews related to the alleged other than the conversation sident #1. Further, there evidence of physical assessments completed for sidents after the facility was a lincident on 04/14/2020. Evealed all allegations of orted timely and thoroughly ed in the Abuse policy.		607			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185141	B. WING		C 06/03/2020	
	ROVIDER OR SUPPLIER	GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	1 00/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR 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 609	accordance with S Survey Agency, wi incident, and if the	age 8 entative 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.	F 60	09		
	by: Based on interview facility's policies, a Revised Statues (If facility failed to ensinvolving abuse or immediately, but not the allegation is matter allegation involved on (1) of four (4) #1). On 04/14/2020, Refisher roommate on his/her legs who resident causing however, the facility allegation of abuse allegation to State abuse allegation with resident causing however.	W, record review, review of the nd review of the Kentucky (RS), it was determined the sure all alleged violations neglect, were reported o later than two (2) hours after ade, if the events that cause live abuse to State Agencies for sampled residents (Resident esident #1 reported either for someone else threw liquid file in bed, and startled the im/her to scream out for help. It ty did not identify this as an erand did not report the Agencies as per Policy. The was not reported to State 26/2020, after Resident #1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	ATE SURVEY OMPLETED
		185141	B. WING			C 06/03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP COL 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		3510512025
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 609	Misappropriation of reviewed and revise alleged violations in neglect, exploitation reported immediatel hours after the alleg reporting requirement reporting time for cethan abuse or negle only to such incident allegations and incidefined in this policy "immediately", as dealined allegation mutwo (2) hours from the received. Review of KRS Chaoral or written report to the State Agencies suspected abuse, neadult. Review of Resident the facility admitted with diagnoses to incurs under the presentation of the state of the	r's "Abuse, Neglect, and Property" Policy, last d 05/08/19, revealed all volving abuse, neglect, or mistreatment are y, but no later than two (2) ation is made. If a State in establishes a longer rtain unusual incidents other ct, that reporting time applies is. In other words, all lents of abuse or neglect, as r, will be reported iffined in this paragraph. Any ist be reported to State within the time the allegation was supported important of the resident on 02/06/2020 clude Rhabdomyolysis, iscle Weakness, Need for sonal Care, Generalized obsessive-Compulsive r Heart Disease, and	F 60	09		
		#1's Admission Minimum essment, dated 02/13/2020.				

