

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/13/2024
NAME OF PROVIDER OR SUPPLIER  Mountain Ridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1901 West Highway 90 Monticello, KY 42633	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46651</p> <p>Based on observation, interview, record review, review of the facility's policy and review of the facility's investigation documentation, the facility failed to protect the resident's right to be free from sexual abuse.</p> <p>On 11/21/2024 at 6:20 PM Certified Nursing Assistant 1 (CNA1) and CNA 2 heard noises coming from Resident 2's (R2) room. Upon entering the room, they observed Resident 3 (R3) naked from the waist down in the bed on top of Resident 2 (R2). R3 was observed pulling at R2's brief and stated, We are fucking. R2 and R3 were immediately separated and R3 was placed on 1:1 staff observation. The facility's administrative staff failed to identify the incident as an allegation of abuse. The facility did not report the incident to the appropriate state agencies or law enforcement. Refer to F609, F835 and F837.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated as implemented on 01/20/2020 and revised on 08/01/2024 revealed it was the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. Abuse meant the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm. Pain or mental anguish which could include certain resident to resident altercations and included sexual abuse. Sexual abuse was defined as non-consensual sexual contact of any type with a resident. Additionally, the facility's policy defined an alleged violation as a situation or occurrence that was observed or reported by staff.</p> <p>Review of Resident 2's (R2) facility document titled, Continuity of Care revealed the facility admitted R2 on 05/15/2024 with diagnoses of unspecified dementia, cognitive communication deficit, muscle weakness, cerebral infarction with left sided weakness, and anxiety.</p> <p>Review of R2's Quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero (00) out of fifteen (15). This score indicated severe cognitive impairment.</p> <p>Review of R3's facility document titled, Continuity of Care revealed the facility admitted R3 on 09/03/2024 with diagnoses of unspecified dementia, disorientation, and anxiety.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of R3's Admission Minimum Data Set Assessment (MDS) dated [DATE] revealed a BIMS score of ninety-nine (99) indicating the assessment was unable to be completed because the resident was rarely or never understood.</p> <p>Review of R3's Comprehensive Care Plan (CCP) dated 09/03/2024 revealed R3 was at risk for elopement related to dementia and wandered into other residents' rooms.</p> <p>Review of R3's Progress Note dated 11/21/2024 at 7:35 PM written by Licensed Practical Nurse 1 (LPN1) revealed R3 was found in a female resident's bed, confused and naked with feces on the bed and both residents. R3 was trying to touch the female resident's breast as he was being removed from the bed. Resident 3 was taken to his room and changed and a CNA was sitting one on one with the resident. Review of R3's Social Services Note, dated 11/22/2024 at 10:25 AM revealed the Admissions/Social Services/Admissions Director ([NAME]) spoke with R3 in regard to his recent behavior and R3 did not recall the incident.</p> <p>In interview on 12/03/2024 at 10:30 AM with Certified Nursing Assistant (CNA) 2, she stated she was at the facility the night of the incident between R3 and R2. CNA2 stated at about 6:20 PM, she and Licensed Practical Nurse 1 (LPN1) were in another room and Licensed Practical Nurse 2 (LPN2) came to get them and told them R3 was in bed with R2. CNA2 stated she went into R2's room and there was fecal matter on the floor and R3 was in the bed with R2 and told staff to get out, they were fucking. CNA2 stated it took three staff to get R3 off of R2 and back in his wheelchair. She stated as they were getting him out of the bed, R3 grabbed R2's breast. CNA2 stated all the aides involved wrote a witness statement and waited until the DON and Administrator returned to the facility which was around 8:00 PM. CNA2 stated the abuse coordinator for the facility was the Administrator and abuse training was offered pretty frequently since the new company had taken over, the most recent being last week. CNA2 stated it was the DON's and the Administrator's responsibility to report incidents like this to the State.