STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopkins Nursing and Rehabilitation Center	460 South College Street Woodburn, KY 42170

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** 52040 Based on interview, record review, review of facility investigations and policies, the facility failed to ensure residents were protected from verbal and physical abuse for 2 of 14 sampled residents (Resident (R) 4 and R5). 1. On 07/17/2024, R4 reported to the Administrator that Kentucky Medication Aide (KMA) 3 had spoke to her like a dog, pointed her finger in the resident's face, and started cussing at her without cuss words. 2. On 10/19/2023, R7 hit R5 in the head with an open hand. The findings include: Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Per policy review, that included, but was not limited to, freedom from corporal punishment, verbal, mental, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Review of the facility policy titled, Resident Rights, revised February 2021, revealed employees should treat all residents with kindness, respect, and dignity. 1. Review of R4's electronic medical record (EMR) revealed the facility admitted the resident on 06/20/2022, with diagnoses which included anxiety disorder, hypertension, and unspecified psychosis. Review of the Minimum Data Set (MDS) Assessment for R4, with an Assessment Reference Date (ARD) of 02/18/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Self-Reported Incident Form Initial Report, dated 07/17/2024, revealed an incident of verbal abuse occurred on 07/17/2024 at approximately 12:45 PM, which R4 reported to the facility's Administrator immediately. Per review of the report, upon notification by R4, an investigation was initiated. Continued review revealed KMA 3 was immediately suspended and vacated the facility until further notice pending the outcome of the investigation. Review revealed a change in condition, head-to-toe skin assessment, and rapid mood screening (RMS) were initiated for R4. Further review revealed due to the complex nature of the allegation, all witnesses prepared written statements and interviews were conducted. In addition, R4's physician, family/Power of Attorney (POA), Department for Community Based Services (DCBS), Adult Protective Services (APS), and the Ombudsman were all notified. Review of the facility's Final Report/5 Day Follow-Up, revealed all materials related to the investigation had been reviewed and it was found the allegation against KMA 3 involving (alleged verbal abuse of) R4 was verified. Per review, the evidence suggested KMA 3 had conducted herself in an unprofessional manner and used a tone and language that could be construed as an act of verbal abuse. Review of the Report, revealed at the time the allegation was made KMA 3 was placed under one-to-one (1:1) observation by the Director of Nursing (DON) while the medication cart was counted. Continued review revealed KMA 3 was then escorted out of the facility and placed on suspension until further notice. Review revealed a verbal education regarding abuse, verbal abuse, and abuse prohibition and reporting was implemented by the Administrator, DON, and Assistant Director of Nursing (ADON) during the investigative period for all 76 active employees. Further review revealed Social Services (SS) or the Administrator conducted routine check-ins with R4 for four weeks following the incident to monitor for any potential distress and to ensure her concerns were resolved. Finally, review further revealed since the allegation against KMA 3 had been verified, she was terminated from employment and did not return to the facility. Review of the facility's, Quality Assurance and Performance Improvement (QAPI) log of activity for the 08/27/2024 meeting revealed abuse - 1 incident; resolved was listed as a topic which was reviewed/discussed. Review of KMA 3's personnel file revealed a hire date of 10/20/2023, as a State Registered Nursing Assistant (SRNA). Per review, KMA 3 transferred on 12/03/2023, into the position of Kentucky Medication Aide after successfully passing the Medication Aide exam on 11/20/2023. Continued review revealed a background check, adult caregiver, nurse aide registry, sex offender and license verification had been performed. Further review revealed no documented evidence of disciplinary actions. Additional review revealed the KMA had received abuse training and was terminated on 07/22/2024. In interview on 05/13/2025 at 2:30 PM R4 stated things are pretty good here now. She stated she had only had problems with that one staff member before and that person was not there anymore. R4 reported that person lost her job over some stuff that went on. She further stated she hated anyone losing a job, but when you do bad that's what happens. R4 said that person talked to her real mean. Telephonic attempts were made to interview KMA 3 on 05/14/2025 at 9:36 AM, 3:42 PM, and 7:45 PM; however, were unsuccessful. Voicemail messages were left each time; however, a return phone call was never received. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 05/13/2025 at 2:20 PM, Licensed Practical Nurse (LPN) 1 stated she relayed another incident to SSD and DON that occurred that same day the incident with KMA 3 and R4 occurred. She stated R3's daughter informed her that her mom (the resident) was told she was acting like a baby by the med tech that morning. LPN 1 said R3 had relayed that information to her daughter when she came to visit the resident at lunch. She reported she she immediately went to tell the Social Services Director (SSD) and the DON. LPN 1 stated she was unaware of the incident involving KMA 3 and R4 when she reported what R3's daughter told her. She further stated however, at that time she learned that KMA 3 had already been removed from the floor and the med carts were being counted. In interview on 05/13/2025 at 2:10 PM, the Receptionist stated she did remember an incident involving KMA 3 and R4. She stated KMA 3 had been a med tech in the facility, and on the day of the incident, R4 called from her personal phone to the facility phone asking about some meds. The Receptionist said after receiving the call, she went to find KMA 3 to let her know because she was the person passing meds. She explained KMA 3 asked her to go to R4's room with her so that no one would put words in my mouth. The Receptionist reported she was surprised when KMA 3 was the one that was verbally aggressive towards the resident. She further stated KMA 3 was cussing and pointing her finger towards the resident. The Receptionist additionally said she got KMA 3 out of the room and went straight to find the Administrator. In interview on 05/13/2025 at 2:40 PM, the SSD stated she was still new when this all happened and remembered very little. She said she did remember KMA 3 as not being kind and it was a form of verbal abuse. The SSD explained her role was to check with residents to make sure they were okay after the incident. She further stated she also checked with staff to see if they had witnessed anything like this occurring. In interview with R11, R1, and R2 on 05/13/2025 at 10:00 AM, they stated they felt well taken care of, staff treated them with respect, and they felt safe in the facility. R3 (Who reported the second incident to her daughter) was unable to be interviewed 05/13/2025 through 05/15/2025 during multiple attempts each day. In interview on 05/15/2025 at 11:19 AM, the DON stated staff abuse education was provided on hire, annually and as needed. The DON said the education was normally provided by her and/or the ADON, and might be provided in person or through a video with a posttest. She explained if she were to witness abuse taking place, she would intervene immediately to keep the resident safe and then report it to the Administrator. The DON stated if an incident of abuse was not reported, it would be possible to have a negative outcome for the residents. She said when the abuse allegation involving R4 was made, KMA 3 was removed from the floor, med carts were counted and then she (KMA 3) was escorted out of the facility. The DON said she thought KMA 3 had been out of the building before the second incident was reported. She further stated resident and staff interviews, as well as staff education were completed as part of the facility's investigation. The DON also stated the facility substantiated the allegation of verbal abuse and KMA 3 was terminated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 05/15/2025 at 11:48 AM, the Administrator stated he was the facility's abuse coordinator, and said all allegations of abuse by staff were handled immediately. He stated the accused staff had been suspended, and they were not allowed back on the premises pending the results of the investigation. The Administrator said residents involved in alleged incidents of abuse were monitored for physical/psychosocial effects related to incidents. He explained he expected staff to immediately report suspected abuse after intervening to keep the residents safe. The Administrator stated, when recalling his memory of the incident between KMA 3 and R4, multiple people had been trying to find him to report the incident. He said the facility's reaction to the allegation was immediate as R4 asked to speak with him as soon as KMA 3 left her room. The Administrator reported KMA 3 had been pulled from off the floor and suspended pending the investigation, and the med cart counted with supervision prior to the KMA being escorted out of the building. He stated as the first investigation was beginning, report of the second incident came in. The Administrator said he was unaware of any allegations regarding KMA 3 until that day, and she (KMA 3) had not seemed problematic, and had been very pleasant and welcoming. He further stated KMA 3 had been terminated for substantiated allegation of abuse against R4. In addition, the Administrator said the facility investigation concluded that KMA could have presented herself in a different manner towards R3; however, there had been no witnesses to verify it reached a level of abuse in that instance. Surveyor: [NAME], [NAME] 2(a). Review of the EMR Admission Record for R5 revealed the facility admitted the resident on 05/29/2022 and discharged the resident on 03/29/2024. Continued review revealed R5 was admitted with the following diagnoses: mild neurocognitive disorder due to known physiological condition without behavioral disturbance, cognitive communication deficit, and unspecified psychosis not due to a substance or known physiological condition. Review of the Significant Change MDS with an ARD of 03/15/2024, revealed the facility assessed R5 to have a BIMS score of a 14 out of 15, indicating the resident was cognitively intact. (b). Review of the EMR Admission Record for R7 revealed the facility admitted the resident on 09/15/2022 and discharged the resident on 11/04/2024, with diagnoses to include: dementia with agitation, schizophrenia, and