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		185141	B. WING			C 06/03/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	·	06/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	having a Brief Interviscore of fifteen (15) intact cognition. Further Assessment, reveal Resident #1 as exhipother behavioral synthesis of the "Comsigned 04/14/2020 to (SSD), revealed Resident #1 as exhipother roommate or on his/her legs and verbally to the Direct Review of the attach 04/15/2020, written reported Resident #1 and investigate som him/her. The DON and investigate som him/her aroommate of 4:30 AM this morning the incide his/her roommate of 4:30 AM this morning there was no acid in could not physically from across the room "Well, someone three was wet." Review of the Long Reported Incident F by the Office of Insp 05/26/2020, revealed occurred on 04/14/2 #1. Resident alleged AM, someone entersomething, either was such as experienced and the something, either was something, either was something, either was something as the something across the room of the Long Reported Incident F by the Office of Insp 05/26/2020, revealed occurred on 04/14/2 #1. Resident alleged AM, someone entersomething, either was something, either was something across the room of the Long Reported Incident F by the Office of Insp 05/26/2020, revealed occurred on 04/14/2 #1. Resident alleged AM, someone entersomething, either was something, either was something across the room of the Long Reported Incident F by the Office of Insp 05/26/2020, revealed occurred on 04/14/2 #1.	assessed the resident as iew for Mental Status (BIMS) out of fifteen (15), indicating ther review of the MDS ed the facility assessed biting no physical, verbal, or	F 60	09		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185141	B. WING				C 03/2020
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2020
				10	02 POCAHONTAS TRAIL		
SIGNATUI	RE HEALTHCARE OF GI	EORGETOWN		G	GEORGETOWN, 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 609	Continued From page	e 11	F	609			
	#2). Resident #1 also this to the Administra	ensed Practical Nurse (LPN) o alleged he/she reported tor via a letter, but the came to his/her room to talk					
	11:30 AM, revealed of someone threw some extremities and this at he/she screamed out State Registered Nur his/her room and he/interview, SRNA #4 hit was wet. Additional came to his/her room instructed him/her necall the staff when nefurther stated he/she the Administrator, but came to talk to him/her visit him from coming to the stated he/she then for Ombudsman, sealed Administrator to give	it to the Ombudsman. e/she wanted to let someone					
	nurse on night shift weveryone down the hLPN #2 by name. Reafunny feeling it might threw the liquid on hinot see this nurse dofalsely accuse the nurse murse of the see the nurse of the see the nurse of the see the nurse do	with Resident #1, revealed a vas mean to him/her and all. Resident #1 identified esident #1 stated he/she had ht have been LPN #2 who m/her, but since he/she did it, he/she did not want to urse. Per interview, Resident nurse. He/she stated, what					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED	
		185141	B. WING _			C 06/03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIF 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		30,00,2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 609	was abuse. Phone interview with 5:05 PM, revealed s 04/14/2020 at 04:30 alleged event, and h went to check on hir Resident #1 said son his/her bed, and he/s startled by this. SRN sheet and bed cover with what appeared the bed. She stated Resident #1 by tellin and the bed linens w stated she thought p kicked over his/her v not recall if she obse over, Further intervier reported this inciden nurse on duty, as shabuse. LPN #2 no longer we unable to be reached linterview with the Di 06/01/2020 at 1:42 F Resident #1 the more being informed the repolice to report some his/her lower extrem resident implied his/	r on 04/14/2020 at 4:30 AM a SRNA #4, on 06/02/2020 at the was working on AM, at the time of the eard Resident #1 yelling and n/her. Per interview, meone spilled something on she was awakened and IA #4 confirmed Resident #1's rings were wet to the touch to be water toward the foot of she tried to reassure g him/her it was "just water", were changed. SRNA #4 rerhaps Resident #1 had water pitcher, but she could erved the water pitcher turned ew revealed SRNA #4 to LPN #2, who was the e felt this was an allegation of orked at the facility and was	F	509		
	have any acid in the #1 insisted that som liquid on his/her lowe	building. Further, Resident eone threw some kind of er extremities. Continued esident #1 conveyed he/she				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		185141	B. WING _			C 06/03/2020
	ROVIDER OR SUPPLIER	GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CO 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 609	Continued From pa	ge 13	F 6	609		
		and this nurse was removed care and no longer worked at				