</p> <p>In interview on 12/03/2024 at 10:45 AM with CNA1, she stated she and CNA4 had heard grunting noises coming from R2's room and when they went in to see what was happening, they observed R3 on top of R2 with no clothes on from the waist down. R3's clothes were on the floor and there was fecal matter on him, the bed and the floor. R2 had on a shirt and her brief and R3 was trying to undo R2's brief. CNA1 stated R3 told staff to get out of the room, they were fucking. CNA1 stated R3 had been combative before, so she had CNA4 stay in the room, and she went to get LPN1 and LPN2 to assist. CNA1 stated R3 was removed from the room, R2 appeared scared and although she had not been able to speak since her stroke, she was making a grunting noise. CNA1 stated she wrote a witness statement and remained at the facility until the Director of Nursing (DON) and the Administrator returned to the facility. 1:1 supervision of R3 began after the incident that night and the next morning, CNA1 stated she had heard the police came to the facility that night and talked to the DON because R2's family had called them. CNA1 stated she had not received any additional abuse training specific to the incident between R2 and R3. She stated she had been told the facility was trying to find new placement for R3 in an all-male facility but there were no beds available. CNA1 stated there had been other incidents with R3 entering the rooms of female residents (R9 and R10).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In interview on 12/03/2024 at 2:00 PM with CNA4 she stated she and another aide were starting their round around 6:20 PM, when they heard a noise coming from R2's room. She stated when they walked in they saw R3 with no brief or pants on, laying on top of R2, with fecal matter on him, the bed and the floor. CNA4 stated R2's blankets and clothes were on, but R2 appeared to be in distress even though she was nonverbal. CNA4 stated staff began to explain to R3 he would have to get up and he began to fight, placing his hand on R2's breast. CNA4 stated R3 was removed from the room and placed on 1:1 staff supervision that night. CNA4 stated LPN2 called the DON and the Administrator but she was not sure if the police came to the facility.</p> <p>In interview on 12/03/2024 at 1:31 PM with LPN1, who was on duty the night of the incident, she stated she was in another resident room with CNA2 when LPN 2 came to get them for assistance. LPN1 stated when they got to R2's room, they observed R3 with his pants and brief off and there was feces everywhere. LPN1 stated R3 told them to shut the door, they were fucking. The LPN stated R3 would not be redirected at that time and as they were trying to get him off R2, he grabbed R2's breast. LPN1 stated R2 could not move her legs and was nonverbal, but she was moving her hands, moaning and appeared visibly distressed. LPN1 stated R2 had on a brief and a shirt but no blankets or sheets were covering her. The LPN stated CNA2 and LPN2 cleaned R2 up and completed skin assessments on both residents with no injuries noted. LPN1 stated she called the DON and the Administrator and waited for them to arrive which took about an hour. She stated she reported any incidents to the DON and/or the Administrator.</p> <p>In a phone interview on 12/02/2024 at 7:06 PM with Resident 2's Daughter #3 (R2D3) and Power of Attorney (POA), she stated she had received a call on 11/21/2024 at 7:47 PM from the DON and was told there had been an incident and a male resident had gone into R2's room, had undressed and was on top of her in her bed. R2D3 stated she lived in Ohio, was R2's POA and was concerned with getting someone from her family to the facility. She stated she called R2D4 who went to the facility to check on R2. Eventually R2D1 and R2D2 (two other family members) also arrived at the facility. R2D3 stated she arrived on Friday 11/22/2024 and spoke with CNA4 who had found R3 on R2. She stated she told R2D3 she had seen R3 at the nurses station in his wheelchair not long before the incident. CNA4 told R2D3 while doing resident rounds, she heard commotion, like yelling and stuff, coming from R2's room and went in to see about it. CNA4 told R2D3 she opened the door and found R3 on top of R2, the blankets were not pulled down but R3 was naked; and when she entered the room, R3 was yelling at her to shut the door. CNA4 told R2D3 she needed help to get R3 off R2 because he was yelling and fighting and R2's eyes were as big as saucers.</p> <p>In interview on 12/02/2024 at 2:56 PM with R2's Daughter 1 (R2D1) and R2's Daughter 2 (R2D2), R2D1 stated she was informed of the incident by R2D3 and immediately drove to the facility. R2D1 went to R2's room where another sister had already arrived and was comforting R2. R2D1 stated R2 was unable to articulate but they could tell she was upset. R2D1 stated the DON told her the facility was trying to move R3 to an all-male facility but had not found one yet. R2D2 stated she and her husband tried to file a police report and a police officer had come to the facility but told them there was nothing he could do. Review of R2's Progress Notes from 11/20/2024-11/22/2024 revealed no documentation or description of the incident. Review of R2's Social Services note dated 11/22/2024 at 10:47 AM written by the Admissions/Social Services Director (ASSD) revealed an interview was conducted with R2 to assess for any mental anguish or signs of distress. R2 had no visible signs of distress, was resting in the bed eating snack and smiled frequently, and monitoring for R2 would continue over the next few days.