| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185205 | A. Building<br>B. Wing | 12/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Signature Healthcare of Carrollton Rehab & Wellnes | 1206 Eleventh Street<br>Carrollton, KY 41045 |

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

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898<br><br>Based on interview, record review, and review of the facility policy, the facility failed to ensure residents were free from verbal abuse for 1 of 9 sampled residents, Resident (R)1.<br><br>On 08/28/2024, the Housekeeper cussed at and called R1 names after the resident was verbally aggressive towards the Housekeeper.<br><br>The findings include:<br><br>Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, last reviewed and revised 09/15/2023, revealed it was the organization's intention to prevent abuse and protect the health, welfare, and rights of each resident residing in the facility. Per review, instances of abuse, irrespective of any mental or physical condition, caused harm, pain, or mental anguish. Continued review revealed abuse included verbal abuse, which encompassed use of oral language with any threat, frightening, disparaging or derogatory language to residents or within their hearing distance, regardless of age, ability to comprehend, or disability.<br><br>Review of the facility policy titled, Resident Rights, last reviewed 09/13/2024, revealed all residents had the right to be treated with respect and dignity, which was to be protected by the facility. Per review, all residents were to be treated in a manner and in an environment that promoted enhancement of quality of life. Review further revealed the facility was to make every effort to support each resident in exercising his/her right to assure the resident was always treated with respect, kindness, and dignity.<br><br>Review of the facility's investigation for an incident on 08/28/2024, revealed the facility investigated a verbal altercation between the Housekeeper and R1 at 11:30 AM. Per review, the facility removed and suspended the Housekeeper. Review of the Housekeeper's written statement (located in the investigation documentation), dated 08/28/2024 at 4:35 PM, revealed it had been written by the Housekeeper's parent, as the Housekeeper had disabilities; however, was signed by the Housekeeper. Continued review of the Housekeeper's written statement revealed R1 called the Housekeeper a fat, ugly bitch over and over. Further review of the Housekeeper's written statement revealed the Housekeeper finally broke and told R1 to get out of her effing face and she too (R1) was a fat, ugly bitch. Further review of the facility's investigation revealed the facility determined the incident had been a situational, reactionary event without willful intent to harm and the staff member would not return to the premises.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Continued review of the facility's investigation documentation, for the incident on 08/28/2024, revealed other staff members' statements. Review of Licensed Practical Nurse (LPN) 1's written statement revealed the nurse heard the Housekeeper yelling at R1 and she told the Housekeeper she could not speak to residents in that manner or that way in the resident area. Review of LPN 3's written statement revealed she heard yelling, which included get out of here you fat bitch and whore. Per review of LPN 3's written statement, LPN 1 asked the Housekeeper if it was her yelling, and the Housekeeper said yes. Further review of LPN 3's statement revealed she (LPN 3) took the Housekeeper's broom and dustpan and escorted the Housekeeper to the timeclock.<br><br>Review of the clinical record for R1 revealed the facility admitted the resident on 06/21/2021, and readmitted R1 on 09/30/2021, with diagnoses that included dementia, schizoaffective disorder and borderline personality disorder.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R1 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact.<br><br>Review of the comprehensive care plan for R1 revealed the facility developed a behavioral problem area dated 07/01/2021 and edited 06/12/2024. Continued review of R1's behavior care plan revealed the resident's behaviors included being verbally abusive; difficult to redirect; known to yell/cuss at staff; and say racial slurs towards staff. Further review revealed the interventions included to provide a non-confrontational environment for care.<br><br>In interview on 12/12/2024 at 2:42 PM, R1 stated a housekeeper yelled at her and cussed at her around a month ago. R1 further stated the Administrator fired the housekeeper.<br><br>In interview on 12/12/2024 at 4:27 PM, the Housekeeper (involved in the incident on 08/24/2024) stated R1 called her a fat ugly bitch and she (the Housekeeper) went off and told R1 to look in the mirror. The Housekeeper stated she said what was noted in her written statement. She further stated the facility wanted her out of the building<br><br>On 12/12/2024 at 5:37 PM, interview with LPN 1 revealed she had been involved in the situation with R1 and the Housekeeper. She stated she had been at the nurse's station and heard loud yelling and knew it was R1. LPN 1 said she went to where the resident was and intervened with R1. She reported she and another nurse told the Housekeeper she could not speak like that to R1 and asked the Housekeeper to leave the resident area. LPN 1 stated the Housekeeper said, that fucking bitch whore (R1) was not going to talk to her like that. The nurse said R1 called the Housekeeper a fucking bitch, and the housekeeper said no you're a fucking bitch. LPN 1 further stated she escorted the Housekeeper to the timeclock and watched the Housekeeper leave the building. She additionally stated she told R1 it (the incident) would be handled through proper channels.<br><br>In interview on 12/18/2024 at 3:16 PM, the Housekeeping District Manager (DM) stated R1 made comments to the Housekeeper and when the Housekeeper attempted to walk away, R1 followed her. She stated the Housekeeper then screamed back at the resident. The Housekeeping DM reported the Housekeeper was walked out of the facility after she raised her voice to R1 and was terminated on the spot. She said she spoke with the Housekeeper and informed her R1 was still a patient and she (the Housekeeper) still needed to follow the facility's protocol. The Housekeeping DM further stated there were other things the Housekeeper could have done in that situation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview on 12/18/2024 at 12:51 PM, the Director of Nursing (DON) stated R1 started to cuss and yell at the Housekeeper while the Housekeeper was cleaning the resident's room. She said the Housekeeper tried to walk away; however, R1 followed the Housekeeper down the hall. The DON stated the Housekeeper began to talk back to R1, yelling and cussing, and was terminated for the verbal abuse.<br><br>Interview on 12/18/2024 at 2:22 PM, the Administrator stated R1 did not need to be provoked in her behaviors. He reported LPN 1 heard the incident between R1 and the Housekeeper (on 08/24/2024) and got the Housekeeper immediately out of the building. The Administrator stated the LPN reported the incident to him and the housekeeper was immediately suspended and eventually terminated. He explained R1 had not wanted her room cleaned at the moment; however, the Housekeeper tried to go ahead and clean the room. The Administrator stated R1 followed the Housekeeper in the hall and called the Housekeeper a retard. He further stated the Housekeeper, who had a developmental disability, said R1's words back to the resident. |

