STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185148	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Health & Rehabilitation Center	287 North 11th Street Williamsburg, KY 40769

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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	Based on interview, record review, document review, and facility policy review, the facility failed to protect a resident's right to be free from verbal abuse by a staff member for 1 (Resident #65) of 1 sampled resident reviewed for abuse.Findings included: A facility policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy, revised 07/2024, indicated, Our facility does not condone or tolerate resident abuse (this includes verbal abuse, sexual abuse, physical abuse and mental abuse), neglect, misappropriation or exploitation under any circumstances by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving or visiting the resident, family members, legal guardians, sponsors, friends, or other individuals. The policy specified, Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to threats of harm, saying things to frighten a resident such as telling a resident that he/she will never be able to see his/her family again. An admission Record revealed the facility admitted Resident (R)65 on 07/16/2021. According to the admission Record, the resident had a medical history that included a diagnosis of Alzheimer's disease. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025, revealed R65 had a Brief Interview for Mental Status (BIMS) score 3, which indicated the resident had severe cognitive impairment. The facility Final Report/5 Day Follow Up dated 09/19/2025, indicated At approximately 7:20 pm on 09/13/25, State Registered Nurse Aide (SRNA) 6, and SRNA 5 were attempting to transfer resident 65 to his/her bed in their room when R65 became combative. R 65 pushed his/her walker over, almost causing SRNA 5 to fall. SRNA 6 stated that SRNA 5 said, my child doesn't' act this way, so you're not going to. SRNA 5 pushed R 65's wheelchair next to the bed in order to complete the transfer and when the bed was lowered, the rail was pushing R65's right knee. SRNA 6 told SRNA 5 to stop, that the rail was on the resident's knee. SRNA 5 moved the rail off the resident's knee and stated to R65, That's what your bratty [curse word] gets. R65 was transferred to bed and stated that their (the resident's) leg hurt and SRNA 5 stated, See R65, you lived. SRNA 6 then reported the incident to LPN (licensed practical nurse) Charge nurse. The Final Report/5 Day Follow Up revealed In conclusion, based upon interviews and witness statements to the alleged incident, the IDT (interdisciplinary team) feels that SRNA 5, responded in this interaction with resident, R65, with an inappropriate verbal response by stating, that's what your bratty [curse word] gets. During an interview on 12/08/2025 at 11:52 AM, R65 stated a staff member said something mean to them, but they could not remember what was said or who said it. During an interview on 12/10/2025 at 10:31 AM, SRNA 5 stated she did not recall saying anything inappropriate to R65 and that she was not mean to the resident. SRNA 5 denied verbally abusing R65. During an interview on 12/10/2025 at 9:27 AM, SRNA 6 stated SRNA 5 was upset because she almost fell over R65's walker. Per SRNA 6, SRNA 5 did not yell or raise her voice to R65, but she did get in R65's face after she got R65's leg out from under the bedrail. SRNA 6 stated it was then that SRNA 5 told R65 in a smart-alecky way, that's what your bratty [curse word] gets. SRNA 6 stated SRNA 5 sounded sarcastic and giggled when she told R65 that he/she would live. Per SRNA 6, what she witnessed would rise a little bit to verbal abuse. During an interview on 12/10/2025 at 12:13 PM, the Administrator stated the facility substantiated verbal abuse based on their abuse policy and SRNA 5 was terminated due to the incident.