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In interview on 12/03/2024 at 2:31 with the DON, he stated the Administrator was the facility's abuse coordinator. He stated that on the night of the incident between R2 and R3, the Administrator had called him, and he arrived at the facility before her. The DON stated he talked to CNA1, CNA4, LPN1 and LPN2 to try and figure out what happened and made sure R3 was separated from R2. The DON stated staff told him they heard noises coming from R2's room and observed R3 on his hands and knees on the bed without any pants on and he had had a bowel movement. The DON stated he assessed R2 and she was not in any distress and was at her baseline (her condition was unchanged from before the incident). LPN1 completed skin assessments on both R2 and R3 with no injuries noted. The DON stated R3 was placed on 1:1 supervision more to protect him than the other residents because R3 did have a history of being confused, wandering and getting into other resident's beds to sleep. The DON stated he could not be sure R3's behavior was sexually motivated or if he just got confused. The DON stated to say the incident was sexually motivated would be discriminatory against R3 and since the facility could not be sure it was, it was not a reportable event. The DON stated the facility did not call law enforcement. The DON stated he was not sure if a police report was filed and he had not signed one.</p> <p>In interview on 12/03/2024 at 2:59 PM with the Administrator she stated she was the facility's abuse coordinator. The Administrator stated she was notified of the incident between R2 and R3 by LPN2 via phone on the night it happened. The Administrator stated LPN2 told her R3 had gone into R2's room and was found with no pants or briefs on, on his hands and knees on top of R2. She stated staff had reported that when they entered R2's room and turned on the lights, R3 stated we are fucking but no one had mentioned if R2 had an erection or not. The Administrator stated she was told R2 was clothed, there were blankets between R2 and R3, and R3 had a bowel movement on the bed. The Administrator stated she was told R2 was grunting and appeared to be upset, so she called the DON and he arrived at the facility before her. The Administrator stated when she arrived, the DON was talking to the nurses, so she went to R2's room and R2 did not appear to be in any distress. The Administrator stated R3 was placed on 1:1 observation before she and the DON had arrived. She stated she had notified the Regional Director of Operations (RDO) the night of the incident and was not instructed to report it. The Administrator stated she did not feel like the incident between R2 and R3 was abuse and did not feel it was a reportable event. The Administrator stated law enforcement was not notified by the facility, but they came to the facility after the family reported the incident and no report had been filed. The Administrator stated R3 was on a wait list for an all-male facility and would remain on 1:1 supervision until he could be transferred.</p> <p>In a follow up interview on 12/04/2024 at 8:20 AM with the DON and the Administrator they both stated neither they or facility staff thought the incident between R2 and R3 qualified as abuse, and if the same situation were to happen again, they would not handle it any differently.</p> <p>In a telephone interview on 12/05/2024 at 5:35 PM with the Medical Director she stated she was aware that R3 had gotten in her R2's bed and kind of scared her but did not really know any other details. When interviewed related to if she knew R3 was naked, she stated yes. The Medical Director stated she knew R3 had said he and R2 were fucking. She stated that the staff she spoke with who were present at the time felt it appeared R3 was assaulting R2. The Medical Director stated the facility notified her of the incident the night it occurred via a Health Insurance Portability and Accountability Act (HIPPA) compliant texting service but she had not spoken to anyone. She stated in talking to R2's family and to the facility staff, she thought the facility had notified the State agency and law enforcement. She stated she was not aware they had not done either until this interview.