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| F 0949<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide behavior health training consistent with the requirements and as determined by a facility assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898<br><br>Based on interview, record review, review of staff training records, and review of the website utilized by the facility for training staff, the facility failed to provide staff training specific to a resident's mental illness diagnoses and behaviors for 1 of 9 sampled residents, Resident (R)1.<br><br>R1's diagnoses included Borderline Personality Disorder and Schizoaffective Disorder, and the resident exhibited behaviors. However, the facility failed to provide training for staff directly related to R1's mental illness and diagnoses.<br><br>The findings include:<br><br>Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, last revised and reviewed on 09/15/2023, revealed it was the organization's intention to prevent the occurrence of abuse. Review of the policy revealed the facility included training to provide for the protection of the health, welfare, and rights of each resident residing in the facility. Continued review revealed training provided included understanding behavioral symptoms of residents that might increase the risk of abuse and how to respond. Review further revealed the resident behavioral symptoms included aggressive or catastrophic reactions of residents, outbursts or yelling out, and resistance to care.<br><br>Review of the facility's investigation of an incident on 08/28/2024, revealed R1 became verbally aggressive toward the Housekeeper. Per review, R1 called the Housekeeper a fat, ugly bitch multiple times, which led to the Housekeeper repeating (the words) back to R1. Review further revealed the Housekeeper was removed and was not to return to the premises.<br><br>Review of the facility's staff training overview for Behavioral Health for Older Adults revealed an overview of the training included the physical decline (of residents), loss of loved ones, and it discussed the most common behavioral disorders, levels of care, and community supports. Continued review revealed the goal of the course was to educate staff in post-acute care on behavioral health in older adults. Review further revealed the course overview did not define specific mental illness or any mental illness, such as R1's diagnoses.<br><br>Review of the website www.reliasacademy.com training Behavioral Health for Older Adults, utilized by the facility, revealed the training included behavioral health disorders common in older adults. Per review, the behavioral health disorders in the training included Depression, Dementia, Alzheimer's Disease, Suicide, Anxiety, Substance Use Disorder, Bipolar Disorder, Eating Disorders, and Schizophrenia. However, further review revealed Borderline Personality Disorder and Schizoaffective Disorders were not identified as included in the training outline.<br><br>Review of R1's clinical record revealed the facility admitted the resident on 06/21/2021 and readmitted R1 on 09/30/2021, with diagnoses which included borderline personality disorder, dementia, and schizoaffective disorder.<br><br>(continued on next page) |