	there was an allegal expectation State A as per facility policy Resident #1 reported at 4:30 AM would be replied, "The resided abused." She stated reported timely to Seacility did not belied the resident's frequence behavior. Per interverported the allegation of the state of th	with the DON, revealed if ation of abuse, it was her gencies were notified timely. When questioned if what at the morning of 04/14/2020 be considered abuse, the DON ant never said {he/she} was at this allegation was not attate Agencies because the we the incident occurred due to be ent paranoid and accusatory ariew, after learning the resident ion to the Corporate Office on agencies were notified of the				
	2:00 PM, revealed the DON of Resider throwing a liquid on interview, administr as an allegation of a Resident #1 had aw because he/she also the police, who did further stated he lat contacted the Corpulleging on 04/14/2 someone entered him/her. Resident with the nurse (LPN #2) responsibility to enswere reported to St	dministrator, on 06/01/2020 at the night shift nurse informed at #1's allegation of someone him/her on 04/14/2020. Per ative staff did not identify this abuse, and thought perhaps wakened from a bad dream oreported he/she had called not come to the facility. He ter learned Resident #1 had prate Office on 05/26/2020, 020 around 4:00 AM, is/her room and threw that or something else on #1 alleged it may have been at Per interview, it was his sure all allegations of abuse at Agencies in a timely although the facility learned				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
				<u> </u>		С
		185141	B. WING _		o	6/03/2020
	ROVIDER OR SUPPLIER RE HEALTHCARE OF GE	ORGETOWN		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 .SC 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 609	Continued From page	· 14	F 6	09		
	allegation was not repuntil 05/26/2020, after allegation to Corporate					
F 610 SS=D	l	forrect Alleged Violation (4)	F6	10		
		se to allegations of abuse, or mistreatment, the facility				
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.				
		t further potential abuse, or mistreatment while the gress.				
	designated represent accordance with State Survey Agency, within incident, and if the all	the results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the aged violation is verified a action must be taken.				
	by: Based on interview, r	is not met as evidenced record review, and review of was determined the facility				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		185141	B. WING _			C 06/03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIF 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	CODE	00/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	
F 610	failed to have evident of abuse, or mistreat investigated for one residents (Resident : Resident #1 alleged threw liquid on his/he him/her and causing However, there was thorough investigation the allegation. (Refe The findings include: Review of the facility Misappropriation of Freviewed and revised organization's policy Administration, or his reasonable investigation unless he of interested or is implificulation." Guidelines Administrator will inverports, grievances, could constitute "allegan unknown source, of crime." The invest interviews of persons of the alleged event applicable, the follow pertinent when condinvestigation: The date and time of	ment are thoroughly (1) of four (4) sampled #1). on 04/14/2020, someone er lower extremities, startling her to yell out for help. no documented evidence a on was conducted related to or to F-607 and F-609). 's "Abuse, Neglect, and Property" Policy, last d 05/08/19, revealed "It is the that the Facility s or her designee, will direct a ation of each such alleged or she has a conflict of cated in the alleged s revealed, "The estigate all allegations, and incidents that potentially gations of abuse," injuries of "exploitation", or "suspicions igation should include s who may have knowledge To the extent possible and ving information may be ucting a reasonable if the incident instances of the incident incident injury injured person	F	510		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			06/03	3/2020
	ROVIDER OR SUPPLIER RE HEALTHCARE OF GE	ORGETOWN		STREET ADDRESS, CITY, STAT 102 POCAHONTAS TRAIL GEORGETOWN, KY 4032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 610	incident The time and date of		F €	310			
	documentation	the person completing the					
	of alleged resident ab (DON) or his/her desi of interviewable resid or the entire facility, a conduct an appropria residents who are not	he Policy, revealed in cases use, the Director of Nursing gnee will conduct interviews ents on the resident's unit, s appropriate; and shall te physical assessment of capable of being stigation will review the					
	The investigation sho company approved, of the Administrator will determine the root ca and will implement co with the investigation	nt's history and condition. uld be documented on					
	last reviewed and rev revealed all residents with respect and dign promoted and protect residents will be treat environment that pror enhancement of quali residents have the rig	have the right to be treated ity. These rights will be ed by the facility. All ed in a manner and in an notes maintenance or					