Alzheimer's disease. Review of the Significant Change MDS with an ARD of 08/20/2024, revealed the facility assessed R7 to have a BIMS score of a zero out of 15, indicating the resident was severely cognitively impaired. Review of the facility's Initial Report dated 10/19/2023, revealed on 10/19/2023 at 11:55 AM, R7 made physical contact with R5's head with her open palm. Continued review revealed the incident was witnessed by SRNA 2. Review of the facility's investigation Final/5-Day Follow Up Report, dated 10/20/2023, revealed the facility concluded the incident was witnessed and therefore verified to have taken place. Review of the psychiatry initial consult dated 10/27/2023, for R7 revealed the resident had been evaluated to have struck another resident on 10/19/2023. Continued review revealed staff reported R7 had been more easily agitated recently. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital emergency department note dated 10/19/2023, revealed R7 had been seen for allegedly slapping another resident, having frequent emotional outbursts, and episodes of aggression, which were not uncharacteristic for her. During an interview with SRNA 2 on 05/13/2025 at 4:32 PM, she stated she was unable to recall all of the details of the incident due to the amount of time that had elapsed. After reading her signed witness statement, SRNA 2 stated she did remember seeing R7 hit R5 in her head with an open hand. She further stated she recalled she immediately separated the two residents. SRNA 2 additionally said R7 was confused most of the time and had the mind of a child. During an interview with SRNA 5 on 05/15/2025 at 10:40 AM, she stated R7 always had some behaviors requiring increased supervision. During an interview with the DON on 05/15/2025 at 11:18 AM, she stated R7 usually did not have physical behaviors towards anyone; however, did have a diagnosis of schizophrenia and had delusions. She stated R7 would yell at nothing and was usually only aggressive towards her delusions. The DON said R7 was monitored by the nursing staff frequently, and stayed in her room or sat at the nursing station. She reported R7 was followed by psychiatric services and had been sent out of the facility for psychiatric evaluations a few times. The DON further stated she expected staff to keep residents safe and report any incident or allegation of abuse to her, their supervisor or the Administrator immediately. During an interview with the Administrator on 05/15/2025 at 11:50 AM, he stated R7 was known to be eccentric and have behaviors. He stated she had diagnoses of schizophrenia, delusions, and hallucinations, but was not usually physically aggressive. The Administrator further stated he expected staff to intervene immediately then report any abuse directly to their supervisor then they should call or text him immediately. 47798

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 52040 Based on interview and record review, the facility failed to provide a notice of discharge to the resident or resident representative along with a copy of the notice to the Office of the State Long Term Care Ombudsman following discharge for 1 of 4 sampled closed record reviews, (Resident (R) 13). R13 was discharged to home on 10/12/2022. However, the facility failed to provide a written notification of transfer/discharge to R13 or the Office of the State Long-Term Care Ombudsman. The findings include: Policies were requested; however, the facility did not provide policies which were in effect on 10/12/2022 for the State Survey Agency (SSA) to review. Review of R13's closed electronic medical record (EMR) Admission Record revealed the facility admitted the resident on 09/30/2022, with diagnoses to include sepsis, type 2 diabetes mellitus and synovitis and tenosynovitis (inflammation) of the hand. Review of the Minimum Data Set (MDS) Assessment for R13 with an Assessment Reference Date (ARD) of 10/12/2022, located in the EMR revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognitive function. Additional review of R13's EMR revealed a Discharge Plan dated 10/12/2022. Further review revealed no additional documentation of discharge or discharge paperwork having been provided to the resident. Review of an electronic mail (e-mail) dated 05/14/2025, from the District Ombudsman, revealed she did not have anything from 2022 on (R13's) discharge. In interview on 05/14/2025 at 2:30 PM, the Regional [NAME] President of Operations, the facility's former Administrator, stated the transfer/discharge policy in effect for 09/30/2022 through 10/02/2022 was unavailable because of facility ownership changes. In interview on 05/15/2025 at 11:19 AM, the Director of Nursing (DON) stated discharge planning began at admission, with goals and plans shared with the team, and social services (SS) being involved. She stated that notification was documented in the resident's chart either in a progress notes or as a change in condition. The DON further stated paperwork was sent with the resident, sent to family, and she thought scanned into the resident's EMR. In an interview on 05/15/2025 at 11:48 AM, the facility Administrator stated the facility was responsible to notify the resident's family and ombudsman of transfers and discharges. He said under most circumstances written notification must be given. the Administrator further stated records should be retained and accessible; however, he was unaware of the specific length of time records should be kept.