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| F 0949<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition.<br><br>Review of R1's comprehensive care plan revealed the facility developed a problem area for behaviors for the resident dated 07/01/2021 and edited 12/09/2024. Review revealed the facility noted R1's behaviors as: being verbally abusive and physically aggressive; refusing care, medications, and psych services; being difficult to redirect; known to yell/cuss and say racial slurs towards staff; and hitting staff. Continued review revealed the facility listed other of R1's behaviors as: attempting to impede the care of others; being destructive to facility property and electronic devices; making unsubstantiated claims and allegations; displaying manipulative behaviors and paranoia; and demanding her care needs be first above other residents. In addition, the facility noted R1 had behaviors of rummaging through others' personal belongings; attempting to rummage through the food carts; and hoarding dishes, linens, food, snacks. Further review of the care plan revealed interventions that included: redirecting and providing education as needed on the benefits and risks of recommended care; two people (present) at all times during care; continuing to offer psychiatric support services; and discussing the behavior with resident if reasonable. Review further revealed other interventions to: intervene as needed to protect the rights and safety of others; divert the resident's attention; remove the resident from a situation as needed; encourage activity; allow the resident to express feelings and provide methods to cope; and re-approach later when she had less agitation.<br><br>Review of R1's progress notes revealed R1 yelled at staff, cussed staff, and/or called staff names on the following dates: 08/05/2024, 08/07/2024, 08/22/2024, 08/25/2024, 08/28/2024, 09/07/2024, 09/19/2024, 09/23/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/18/2024, 10/19/2024, 10/22/2024, 11/03/2024, 11/11/2024, 11/19/2024, 11/29/2024, 11/30/2024, 12/02/2024, 12/03/2024, 12/07/2024, 12/08/2024, and 12/09/2024.<br><br>In interview on 12/12/2024 at 2:42 PM, R1 stated she was calling the federal government and the governor to report staff at the facility. She stated an Adult Protective Services (APS) worker came to speak with her yesterday and the APS worker was going to call the supervisor of the State Survey Agency (SSA) to make her report. R1 spoke of how staff treated her in the facility, calling her names and cussing her.<br><br>In interview on 12/13/2024 at 9:58 AM, the APS worker stated R1 had a lengthy history with the state. She reported she saw R1 on 12/11/2024, for allegations the resident made against Certified Nurse Aide (CNA) 1 and Licensed Practical Nurse (LPN) 2.<br><br>In interview on 12/12/2024 at 5:37 PM, LPN 1 stated R1 had diagnoses that caused her to have mental health issues. She further stated R1 got the whole building in an uproar in general, and that was just who she was.<br><br>In interview on 12/18/2024 at 10:36 AM, the Social Services Director (SSD) stated staff received education for dementia and mental illness when hired, and with yearly competencies (however, review of the facility's training revealed it did not specifically address R1's diagnoses of schizoaffective disorder and borderline personality disorder). The SSD reported staff used R1's care plan interventions when she had behaviors, although they did not prevent the resident's behavior of hitting staff.<br><br>(continued on next page) |

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| F 0949<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In interview on 12/18/2024 at 3:16 PM, the Housekeeping District Manager (DM) revealed the housekeepers completed the same trainings the facility staff completed, either in person or online. She stated the housekeepers completed their own training and any general education with the facility. The Housekeeping DM was unsure if facility staff completed training regarding a resident's mental illness.<br><br>In interview on 12/18/2024 at 6:16 PM, CNA 4 stated she was very familiar with R1, although she did not usually provide care for the resident. She stated R1 called staff names, cussed at staff, and harassed certain staff. CNA 4 stated the facility provided training for working with residents with mental illnesses, such as mental disability or M.R. (mental retardation).<br><br>In interview on 12/19/2024 at 10:24 AM, the MDS Nurse stated she did not know if any staff received training specific to R1's psychiatric diagnoses (of borderline personality disorder and schizoaffective disorder). She stated the facility had not had a Staff Development Coordinator (SDC) to provide staff education for about two months. The MDS Nurse said facility staff had different learning based on their various roles. She further stated she had not received training related to R1's mental illness diagnoses.<br><br>In interview on 12/19/2024 at 12:51 PM, the Director of Nursing (DON) stated she was also the current SDC. She said staff had to walk on eggshells with R1 as they did not know how she would react to them. The DON said you could say good morning to R1 and she would cuss you out, or be as nice as can be. She reported each behavior was situational and the majority of R1's behaviors were from the same root cause, her personality disorder. The DON explained R1 targeted specific staff and called staff names and talked derogatively about them. She stated R1 has difficulty interacting appropriately with others and became defensive and angry. Per the DON in interview, the facility did not typically complete resident mental health training for staff as the facility was not a mental health facility. She said staff were trained in dementia and dementia type behaviors when hired and yearly. The DON reported however, staff were not trained on schizoaffective disorder or borderline personality disorder. She said the training the facility provided titled, Behavioral Health for Older Adults was dementia training. The DON stated training in schizoaffective disorder and borderline personality disorder was situational, as everybody's situation was different. She said the purpose of providing training for staff was to help them know how to handle situations or provide care or diversional activities for residents. The DON further stated housekeeping was a different company and she could not answer if they completed the same trainings the facility completed.<br><br>In interview on 12/19/2024 at 2:22 PM, the Administrator stated R1 did things without being provoked. He said he was aware of R1's mental illness and it was uniquely directed toward staff and visitors and that was just who R1 was. The Administrator reported R1 responded to some staff better than others. He stated R1 hit a CNA and attempted to hit a nurse (on 12/09/2024), and the root cause of those two events had been R1's mental illness. Per the Administrator in interview, staff were trained on R1's mental illnesses in the Behavioral Health for Older Adults training. He stated that the facility's training was a general behavioral training for older adults and R1's diagnoses should be included in the training (however, schizoaffective disorder and borderline personality disorder were not included in the training outlined on the website). The Administrator said the purpose of the trainings was to educate staff on how to manage a resident's behaviors, whether it was mental illness or behavioral, to provide quality of life for residents and person centered care. He further stated the facility was the last stop for many of the residents and the facility wanted to make them as happy and comfortable as possible, and the trainings help in providing that kind of life for the residents. |