C / 03/2020
00,2020
(X5) COMPLETION DATE

AND DUAN OF CODDECTION DEPOTED AND DESCRIPTION NUMBER.		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		185141	B. WING		C 06/03/2020	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	00/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 610	The "Results of Actic Report, dated 04/18, revealed "investigate was {his/her} roomm stated, "Well, someowho. Review of the Report, dated 04/18, revealed complaint/gresident seemed sat Review of the attach 04/15/2020, written be reported Resident # and investigate some him/her. The DON a Nursing (ADON) were garding the incident his/her roommate of 4:30 AM this morning there was no acid in not physically throw across the room. Resomeone threw som wet." The DON explays to notify either thand not to call the polooked at the resider extremities, and no stand what he/she was by the Wound Physic However, further revealed there was restatements obtained interviews related to conversation that oc addition, there was respectively.	attached sheet of interview". In Taken" Section of the 2020, signed by the DON, ed, {he/she} was insistent it ate." Resident #1 then one threw it", but never stated "Resolution" Section of the 2020, signed by the SSD, prievance resolved, and isfied. In the Book of the 2020, signed by the SSD, prievance resolved, and isfied. In the Book of the 2020, signed by the SSD, prievance resolved, and isfied. In the Book of the 2020, signed by the SSD, prievance resolved, and isfied. In the Book of the 2020, signed by the SSD, prievance resolved, and isfied. In the Book of the SSD, prievance resolved, and isfied. In the Book of the SSD, prievance resolved, and isfied. In the Book of the SSD, prievance resolved, and isfied. In the Book of the SSD, prievance resident the resident the resident the resident the sident the resident the second the second the proper procedure of the Book of the Administrator of the Book of the Administrator of the Book of the Skin issues were noted other is currently being treated for	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		185141	B. WING			C	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	DE	06/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 610	Continued From pag		F 6	10			
	04/14/2020, revealed	#1's Progress Notes, dated dono documentation depicting t which allegedly occurred at					
	Reported Incident For by the Office of Insponsive Market 1 (1974) 1974 (1974)	220 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 nsed Practical Nurse #2). eges he/she reported this to a letter, and he never came					
	11:30 AM, revealed of facility about three (3 receiving rehabilitation interview, on April 14 threw something on this alarmed him/her out for help. Resider Nurse Aide (SRNA); and she reported this frightened. He/she schange his/her bed a interview revealed the following morning never to call the police needing help. Resider requested to speak to	ent #1, on 06/01/2020 at me/she was admitted to the B) months ago, and was on after falling at home. Per eth at at 4:30 AM, someone his/her lower extremities and 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 ce, but call the staff when ent #1 stated he/she then to the Administrator, but the came to talk to him/her.					

