STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185359	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROBERTSON COUNTY HEALTH CARE FACILITY	**1030 KENTONTOWN ROAD, P O BOX 170 MOUNT OLIVET, KY 41064**

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, it was determined the facility failed to protect one (1) of six (6) sampled residents, (Resident #1) from physical abuse. On 06/27/2020 at approximately 1:30 PM, Resident #1 asked State Registered Nursing Assistant (SRNA) #3, (the alleged perpetrator) to assist him/her to the bathroom. SRNA #3 told Resident #1 to wait until after she made another resident's bed. Resident #1 told SRNA #3 to forget about helping him/her to the bathroom, to leave him/her alone. He/She proceeded to ask SRNA #1 for help to the bathroom. While Resident #1 was asking SRNA #1 for help, SRNA #3 came and jerked Resident #1's wheelchair around and took off with the resident's fingers in the spokes of the wheelchair. Resident #1 began yelling, saying she was hurting his/her fingers while hitting SRNA #3 telling her to stop. The findings include: Review of the facility's Abuse Prevention Policy, dated 02/2004, revealed it is the policy of this facility to encourage residents, families, and staff to report concerns, incidents, and grievances without the fear of retribution. This facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, the staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. It is the goal of this facility to achieve and maintain an abuse-free environment. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Review of Resident #1's closed medical record revealed the facility admitted the resident on 03/11/2020 with [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was cognitively intact and interviewable. Also, per the MDS, the resident was dependent on two (2) staff assistance for toileting. Review of Resident #1's Comprehensive Care Plan, initiated 03/11/2020, revealed the resident was at risk for toileting elimination deficit related to impaired mobility/balance, with a goal that the resident will be clean, warm and odor-free through adequate toileting. Intervention included staff assistance with toileting. The care plan revealed Resident #1 was at risk for routine care needs related to requiring assistance, with a goal that the resident will have needs met by the assistance of staff as needed. Intervention included two (2) caregivers for providing care. In addition, Resident #1 was at risk for psychosocial well being related to past life stressors identified as physical abuse by a family member. Interventions included inform resident of care to be delivered BEFORE starting care-give resident time to process. Resident #1 was discharged to another Skilled Nursing Facility on 07/03/2020; therefore was unavailable for observation and interview during the survey. Review of the Ombudsman report, dated 06/30/2020, at 6:17 PM, revealed she received a phone call from Registered Nurse (RN) #1 on 06/30/2020 stating she reported an alleged abuse incident to facility administration involving Resident #1 on 06/27/2020. Per the report, the Ombudsman called the facility to speak with Resident #1. Resident #1 stated that on Saturday afternoon, 06/27/2020 he/she was in his/her room when SRNA #3 walked in. Resident #1 asked SRNA #3 if she would take him/her to the bathroom. With linens in her hands, SRNA #3 told Resident #1 that she had to make someone's bed first. Resident #1 then rolled out into the hallway close to the nurses' station. She saw a second aide, SRNA #1, and asked her to assist to the bathroom. Resident #1 said SRNA #1 replied that she needed to chart before she could assist. Resident #1 stated that SRNA #3 grabbed his/her wheelchair from behind and jerked it around very fast. Resident #1's fingers were in the wheelchair spokes when the wheelchair was turned. Resident #1 admits to hitting SRNA #3, saying he/she was caught off guard and acting in self-defense. Resident #1 stated that his/her fingers were still very sore and swollen. Resident #1 stated he/she was scared of SRNA #3 and was having trouble sleeping. Per the report, Resident #1 told the Ombudsman he/she worried that SRNA #3 was going to hurt him/her and stated, she tears my nerves all to pieces. Review of a facility investigation summary, dated 07/03/2020 (initiated 06/29/2020, three days after the incident), signed by the Administrator, revealed after the investigation, the facility determined that SRNA #3 went to turn the resident's wheelchair to take him/her to the bathroom as asked, and his/her fingers were on the wheel. The resident has exhibited no psychosocial issues related to the incident and continues to be at his/her normal baseline with functioning. The resident has had acute monitoring every shift with no injury noted. X-ray of the right hand was done on June 30, 2020, and results were negative. The resident is able to use his/her right hand and move all digits and range is within normal limits. SRNA #3 was re-educated regarding providing care to residents and making sure they hear what you say before assisting with activities of daily living (ADL) and to make sure all hands and feet are up