STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185180	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at North Hardin Rehab & Welln	599 Rogersville Road Radcliff, KY 40160

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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30898 Based on interview, record review, and review of the facility policy, the facility failed to ensure an allegation of abuse was reported to the Administrator and to the State Survey Agency within 2 hours for one of seven sampled residents, Resident (R)1. On 01/08/2025, a Certified Nurse Aide (CNA) reported to facility leadership an allegation of abuse involving R1 which allegedly occurred on 01/07/2025, approximately twenty-four hours prior the CNA reporting the allegation. The findings include: Review of the facility policy Abuse, Neglect and Misappropriation of Property last reviewed 09/13/2024, revealed the facility intended to prevent occurrence of abuse and assure all alleged violations of federal and state laws which involve abuse were reported immediately to the Administrator and State Survey Agency. The facility would include reporting to provide protection for the health, welfare, and rights of each resident. Every Stakeholder must intervene immediately, protect the alleged victim, and integrity of the investigation. If a Stakeholder observes any form of abuse, the Stakeholder will intervene immediately and assure the resident's safety. Further review of the policy, revealed every Stakeholder shall immediately report any allegation of abuse to the Administrator. Review of the facility policy Resident Rights last reviewed 09/13/2024, revealed all residents had the right to be treated with respect and dignity. These rights would be protected by the facility. Further review of the policy revealed the facility will make every effort to assure the resident was treated with respect, kindness, and dignity. Review of the facility investigation revealed on 01/08/2025 at 10:30 PM, the Administrator was notified a staff member voiced a care concern related to evening care provided to R1. The CNA reported redirection approaches to prevent the R1 from falling while the resident was agitated. CNA2 reported the following occurred: CNA9 pulled R1 down by his gown when the resident attempted to stand; CNA8 and CNA10 held the resident's gown and sat him back down when he stood up; CNA8 tapped R1 on the back of his head; and Licensed Practical Nurse (LPN)2 put R1's medications in yogurt, and placed the medications in the resident's mouth after he refused to take medication from the Certified Medication Technician (CMT). Continued review of the facility investigation revealed CNA2's witness statement dated 01/08/2025, revealed she had witnessed the above incidents with R1 on 01/07/2025. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the investigation revealed the facility reported an allegation of abuse to the State Survey Agency on 01/08/2025, with date and time confirmation, on 01/09/2025 at 12:23 AM. The allegation was reported by Certified Nurse Aide (CNA)2 and alleged concerns against CNA8, CNA9, CNA10, and an agency Licensed Practical Nurse, (LPN)2. Review of a Stakeholder Suspension Form dated 01/08/2025 revealed CNA2 was suspended from working, pending the facility's completed investigation. Review of the facility staffing schedule revealed CNA9 was not scheduled to work on 01/07/2025 but all the staff (CNA8, CNA9, CNA10 and LPN2) which CNA2 reported abused R1 were scheduled to work on 01/06/2025. Additionally, CNA2 also was scheduled to work on 01/06/2025. In interview on 01/21/2025 at 8:11 AM and on 01/23/2025 at 7:01 AM, CNA2 stated she reported to the Weekend Manager allegation involving R1. CNA2 stated she failed to report the alleged incident timely and reported approximately 24-hours after the event occurred. CNA2 stated she was trained on abuse when she was employed in October 2024 and understood that allegations of abuse were to be reported immediately. CNA2 stated she was also suspended for not reporting timely. She further stated she did not report the allegation earlier as CNA8 told her to keep my mouth shut. Per CNA2, the purpose of reporting timely was to keep all residents safe. In interview on 01/23/2025 at 1:04 PM, the Director of Nursing (DON) stated CNA2 reported to the Weekend Manager, who then called her (the DON). She stated she (the DON) and the Administrator came in to talk with CNA2 as the aide did not feel comfortable speaking on the phone. The DON stated the CNA witnessed the incidents with R1 several days prior to voicing to anyone. The DON further stated CNA2 was suspended from work for not reporting allegations immediately. She also stated CNA2 was re-educated on timeliness of reporting abuse and to whom to report. The DON stated the purpose of reporting timely was to have an intervention in place for the resident's safety. Interview with Weekend Manager on 01/23/2025 at 1:45 PM revealed CNA2 called her on Wednesday (01/08/2025) to report abuse of R1 which CNA2 reported happened the night before. She stated she asked CNA2 why she did not call the Administrator when it happened, and the aide told her she did not know what to do. The Weekend Manager further stated she told CNA2 the facility had 2 hours to act, and she immediately called the DON. She stated the purpose of reporting in 2 hours was for the protection and safety of the elders (residents). She also stated an obligation to report as soon as staff see it (alleged abuse). In interview on 01/23/2025 at 1:59 PM, the Administrator stated CNA2 was suspended for failure to report timely. Per the Administrator, CNA2 reported the allegation about one day after the incident allegedly occurred. She stated staff were trained on abuse and that abuse allegations should be reported to herself and the DON immediately. She further stated the purpose of reporting in 2 hours was to perform an investigation and ensure the resident's safety.