</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46651</p> <p>Based on interview, record review, and review of the facility's policy, the facility failed to immediately report an allegation of sexual abuse (defined as non-consensual contact of any type with a resident) involving two (Resident (R) 2 and R3) of nine sampled residents reviewed for abuse.</p> <p>On 11/21/2024 at 6:20 PM, Certified Nursing Assistant (CNA) 1 and CNA 4 heard noises coming from R2's room. Upon entering the room, they observed R3, who was naked from the waist down, in the bed on top of R2. R3 was observed pulling at R2's brief and stated, We are fucking. The facility failed to report the incident of sexual abuse of R2, who did not have the capacity to consent to sexual contact, to either the State Survey Agency or to law enforcement for investigation. The facility's failure to ensure that all allegations of alleged sexual abuse were reported to the appropriate State agencies/law enforcement and failure to comply with regulations designed to prevent/report allegations of abuse has the likelihood to place residents at risk for further potential abuse.</p> <p>Refer to F600, F835 and F837.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated as implemented on 01/20/2020 and revised on 08/01/2024, revealed that under the section titled, Policy Explanation and Compliance Guidelines, the facility would designate an Abuse Prevention Coordinator in the facility who was responsible for reporting allegations or suspected abuse to the State Survey Agency and other officials in accordance with state law. Further review of the policy, under the section titled, Reporting/Response, revealed reporting of alleged violations to the Administrator, the state agency, adult protective services, and all other required agencies would occur immediately but not later than two hours after the allegation was made if the event involved abuse or serious bodily injury.</p> <p>Further review of the policy revealed that Sexual abuse is defined at non-consensual sexual contact of any type with a resident.</p> <p>Review of R2's Continuity of Care document revealed the facility admitted R2 on 05/15/2024 with diagnoses including unspecified dementia, cognitive communication deficit, muscle weakness, cerebral infarction with left sided weakness, and anxiety.</p> <p>Review of R2's Minimum Data Set Assessment (MDS), dated [DATE], revealed the facility assessed the resident as moderately cognitively impaired. Further review of R2's electronic medical record (EMR) revealed no evidence that the facility assessed the resident to determine if she was competent to consent to sexual contact.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 12/3/2024 at 10:45 AM with CNA1 revealed she and CNA4 heard grunting noises coming from R2's room and, when they went in to see what was happening, they observed R3 on top of R2 in R2's bed. R3 had no clothes on from the waist down. His clothes were on the floor and there was fecal matter on him, the bed, and the floor. R2 had on a shirt and her brief and R3 was trying to undo R2's brief. CNA1 stated R3 told staff to get out of the room, adding they were fucking. Further interview with CNA1 revealed that she believed what she witnessed was abuse which needed to be reported to the state and therefore, she immediately reported what she witnessed to Licensed Practical Nurse (LPN) 2, who then went and got LPN1.</p> <p>In interview on 12/03/2024 at 2:00 PM, CNA4 stated that she had witnessed R3 on top of R2 in bed, and that R3 told them to leave the room because the residents were fucking. CNA4 stated that she viewed this as an allegation of abuse that would need to be reported to the state and they immediately told the nurse.</p> <p>Interview on 12/03/2024 with LPN1 at 1:31 PM, revealed she was informed that the CNAs found R3 on top of R2 in R2's bed. LPN1 stated that she took the information as an allegation of abuse that needed to be reported and immediately contacted the Director of Nursing (DON) and Administrator.</p> <p>However, review of State Survey Agency (Office of Inspector General - OIG) records revealed no evidence that the facility reported the allegation of sexual abuse. Interviews with both the DON on 12/03/2024 at 2:31 PM, and the Administrator at 2:59 PM confirmed that neither the SSA/OIG nor law enforcement was contacted for investigation of an allegation of abuse and/or a possible crime.</p> <p>In interview on 12/03/2024 at 2:31 PM with the DON, he stated that the allegation of sexual abuse, which CNA1, CNA4, and LPN1 passed on to administrative staff, was not reported to either the SSA/OIG or law enforcement agencies within two hours as required by regulation. The DON stated he and the Administrator arrived at the facility on 11/21/2024 after the incident between R2 and R3 and obtained witness statements from staff. Review of the witness statements revealed the interviews with CNA1 and CNA4 in which they described their observations met the definition of an allegation of sexual abuse. However, the DON stated that after determining that R2 was not physically harmed and appeared at her baseline cognition, both he and the Administrator agreed that no allegation of abuse had occurred, and the incident did not require reporting to law enforcement or to the SSA. The DON stated the Administrator was the facility's abuse coordinator and was responsible for the reporting of incidents of abuse to the state.