before assisting residents who are in wheelchairs. Interview with SRNA #1, on 07/06/2020 at 1:54 PM, employed at the facility four (4) years, revealed Resident #1 asked to be pulled up in his/her wheelchair. SRNA #3 walked up and Resident #1 told SRNA #3 she had caused him/her enough grief already and did not want her help. SRNA #3 proceeded to push Resident #1's wheelchair from behind, even after being told not to. In addition, SRNA #1 stated, I don't think SRNA #3 meant to catch Resident #1's fingers in the spokes of the wheelchair; however, she went against what Resident #1 asked her not to do. Continued interview revealed SRNA #1 felt the wheelchair was pushed rudely and aggressively and she said yes, adding this was not the first time SRNA #3 had been reported for rude behavior. SRNA #1 stated Resident #1 revealed to her that he/she and SRNA #3 did not get along and did not have a good relationship. Interview with SRNA #2, on 07/06/2020 at 2:07 PM, employed at the facility approximately three (3) years, revealed she did not witness the incident; however, she was working the date of the incident. She revealed she made several complaints against the aide to the Assistant Director of Nursing (ADON) and the Administrator for being mean, rude, and screaming at a resident in the past and the ADON told her the resident that was allegedly yelled by SRNA #3 was yelled at was hard of hearing. SRNA #2 said it was not necessary to yell at someone even if they are hard of hearing. Also, she said SRNA #3 revealed that Resident #1 did not like her. Telephonic interview with Registered Nurse (RN) #1, on 07/06/2020 at 11:09 AM, employed at the facility eight (8) years, revealed she was the nurse on duty the day of the alleged incident. She was on the phone when she heard Resident #1 yelling. She got off the phone and observed SRNA #1 motioning for her to come to where Resident #1 and SRNA #3 were at. When she got to that section of the hallway, SRNA #3 was saying to Resident #1, I'm sorry J----, I'm sorry J----, then SRNA #3 walked away. Resident #1 told RN #1 that SRNA #3 grabbed his/her wheelchair after being told not to, started pushing it, catching his/her fingers in the spokes of the wheel. The resident yelled out in pain. In addition, Resident #1 stated he/she felt threatened by SRNA #3, and this was not the first time he/she had trouble with SRNA #3. Additionally, RN #1 said SRNA #3 reported she did not know that Resident #1's fingers were near the wheelchair spokes. RN #1 stated she called the Director of Nursing (DON) at home to report the incident. The DON said she needed to talk to the Social Worker, then call her back. The DON instructed RN #1 to have SRNA #3 clock out, leave the facility, and then file an incident report. Head to toe assessment was performed on Resident #1 by RN #1 and Resident #1's daughter and Physician were notified of the incident. Continued interview with RN #1 revealed the event happened around 1:30 PM on 06/27/2020. She stated the DON did

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185359	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROBERTSON COUNTY HEALTH CARE FACILITY	**1030 KENTONTOWN ROAD, P O BOX 170 MOUNT OLIVET, KY 41064**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) not come in when the event was reported. She came in to staff the unit around 9:00 PM due to a call-in and the Administrator was on vacation. RN #1 stated she did not have further conversation with the DON or Administrator and they did not ask her for a written statement of the event, until she contacted them on Monday, 06/29/2020, about reporting the incident. She revealed she read the Administrator's written report regarding the incident and did not agree with the statement that Resident #1 felt safe because Resident #1 told RN #1 he/she felt threatened and RN #1 said she informed the Administrator. She said it was very obvious the act was abusive, intentionally grabbing the wheelchair, turning it aggressively and catching the resident's fingers in the spokes of the wheelchair hurting them, after going against the resident's request to leave him/her alone. Telephonic interview with the Social Service Director (SSD) on 07/07/2020 at 12:05 PM, employed at the facility three years (3), and as Social Service Director approximately two (2) months, revealed she was not working the day of the incident and was not called. She learned about the incident when she returned to work on Monday, 06/29/2020, stating her understanding was it was an accident report. She does not recall it reported as an alleged abuse. On Tuesday, 06/30/2020, she learned from the DON this had been reported by the nurse as an alleged abuse incident. The SSD and the DON talked to Resident #1. Resident #1 told them she asked SRNA #3's assistance to the bathroom. SRNA #3 told him/her she would be back. Resident #1 then asked another SRNA to help him/her to the bathroom. SRNA #3 came up behind him/her, turned the wheelchair around, and caught his/her hand in the wheel. According to the SSD, Resident #1 reported he/she yelled and punched SRNA #3 several times to make her stop. She further stated she did not think it was right for SRNA #3 to go against