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324 D PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 610 Continued From page 20 Continued interview revealed Resident #1 called the Ombudsman, who told him/her visitation restrictions prohibited him from coming to the facility. Resident #1 stated he/she then formulated a letter for the Ombudsman, sealed it, and asked the Administrator to give it to the Ombudsman, which he did. Per interview, he/she wanted to let someone know what was going on at the facility. Additional interview with Resident #1, revealed a nurse on night shift was mean to him/her and everyone down the hall. Resident #1 identified the nurse by name, Licensed Practical Nurse (LPN) #2. Resident #1 stated he/she had a funny			185141	B. WING _			C 06/03/2020
F 610 Continued From page 20 Continued interview revealed Resident #1 called the Ombudsman, who told him/her visitation restrictions prohibited him from coming to the facility. Resident #1 stated he/she then formulated a letter for the Ombudsman, sealed it, and asked the Administrator to give it to the Ombudsman, which he did. Per interview, he/she wanted to let someone know what was going on at the facility. Additional interview with Resident #1, revealed a nurse on night shift was mean to him/her and everyone down the hall. Resident #1 identified the nurse by name, Licensed Practical Nurse (LPN) #2. Resident #1 stated he/she had a funny			GEORGETOWN		102 POCAHONTAS TRAIL	DE	00/00/2020
Continued interview revealed Resident #1 called the Ombudsman, who told him/her visitation restrictions prohibited him from coming to the facility. Resident #1 stated he/she then formulated a letter for the Ombudsman, sealed it, and asked the Administrator to give it to the Ombudsman, which he did. Per interview, he/she wanted to let someone know what was going on at the facility. Additional interview with Resident #1, revealed a nurse on night shift was mean to him/her and everyone down the hall. Resident #1 identified the nurse by name, Licensed Practical Nurse (LPN) #2. Resident #1 stated he/she had a funny	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
liquid on him/her, but since he/she did not see this nurse do it, he/she did not want to falsely accuse. Resident #1 stated she overheard LPN #2 saying, "she probably threw it on {himself/herself}." Per interview, Resident #1 was afraid of this nurse. Further interview revealed he/she felt what happened to him/her on the night of 04/14/2020 at 4:30 AM was abuse. Phone interview with SRNA #4, on 06/02/2020 at 5:05 PM, revealed she was working on 04/14/2020 at 04:30 AM, the night of the alleged event, and was assigned to Resident #1. She stated she heard Resident #1 yelling and went to check on him/her. Per interview, Resident #1 said someone spilled something on his/her bed, and he/she was awakened and startled. SRNA #4 stated Resident #1's sheet and bed covering were wet to the touch with what appeared to be water toward the foot of the bed. She stated she tried to reassure Resident #1 by telling him/her it	F 610	Continued interview the Ombudsman, w restrictions prohibite facility. Resident #1 formulated a letter fand asked the Adm Ombudsman, which wanted to let some at the facility. Additional interview nurse on night shift everyone down the nurse by name, Lice #2. Resident #1 stafeeling it might have liquid on him/her, but this nurse do it, he/s accuse. Resident # #2 saying, "she proof {himself/herself}." Fafraid of this nurse. he/she felt what hap of 04/14/2020 at 4:30 event, and was ass stated she heard Recheck on him/her. It said someone spilled and he/she was aw stated Resident #15 were wet to the tour water toward the formulations prohibited.	revealed Resident #1 called ho told him/her visitation ed him from coming to the stated he/she then or the Ombudsman, sealed it, inistrator to give it to the he did. Per interview, he/she one know what was going on with Resident #1, revealed a was mean to him/her and hall. Resident #1 identified the ensed Practical Nurse (LPN) ated he/she had a funny to been LPN #2 who threw the at since he/she did not see she did not want to falsely 1 stated she overheard LPN bably threw it on Per interview, Resident #1 was Further interview revealed opened to him/her on the night so AM was abuse. The SRNA #4, on 06/02/2020 at she was working on 0 AM, the night of the alleged igned to Resident #1. She esident #1 yelling and went to Per interview, Resident #1 and something on his/her bed, akened and startled. SRNA #4 as sheet and bed covering the with what appeared to be of the bed. She stated she	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 _			C 06/03/2020
	ROVIDER OR SUPPLIER	EORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		3570572025
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	pitcher. When questi water pitcher turned could not recall. Furt #4 reported this incid nurse on duty, as she abuse. Per interview resident's room and SRNA #4 stated Resincident to her again, interviewed her related Interviewed her related Interviewed her related Interviewed complaints, on the nature of the convestigation and followers department. The SSI Resident #1 on 04/14 resident's roommate while he/she was slesstated Resident #1 eand woke him/her up Per interview, Resident #4 denied to Resident #1. Continulater, Resident #1 su who threw something interviews or any docto the incident, other occurred with Resident #1 thought Resident #1.	ed over his/her water oned if she observed the over, SRNA #4 stated she her interview revealed SRNA ent to LPN #2 who was the e felt this was an allegation of LPN #2 entered the observed the wet sheets. Ident #1 did not mention the and no one at the facility ed to the incident. Cial Service Director (SSD), 30 PM, revealed she initially grievances, then depending complaint, directed the owed-up with the appropriate D stated she met with 1/2020 and was informed the threw water on his/her legs eping. The SSD further explained this startled him/her and he/she screamed out. Ent #1 was insistent at first it the that did this, but then the threw it", but was unable id this. The SSD stated shrowing anything on led interview revealed weeks spected it might be a nurse	F6	10		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	PLE CONSTRUCTION IG			PLETED
		185141	B. WING _				C 03/2020
	ROVIDER OR SUPPLIER	GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 610	Interview with LPN PM; SRNA #3 at 4:4 PM, revealed they to 04:30 AM. However related to the allege #1, nor were they a Interview with the A (ADON), on 06/02/2 received information alleged 04/14/2020 #1. She stated she Resident #1 insinual (Resident #4) had t Per interview, she a Resident #1's room incident and noted were separated by the curtain usually r #4 was not able to g Resident #1 could r have done this to hi Resident #1 alleged but the police did no stated a skin assess Resident #1 with no agreed abuse alleg investigated; howev statements obtained interviews related to	orked at the facility and could	F	10	DELI ISLENG!		
	Interview with the D 06/01/2020 at 1:42 Resident #1 the mo	pirector of Nursing (DON), on PM, revealed she visited prning of 04/14/2020, after ent had contacted the police					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185141	B. WING _			C 06/03/2020	
	ROVIDER OR SUPPLIER	GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CO 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 PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 610	on his/her lower ext resident implied his she told Resident # acid in the building. #1 got off the issue someone threw son lower extremities. Oskin assessments w #1 with negative fin conveyed he/she di nurse was removed no longer worked at Additional interview there was an allega expectation the resi a full investigation v subsequent follow u zero-tolerance for a what Resident #1 re 04/14/2020 at 4:30 abuse, the DON reg {he/she} was abuse was no documented investigation to incluresident interviews than the conversation #1. She stated this not believe the incic resident's frequent pehavior. Interview with the A 2:00 PM, revealed to the DON of Resider throwing a liquid on interview, staff thou interview, staff thou	ort someone had thrown acid remities. Per interview, the //her roommate did this, and 1 the facility did not have any Further, eventually Resident of acid, but insisted that he kind of liquid on his/her continued interview revealed were performed on Resident dings. Also, Resident #1 d not like LPN #2 and this from Resident #1's care and at the facility. with the DON, revealed if tion of abuse, it was her dent was assured safety, and	F	510			

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				1	TREET ADDRESS, CITY, STATE, ZIP CODE 02 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 610	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	610			

PRINTED: 07/07/2020 FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
					С	;							
		100381	B. WING		06/0	3/2020							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL													
SIGNATURE HEALTHCARE OF GEORGETOWN GEORGETOWN, KY 40324													
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE							
N 000	Initial Comments A Complaint Survey in KY#00031775 and a Infection Control Surv 06/01/2020 and comp Complaint KY#00031 with related deficience to be in compliance we control regulations and Centers for Medicare (CMS) and Centers for	nvestigating Complaint COVID-19 Focused vey was initiated on pleted on 06/03/2020. 775 was unsubstantiated ies. The facility was found with 42 CFR 483.80 infection and has implemented the and Medicaid Services or Disease Control and commended practices to	N 000		ROPRIATE	DATE							

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

TITLE

(X6) DATE

06/29/20