STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185326	A. BUILDING _____ B. WING _____	**05/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON-HICKMAN COUNTY NURSING FACILITY	**366 SOUTH WASHINGTON STREET CLINTON, KY 42031**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility investigation review, and facility policy review, it was determined the facility failed to take action to prevent further abuse while the investigation process was completed for one (1) of three (3) sampled residents (Resident #1) . On 05/07/2020, Resident #1 reported to two (2) staff members that he/she was abused by Certified Nurse Aide (CNA) #1. The two staff members failed to protect the residents when they left the alleged perpetrator providing care to residents while they each reported the allegation. The findings include: Review of facility policy titled, Abuse Prevention Program, dated March 2017 revealed residents have the right to be free from abuse-this includes but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical abuse. As part of the abuse prevention program the administration will protect the resident from anyone, facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals. Review of facility policy titled, Abuse Reporting and Prevention. last revised March 2017, revealed the Administrator will ensure that any further potential abuse is prevented. Record review revealed the facility admitted Resident #1 on 01/29/2020 with [DIAGNOSES REDACTED]. Review of abuse allegation investigation for Resident #1 dated 05/07/2020 revealed Resident #1 alleged Certified Nursing Assistant (CNA) #1 hit his/her arm and pushed him/her on to bed. Statements were obtained from the Physical Therapy Assistant/Regional Manager (PTA/RM), Social Services Director (SSD), Unit Manager (UM), and Licensed Practical Nurse (LPN) #1. The facility determined the allegation was unsubstantiated. Further review of the investigation revealed there was no documented evidence the facility identified PTA/RM and LPN #1 failed to protect residents when they left CNA #1 providing care to residents while each of them reported the allegation. Resident #1 was unavailable for interview due to being transferred to a geriatric behavioral health facility on 05/11/2020. Interview with CNA #1 on 05/14/2020 at 12:01 PM revealed she went into Resident #1's room and the resident stated that roommate (sibling) was dying and needed to call family. CNA #1 stated Resident #1 then became irate, and yelled and threatened her. CNA #1 revealed she informed Resident #1 that she was just changing roommate, and it would not take long. CNA #1 said Resident #1 then went in the hall and shortly after that LPN #1 came into room stating that Resident #1 had told PTA/RM that CNA #1 had hit the resident and pushed resident down. The CNA stated LPN #1 then talked with Resident #1 and kept resident at bay while CNA #1 was changing the roommate. Resident #1 told the nurse that she had pushed her down. CNA #1 revealed she then left the room and went and changed another resident and was trying to finish rounds when LPN #1 came to her a few minutes later and told her, she had to clock out and leave. CNA #1 stated she clocked out at 2:22 PM, but did not know what time she had went into Resident #1's room. CNA #1 revealed she was educated by the facility that when an abuse allegation is made, then staff should immediately remove the resident out of harms way. Interview with PTA/RM on 05/14/2020 at 1:02 PM revealed she was obtaining a wheelchair from the storage unit across from Resident #1's room when she heard a loud conversation from behind the closed door of Resident #1's room. PTA/RM stated Resident #1 opened the door, walked out into hallway, and told her to get CNA #1 out of room or wanted the CNA out of the room. PTA/RM revealed she asked the resident what was wrong and explained to the resident that CNA #1 was providing care. Resident #1 stated he/she did not care, that CNA #1 had pushed him/her down on bed and hit him/her. PTA/RM stated she told the resident to let her go see what she could do and the resident stated okay and went back into room. PTA/ RM revealed she went to LPN #1 and told her about the resident's allegation. PTA/RM said she told LPN #1 that she may want to check in the room because CNA #1 was still in the room with the resident. PTA/RM further revealed she had been educated to remove a resident from the alleged abuse situation immediately. Interview with LPN #1, on 05/14/2020 at 12:30 PM and 4:05 PM, revealed she was told by PTA/RM that there were loud voices coming from Resident #1's room and she needed to go see what was going on. LPN #1 stated that PTA/RM told her that Resident#1 had stated he/she had been hit on the arm and pushed on the bed, by CNA #1. LPN #1 revealed she entered the room and Resident #1 was to the right of CNA #1, and the resident stated he/she was going to slap CNA #1 if she did not get out of the room. LPN #1 stated she had the resident step to the side of the room and CNA #1 continued providing care to Resident #1's roommate and then stepped from the room. Resident #1 then told LPN #1 that CNA #1 hit and pushed him/her on to the bed. LPN #1 revealed she looked at Resident #1's skin and found no abrasions, marks and no signs of scuffle or anything. LPN #1 stated she then went to report the allegation to DON and then sent CNA #1 home immediately. LPN #1 stated she went to find CNA #1; and CNA #1 was coming out of the kitchen pushing a linen cart down the hallway. LPN #1 revealed she did not know where CNA #1 was before being found coming out of the kitchen. LPN #1 stated there was a few minutes before she got the DON out of a meeting to tell of the allegation. LPN #1 revealed she had been educated if an allegation of abuse occurred they are to automatically remove the resident from harm, and report to abuse coordinator (Administrator), and if she was not there, report to DON. LPN #1 stated she felt she had ensured the safety of Resident #1 immediately. Interview with the SSD on 05/14/2020 at 10:13 AM, revealed when an allegation of abuse is reported, the staff is to tell the immediate supervisor, and if alleged perpetrator is a staff member, he/she should be removed from care and sent home immediately to ensure the safety of all residents. Interview with the Director of Nursing (DON) on 05/14/2020 at 1:53 PM and 3:44 PM, revealed when an allegation is received it is to be reported immediately. The DON stated if the alleged perpetrator is a staff member, then he/she should be sent home immediately. She revealed when staff are educated on abuse, they are told to make resident safe and notify the administrator immediately. The DON stated she felt that the residents were protected as the allegation was reported and CNA #1 was sent home. Interview with the Administrator on 05/14/2020 at 4:51 PM revealed she did not realize the resident or CNA #1 was not with LPN #1 when she reported the allegation. The Administrator stated she agreed that CNA #1 should have been with the nurse when she reported the allegation; and the PTA/RM should not have left CNA #1 with the residents.

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

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