the resident's request to leave him/her alone. Telephonic interview with the DON on 07/07/2020 at 12:27 PM, employed at the facility less than two (2) months, revealed she was called by RN #1 on 06/27/2020 around 2:00 PM to report the incident between Resident #1 and SRNA #3. She recalls being told that Resident #1 was ready to go to the bathroom and SRNA #3 could not assist at the time. When SRNA #3 was ready to assist, she came up from behind the wheelchair and began backing the wheelchair up. Resident #1's hand was caught in the wheel. She instructed RN #1 to have SRNA #3 clock out and leave the facility and to complete an incident report. She did not talk to RN #1 further that day regarding the incident or the other SRNA's on duty at the time of the incident. The DON stated she regarded this incident as an accident. When asked if it was standard practice to send staff home after an accident, the DON replied yes. Interview with the facility Administrator on 07/06/2020 at 3:00 PM revealed the incident happened on 06/27/2020. She did not report the incident to the Office of Inspector General (OIG) until 06/30/2020 because when she initially heard about the incident, it was reported as an accident. The accident report was the SRNA pushed Resident #1's wheelchair, catching the resident's hand in the spokes of the wheel. No one alleged the incident as abuse. Additional interview revealed RN #1 called the Administrator on 06/29/2020 asking why the reported incident had not been investigated and reported as per policy. RN #1 said the aggressive behavior demonstrated by SRNA #3 toward Resident #1 was abusive. The Administrator stated RN #1 had given Resident #1 the Ombudsman's phone number. Continued interview with the Administrator revealed the facility failed to identify the incident as an allegation of abuse. However, further interview revealed the facility should have initiated an investigation immediately and interviewed Resident #1 as well as SRNA #3 on 06/27/2020, as well as obtained written statements. She expects all residents to be free from abuse and that abuse or alleged abuse is reported and investigated immediately per policy.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy, it was determined the facility failed to ensure its abuse policy and procedures were implemented for one (1) of six (6) sampled residents (Resident #1). The facility failed to implement their written abuse policies related to completing a thorough investigation after Registered Nurse (RN) #1 reported to the Director of Nursing (DON) that Resident #1 alleged that SRNA #3 came and jerked his/her wheelchair around and took off, after the resident told SRNA #3 not to, with the resident's fingers in the spokes. Resident #1 yelled and complained of pain to fingers on his/her right hand. (Refer to F600) The findings include: Review of the facility's Abuse Investigations Policy, undated, revealed all reports of resident abuse, neglect, and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. Should an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source be reported, the Administrator, or his/her designee, will investigate the alleged incident. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. The individual conducting the investigation will, as a minimum: Review the completed forms; Review the resident's medical record to determine events leading up to the incident; Interview the person (s) reporting the incident; Interview any witnesses to the incident; Interview the resident (as medically appropriate); Ensure the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate, family members, and visitors; Interview other residents to whom the accused employee provides care or services; and Review all events leading up to the alleged event. Witness reports will be obtained in writing. Witnesses will be required to sign and date such reports. Review of Resident #1's closed medical record revealed the facility admitted the resident on 03/11/2020 with [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was cognitively intact and interviewable. Also, per the MDS, the resident was dependent on two (2) staff assistance for toileting. A review of the Ombudsman report, dated 06/30/2020 at 6:17 PM, revealed she received a phone call from Registered Nurse (RN) #1 on 06/30/2020 stating she reported an alleged abuse incident to facility administration involving Resident #1 on 06/27/2020. Per the report, the Ombudsman called the facility to speak with Resident #1. Resident #1 told the Ombudsman that on Saturday afternoon, 06/27/2020 he/she was in his/her room when SRNA #3 walked in. Resident #1 told the Ombudsman that he/she asked SRNA #3 if she would take him/her to the bathroom. With linens in her hand, SRNA #3 told Resident #1 that she had to make someone's bed first. Resident #1 then rolled out into the hallway close to the nurses' station. She saw SRNA #1, and asked her for assistance getting to the bathroom and SRNA #1 told the resident she needed to chart before she could assist. Resident #1 stated that SRNA #3 grabbed his/her wheelchair from behind and jerked it around very fast while Resident #1 was telling SRNA #3 to leave him/her alone. Resident #1's fingers were in the wheelchair spokes when the wheelchair was turned. Per the report, Resident #1 stated his/her fingers were still very sore and swollen. Per the report, Resident #1 stated he/she was scared of SRNA #3 and was having trouble sleeping and stated he/she worried SRNA #3 was going to hurt him/her and stated, she tears my nerves all to pieces. Review of Resident #1's Medical Record Progress Notes dated 06/27/2020 at 3:19 PM written by RN #1 revealed Resident #1 asked SRNA #3 to go to the bathroom. SRNA #3 told Resident #1 to wait until she mad another resident's bed. Resident #1 asked SRNA #1 to help with toileting and SRNA #1 told the resident to wait one second while she charted. Resident #1 sat waiting and SRNA #3 came and jerked the wheelchair around and took off with the resident's fingers in the spokes. Resident #1 slapped her and yelled at her because she hurt his/her fingers. Interview with SRNA #1, on 07/06/2020 at 1:54 PM, employed at the facility four (4) years, revealed on 06/27/2020 around 1:30 PM, Resident #1 asked SRNA #1 to pull him/her up in the wheelchair when SRNA #3 walked up and Resident #1 told SRNA #3 she had caused him/her enough grief already and did not want her help. SRNA #3 proceeded to push Resident #1's wheelchair from behind, even after being told not to and even though she didn't think SRNA #3 intended to catch Resident #1's fingers in the wheel, she went against what Resident #1 asked her not to do. She stated SRNA #3 rudely and aggressively jerked the wheel chair. She said she immediately motioned for RN #1 to come to the scene. Telephonic interview with RN #1, on 07/06/2020 at 11:09 AM, revealed she was the nurse on duty the day of the alleged incident on 06/27/2020 around 1:30 PM. She said she was on the phone when she heard Resident #1 yelling. She got off the phone and observed SRNA #1 motioning for her to come to where Resident #1 and SRNA #3 were. When she got to that section of the hallway, SRNA #3 was saying to Resident #1, I'm sorry J---, I'm sorry J---, then SRNA #3 walked away. Resident #1 told RN #1 that SRNA #3 grabbed his/her wheelchair after being told not to, started pushing it, catching his/her fingers in the spokes of the wheel. Also, Resident #1 stated he/she felt threatened by SRNA #3, and this was not the first time he/she had trouble with SRNA #3. RN#1 stated she called the Director of Nursing (DON) at home to report the incident. The DON said she needed to talk to the Social Worker, then call her back. The DON called back and instructed RN #1 to have SRNA #3 clock out, leave the facility, and then file an incident report. She stated the DON did not come to the facility to conduct and investigation and did not tell RN #1 to report the incident to the State Agency. She stated the DON cam to the facility around 9:00 PM to handle a staff issue but did not initiate an investigation at that time. Continued interview with RN #1 revealed she did not have further conversation with the DON or Administrator until she contacted them on Monday, 06/29/2020, about reporting the incident. She revealed she read the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185359	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROBERTSON COUNTY HEALTH CARE FACILITY	**1030 KENTONTOWN ROAD, P O BOX 170 MOUNT OLIVET, KY 41064**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Administrator's written report regarding the incident and did not agree with the statement that Resident #1 felt safe. Resident #1 told RN #1 she felt threatened. Additionally, RN#1 said it was very obvious the act was abusive, intentionally grabbing the wheelchair, turning it aggressively and catching the resident's fingers in the spokes of the wheelchair hurting them, after going against the resident's request to leave him/her alone. Telephonic interview with the Social Service Director (SSD) on 07/07/2020 at 12:05 PM, revealed she was not working the day of the incident, nor was she called on 06/27/2020. She learned about it when she returned to work on Monday, 6/29/2020, stating her understanding was it was an accident report not an abuse allegation. She stated on 06/30/2020, she learned from the DON that RN #1 reported the incident as an abuse incident. Telephonic interview with the Director of Nursing (DON) on 07/07/2020 at 12:27 PM, employed at the facility less than two (2) months, revealed she was called by RN #1 on 06/27/2020 around 2:00 PM to report the incident between Resident #1 and SRNA #3. She recalls from the conversation, Resident #1 was ready to go to the bathroom and SRNA #3 could not assist at the time. When SRNA #3 could help, she came up from behind the wheelchair and began backing it up. Resident #1's hand got caught in the wheel. She instructed RN #1 to have SRNA #3 clock out and leave the facility and to complete an incident report. She did not talk to RN #1 further that day regarding the incident or the other SRNA's on duty at the time. The DON stated she regarded this incident as an accident and that is was the standard practice to send staff home after an accident. Continued interview with the DON revealed she failed to identify the reported incident as an allegation of