</p> <p>In interview on 12/03/2024 at 2:59 PM with the Administrator, she stated she was the facility's abuse coordinator. The Administrator stated she was aware that allegations of abuse were to be reported within two hours. The Administrator stated that staff informed her that R3 was found on top of R2 in bed, pulling at R2's brief, and was stating that they were fucking, but There was no allegation of abuse by staff. The Administrator repeatedly stated that R3 was confused and meant no harm; therefore, she did not feel like the incident between R2 and R3 was abuse and as a result, she did not feel it that a reportable event. She stated her investigation found that R3 was on all fours with no erection and had had a bowel movement, so she felt because he had dementia, was confused, and had no history of sexual behaviors, R3 thought he was in the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 12/03/2024 at 3:33 PM with the Regional Director of Operations (RDO) revealed that although she was made aware of the incident between R2 and R3 on the night it occurred by the Administrator, as regional support, they did not give guidance or directive on reportable incidents. The RDO stated it was ultimately the Administrator's decision to determine whether or not to report an incident or event.</p> <p>In a follow up interview on 12/04/2024 at 8:20 AM with the DON and the Administrator, they both stated neither they nor facility staff thought the incident between R2 and R3 qualified as abuse, and if the same situation were to happen again, they would not handle it any differently. However, the interviews noted above with CNA1, CNA4, and LPN1 on 12/03/2024 revealed that the DON and Administrator's statement was not accurate, as the direct care staff had viewed the incident between R2 and R3 as abuse which needed to be reported.</p> <p>Interviews with the Medical Director (MD) by telephone on 12/05/2024 at 5:35 PM and on 12/09/2024 at 10:13 AM, revealed she first stated she knew R3 had gotten in R2's bed and kind of scared her but did not really know any other details. Then the Medical Director stated she knew R3 was naked and that R3 had stated he and R2 were fucking. She added that she heard the staff present at the time felt it appeared R3 was assaulting R2. The Medical Director stated the facility notified her of the incident the night it occurred via a texting service, but she was not aware the facility did not report the incident to law enforcement or the state agency until the interview with the State Survey Agency Surveyor. The Medical Director stated if the facility had actually spoken with her on the night of the incident related to reporting, she would have suggested the incident be reported.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>46651</p> <p>Based on interview, record review, and review of the facility's policy and documents, the facility failed to ensure that it was administered in a manner to ensure the highest practicable physical, emotional, and psychosocial wellbeing for one (Resident (R) 2) of nine sampled residents reviewed for abuse.</p> <p>Administrative staff, including the Administrator and Director of Nursing (DON) were aware that on 11/21/2024, Certified Nursing Assistant (CNA) 1, and CNA 4 observed R3 naked from the waist down, while in bed on top of R2. R3 was observed pulling at R2's brief and stated, We are fucking. However, the administrative staff failed to make a report of an allegation of sexual abuse to either the State Survey Agency (SSA)/(Office of Inspector General - OIG) or to law enforcement. The facility failed to report the incident of sexual abuse of R2, who did not have the capacity to consent to sexual contact, to either the State Survey Agency or to law enforcement for investigation. The facility's failure to ensure that all allegations of alleged sexual abuse were reported to the appropriate State agencies/law enforcement and failure to comply with regulations designed to prevent/report allegations of abuse has the likelihood to place residents at risk for further potential abuse.</p> <p>Refer to F600, F609, and F835.