abuse. As a result, an investigation was not immediately initiated. Additionally, the DON stated the expectation is an alleged abuse be reported immediately to facility management, within two hours of occurrence to appropriate regulatory agencies if injury, and within twenty-four (24) hours of occurrence if without injury. Likewise, a facility investigation report was to be completed within five days. Interview with the facility Administrator on 07/06/2020 at 3:00 PM revealed the incident happened on 06/27/2020. She did not report the incident to the Office of Inspector General (OIG) until 06/30/2020 because when she initially heard about the incident, it was reported as an accident. The accident report was the SRNA pushed Resident #1's wheelchair, catching the resident's hand in the spokes of the wheel. Additional interviews revealed RN #1 called the Administrator on 07/29/2020 asking why the reported incident had not been investigated and reported as per policy. RN #1 said the aggressive behavior demonstrated by SRNA #3 toward Resident #1 was abusive. The Administrator stated RN #1 had given Resident #1 the Ombudsman's phone number. Continued interview with the Administrator revealed the facility failed to identify the incident as an allegation of abuse; therefore, an investigation was not immediately initiated. However, further interviews revealed the facility should have initiated an investigation immediately and interviewed Resident #1 as well as SRNA #3 on 06/27/2020, as well as obtained written statements from all staff on duty at the time of the incident. Further interview revealed there was no documented evidence of staff interviews, affected resident follow-up, witness statements, or any interviews related to the incident. Staff interviews confirmed interviews did not occur until three (3) days after the incident was reported.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of the facility's policy, it was determined the facility failed to ensure an allegation of abuse was reported immediately, but no later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse, to the Administrator and State Agencies as per State Law for one (1) of six (6) sampled residents (Resident #1). Registered Nurse (RN) #1 reported to the Director of Nursing (DON) on 06/27/2020, at approximately 1:30 PM, she heard Resident #1 yelling from the hallway and went to investigate what was happening. Resident #1 told RN #1 that State Registered Nursing Assistant (SRNA) #3 came and jerked his/her wheelchair around, after Resident #1 told SRNA #3 to leave him/her alone and took off with the resident's fingers in the spokes. Resident #1 said she slapped SRNA #3 and yelled at her because she hurt his/her fingers. Additionally, Resident #1 told RN #1 she felt threatened by SRNA #3. There was no documented evidence the facility reported the allegation to State Agencies within two (2) hours of the facility learning of the allegation on 06/27/2020. The incident was not reported to State Agencies until 06/30/2020. (Refer to F600) The findings include: Review of the facility's policy titled, Reporting Abuse to State Agencies and Other Entities/Individuals, undated, all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident: The State licensing/certification agency responsible for surveying/licensing the facility; The local/state Ombudsman; The Resident's Representative of Record; Adult Protective Services; Law enforcement officials; The Attending Physician and the facility Medical Director. Notices will include the name of the resident, room number, type of abuse committed, date, and time the alleged incident occurred and what immediate action was taken by the facility. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed with a written report of the investigation findings within five (5) working days of the occurrence of the incident. Review of Resident #1's closed medical record revealed the facility admitted the resident on 03/11/2020 with [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was cognitively intact and interviewable. Also, per the MDS, the resident was dependent on two (2) staff assistance for toileting. A review of the Ombudsman report, dated 06/30/2020 at 6:17 PM, revealed she received a phone call from Registered Nurse (RN) #1 on 06/30/2020 stating she reported an alleged abuse incident to facility administration involving Resident #1 on 06/27/2020. Per the report, the Ombudsman called the facility to speak with Resident #1. Resident #1 told the Ombudsman that on Saturday afternoon, 06/27/2020 he/she was in his/her room when SRNA #3 walked in. Resident #1 told the Ombudsman that he/she asked SRNA #3 if she would take him/her to the bathroom. With linens in her hand, SRNA #3 told Resident #1 that she had to make someone's bed first. Resident #1 then rolled out into the hallway close to the nurses' station. She saw SRNA #1, and asked her for assistance getting to the bathroom and SRNA #1 told the resident she needed to chart before she could assist. Resident #1 stated that SRNA #3 grabbed his/her wheelchair from behind and jerked it around very fast while Resident #1 was telling SRNA #3 to leave him/her alone. Resident #1's fingers were in the wheelchair spokes when the wheelchair was turned. Per the report, Resident #1 stated his/her fingers were still very sore and swollen. Per the report, Resident #1 stated he/she was scared of SRNA #3 and was having trouble sleeping and stated he/she worried SRNA #3 was going to hurt him/her and stated, she tears my nerves all to pieces. Interview with SRNA #1, on 07/06/2020 at 1:54 PM, employed at the facility four (4) years, revealed on 06/27/2020 around 1:30 PM, Resident #1 asked SRNA #1 to pull him/her up in the wheelchair when SRNA #3 walked up and Resident #1 told SRNA #3 she had caused him/her enough grief already and did not want her help. SRNA #3 proceeded to push Resident #1's wheelchair from behind, even after being told not to and even though she didn't think SRNA #3 intended to catch Resident #1's fingers in the wheel, she went against what Resident #1 asked her not to do. She stated SRNA #3 rudely and aggressively jerked the wheel chair. She said she immediately motioned for RN #1 to come to the scene. Telephonic interview with RN #1, on 07/06/2020 at 11:09 AM, revealed she was the nurse on duty the day of the alleged incident on 06/27/2020. She said she was on the phone when she heard Resident #1 yelling. She got off the phone and observed SRNA #1 motioning for her to come to where Resident #1 and SRNA #3 were. When she got to that section of the hallway, SRNA #3 was saying to Resident #1, I'm sorry J---, I'm sorry J---, then SRNA #3 walked away. Resident #1 told RN #1 that SRNA #3 grabbed his/her wheelchair after being told not to, started pushing it, catching his/her fingers in the spokes of the wheel. Also, Resident #1 stated he/she felt threatened by SRNA #3, and this was not the first time he/she had trouble with SRNA #3. RN#1 stated she called the Director of Nursing (DON) at home to report the incident. The DON said she needed to talk to the Social Worker, then call her back. The DON called back and instructed RN #1 to have SRNA #3 clock out, leave the facility, and then file an incident report. She stated the DON did not come to the facility to conduct and investigation and did not tell RN #1 to report the incident to the State Agency. Continued interview with RN #1 revealed she did not have further conversation with the DON or Administrator until she contacted them on Monday, 06/29/2020, about reporting the incident. She revealed she read the Administrator's written report regarding the incident and did not agree with the statement that Resident #1 felt safe. Resident #1 told RN #1 she felt threatened. Additionally, RN#1 said it was very obvious the act was abusive, intentionally grabbing the wheelchair, turning it aggressively and catching the resident's fingers in the spokes of the wheelchair hurting them, after going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185359	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROBERTSON COUNTY HEALTH CARE FACILITY	**1030 KENTONTOWN ROAD, P O BOX 170 MOUNT OLIVET, KY 41064**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) against the resident's request to leave him/her alone. Telephonic interview with the Director of Nursing (DON) on 07/07/2020 at 12:27 PM, revealed she was called by RN #1 on 06/27/2020 around 2:00 PM to report the incident between Resident #1 and SRNA #3. She stated she recalled being told that Resident #1 was ready to go to the bathroom and SRNA #3 could not assist at the time. When SRNA #3 was ready to assist, she came up from behind the wheelchair and began backing the wheelchair up and Resident #1's hand was caught in the wheel. She stated she instructed RN #1 to have SRNA #3 clock out and leave the facility and to complete an incident report. She did not talk to RN #1 further that day regarding the incident or the other SRNA's on duty at the time of the incident. The DON stated she regarded this incident as an accident and not as abuse so she did not report the incident to the State Agency. Additionally, the DON stated the expectation was for alleged abuse to be reported immediately to facility management, within two hours of occurrence to appropriate regulatory agencies. Interview with the facility Administrator on 07/06/2020 at 3:00 PM revealed the incident happened on 06/27/2020. She did not report the incident to the Office of Inspector General (OIG) until 06/30/2020 because when she initially heard about the incident, she perceived it as an accident, not as abuse. Additional interview with the Administrator revealed when RN #1 called the Administrator on 07/29/2020 and asked why the reported incident had not been investigated and reported to regulatory agencies as per policy until RN #1 said the aggressive behavior demonstrated by SRNA #3 toward Resident #1 was abusive and the facility failed to identify the incident as an allegation of abuse; therefore, it was not reported within two (2) hours and an investigation was not immediately initiated. However, further interviews revealed the facility should have reported the incident and initiated an investigation immediately. She expected all residents to be free from abuse and that abuse or alleged abuse should be reported and investigated immediately per policy.