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated as implemented on 01/20/2020 and revised on 08/01/2024, revealed under the section, Policy Explanation and Compliance Guidelines, the facility would designate an Abuse Prevention Coordinator in the facility who was responsible for reporting allegations or suspected abuse to the state survey agency and other officials in accordance with state law. Further review revealed under the Reporting/Response section, that reporting of alleged violations to the state agency, adult protective services and all other required agencies would occur immediately but not later than two hours after the allegation was made if the event involved abuse or serious bodily injury or not later than twenty-four hours if the events that caused the allegation did not involve abuse and do not involve bodily injury.</p> <p>Review of the facility's document titled, Job Description-Administrator, dated 12/2018, revealed the Administrator's responsibilities included directing the overall operations of the facility in accordance with government regulations. Further review of the document, under the Essential Duties and Responsibilities section, revealed the Administrator maintained a working knowledge of and confirmed compliance with all governmental regulations.</p> <p>Review of the facility's document titled, Job Description-Director of Nursing (DON), updated 12/2011, revealed the DON managed the overall operations of the Nursing Department in accordance with company policies, standards of nursing practices and governmental regulations. Review of the Essential Duties and Responsibilities section of the policy revealed the DON's duties included informing the state of any reportable incidents within appropriate timeframes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/13/2024
NAME OF PROVIDER OR SUPPLIER  Mountain Ridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1901 West Highway 90 Monticello, KY 42633	
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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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 12/03/2024 at 10:45 AM with CNA1 revealed that on 11/21/2024, she and CNA4 heard grunting noises coming from R2's room and, when they went in to see what was happening, they observed R3 on top of R2 in R2's bed. R3 had no clothes on from the waist down. His clothes were on the floor and there was fecal matter on him, the bed, and the floor. R2 was wearing a shirt and her brief, and R3 was trying to undo R2's brief. CNA1 stated R3 told staff to get out of the room, saying they were fucking. Interview on 12/03/2024 at 2:00 PM with CNA4 as well as a review of both CNAs written witness statements confirmed CNA1's description of their first-hand observations.</p> <p>Further interview with CNA1 on 12/03/2024 at 10:45 AM revealed that she believed what she witnessed was abuse which needed to be reported to the state and therefore, she immediately reported what she witnessed to nursing staff. Interview on 12/03/2024 at 2:00 PM with CNA4 confirmed CNA1's statement. Interview on 12/03/2024 with Licensed Practical Nurse (LPN) 1 at 1:31 PM, confirmed that after being informed that the CNAs found R3 on top of R2 in R2's bed, she took the information as an allegation of abuse that needed to be reported and the facility immediately contacted the DON and Administrator.</p> <p>Interviews and review of the written witness statements, revealed direct care staff (CNA1, CNA4, and LPN1) were all aware of and immediately identified a situation which constituted an allegation of abuse. The staff reported the incident as required to administrative staff, including the Administrator and DON. However, review of OIG records revealed no evidence that the Administrator (as Abuse Coordinator) or the DON (whose job responsibilities included informing the state of any reportable incidents within appropriate timeframes) reported the allegation of abuse. Interviews with both the DON on 12/03/2024 at 2:31 PM, and the Administrator at 2:59 PM confirmed that neither the OIG nor law enforcement was contacted for investigation of an allegation of abuse and/or a possible crime.</p> <p>In interview on 12/03/2024 at 2:31 PM with the DON, he stated he had worked at the facility for about two years and had been the DON for about a year. The DON stated he and the Administrator arrived at the facility on 11/21/2024 after being informed of the incident between R2 and R3. After obtaining witness statements from staff and determining that R2 was not physically harmed and appeared at her baseline cognition (diagnosis of dementia and moderative cognitive impairment), they both agreed no allegation of abuse had occurred and the incident did not require reporting to law enforcement or to the state agency. The DON stated he felt due to R3's diagnosis of dementia, he had been confused and was looking for the bathroom. The DON stated he did not feel it was fair to assume R3's behaviors were sexual in nature because he did not have a prior history of inappropriate sexual behaviors. The DON stated that if he had thought the incident was abuse, he would have reported it. However, he did not see this as an allegation of abuse, because he did not feel R3 meant to harm R2. The DON stated the Administrator was the facility's abuse coordinator and she was the person responsible for the reporting of incidents of abuse to the state. The DON stated that the direct care staff who made the report never stated that what was witnessed was an actual abuse allegation. As a result, the Administrator chose not to immediately report the initial allegation in which staff witnessed R3, who was naked from the waist down, on top of R2, pulling at her brief and telling staff that they were fucking.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In interview on 12/03/2024 at 2:59 PM with the Administrator, she stated she had worked at the facility for two years and confirmed that she was the facility's abuse coordinator. The Administrator stated she was notified of the incident between R2 and R3 via phone on the night it happened and was told what the CNAs described. The Administrator stated she was aware that all allegations of abuse were to be reported immediately/no more than two hours. However, the allegation that staff made was not immediately reported to either the OIG or to law enforcement. The Administrator stated that instead, staff interviews were conducted, and written statements (which verified staff interviews) were reviewed. After review of this information, the Administrator stated she did not feel like the incident between R2 and R3 was abuse and did not feel it was a reportable event. The Administrator stated that R3, who had a history of wandering into other resident rooms while looking for his wife, did not have an erection, was on all fours, and had had a bowel movement when he was found on top of R2. The Administrator stated that based on her investigation, because she felt R3 had dementia, was confused, and had no history of sexual behaviors, the resident thought he was in the bathroom. The Administrator stated that the direct care staff who made the report never stated that what was witnessed was an actual abuse allegation. The Administrator did not immediately report the initial allegation that staff had witnessed and reported R3.</p> <p>In interview on 12/03/2024 at 3:33 PM with the Regional Director of Operations (RDO), she stated she was made aware of the incident between R2 and R3 by phone on the night it occurred. The RDO stated as regional support, they did not give guidance or directive on reportable incidents (Cross Reference to F837.). The RDO stated it was the Administrator's name on the facility license which hung on the wall, the Administrator's responsibility, and ultimately the Administrator's decision to determine whether or not to report an incident or event.</p> <p>In additional interview on 12/04/2024 at 8:20 AM with the DON and Administrator, they confirmed that, after taking witness statements from staff, and speaking with R2's family, they did not feel like the incident was abuse or should have been reported to the state agency or to law enforcement. They stated looking back, they would not have handled the situation any differently.</p>		

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<p>F 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>46651</p> <p>Based on interview, record review, and facility policy/document review, the facility's Governing Body failed to provide effective oversight to the Administrator to ensure the facility implemented policies, including identifying and reporting an allegation of sexual abuse of one (Resident (R) 2) of nine sampled residents reviewed for abuse.</p> <p>On 11/21/2024, staff observed R3, who was naked from the waist down, in bed on top of R2. R3 was observed pulling at R2's brief and stated, We are fucking. The Administrator and Director of Nursing (DON), who were both members of the Governing Body, reported this incident to additional members of the Governing Body, including the Regional Director of Operations (RDO) and Regional Director of Clinical Services (RDCS). on the same night it occurred. However, the regional members of the Governing Body responsible for ensuring compliance with federal regulations failed to provide regulatory guidance/direction to the Administrator and DON, who made the determination to not report the allegation to either the State Survey Agency (Office of Inspector General - OIG) or appropriate law enforcement staff. The Governing Body's failure to provide oversight and ensure that facility administration comply with regulations designed to prevent/report allegations of abuse has the likelihood to place residents at risk for abuse. Refer to F600, F609, and F835.</p> <p>The findings include:</p> <p>Review of an undated typed document, provided by the DON on 12/10/2024 at 3:35 PM, revealed the members of the Governing Body were the RDO, the RDCS, the Administrator and the DON.</p> <p>Review of the facility's document titled, Job Description-Director of Nursing (DON), updated 12/2011, revealed the DON's responsibilities included managing the overall operations of the Nursing Department in accordance with governmental regulations.</p> <p>Review of the facility's document titled, Job Description-Administrator, dated 12/2018, revealed the Administrator led and directed the overall operations of the facility in accordance with government regulations. Further review of the document under the Essential Duties and Responsibilities section revealed the Administrator maintained a working knowledge of and confirmed compliance with all governmental regulations.</p> <p>Review of the facility's policy titled, Governing Body, effective 10/06/2021 and revised 04/07/2023, revealed the governing body was the corporate entity or licensee responsible for the overall operation of the facility. Per the policy, the governing body ensured compliance with state and federal regulations.</p> <p>Interviews with Certified Nursing Assistant (CNA) 1 on 12/03/2024 at 10:45 AM and CNA4 on 12/03/2024 at 2:00 PM revealed that on 11/21/2024, she and CNA4 heard grunting noises coming from R2's room and, when they went in to see what was happening, they observed R3 on top of R2 in R2's bed. R3 had no clothes on from the waist down. R2 was wearing a shirt and her brief, and R3 was trying to undo R2's brief. Per the CNAs, R3 told staff to get out of the room, adding they were fucking.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Further interview with the two CNAs revealed that they believed what they witnessed was abuse which needed to be reported to the state and therefore, they immediately reported it to nursing staff. During interview on 12/03/2024 with Licensed Practical Nurse (LPN) 1 at 1:31 PM, she stated she was informed that the CNAs found R3 on top of R2 in R2's bed. LPN1 stated that she took the information as an allegation of abuse that needed to be reported and immediately contacted the DON and Administrator. Although CNA1, CNA4, and LPN1 were all aware of and immediately reported the allegation up their chain of command, review of OIG records revealed no evidence that the facility reported the allegation of sexual abuse. Interviews with both the DON on 12/03/2024 at 2:31 PM, and the Administrator at 12/03/2024 at 2:59 PM confirmed that neither the OIG nor law enforcement was contacted for investigation of an allegation of abuse and/or a possible crime.</p> <p>During interview on 12/03/2024 at 2:31 PM with the DON and on 12/03/2024 at 2:59 PM with the Administrator they stated that they did not identify the situation between R2 and R3 as possible abuse and did not ensure it was reported to the OIG or law enforcement. The Administrator stated she notified members of the Governing Body on the night of the incident; however, she was not instructed to report it.</p> <p>In interview on 12/03/2024 at 3:33 PM with the RDO, she stated she was made aware of the incident between R2 and R3 on the night it occurred by the Administrator on a three-way call with the RDCS and the Administrator. The RDO stated it was the Administrator's responsibility, and ultimately their decision as to whether or not to report an incident or event. Although the facility's policy stated the governing body's responsibilities included ensuring compliance with federal regulations, the RDO stated it was not their job to guide or direct a facility to report an incident of suspected abuse. During the interview, the RDO refused to answer as to whether the initial allegation of sexual abuse should have been reported to the OIG and law enforcement, stating that she could not speak to the incident because she was not in the facility when it occurred.</p> <p>During interview on 12/05/2024 at 10:46 AM with the RDCS, she stated that the corporate's role was to guide the facility on regulation and policy, but not to make decisions on whether or not to report allegations of abuse. The RDCS stated she was made aware of the incident between R2 and R3 on the night it occurred and understood it was not being reported because the Administrator, who was responsible for reporting, did not feel like there was an allegation of abuse. The RDCS stated that it was the corporate/Governing Body's expectation that staff follow the Centers for Medicare and Medicaid Services' (CMS) guidelines and policies on abuse reporting. The RDCS refused to answer as to whether the initial report of sexual abuse should have been reported to the OIG and law enforcement, stating that she could not speak to the incident because she was not in the facility when it occurred.</p>		