

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/25/2025
NAME OF PROVIDER OR SUPPLIER  Stanton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  31 Derickson Lane Stanton, KY 40380	

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 - Minimal harm or potential for actual harm</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** 51174</b></p> <p>Based on interview, record review, and review of facility policy, the facility failed to protect the resident's right to be free from verbal and physical abuse by staff for one (Resident (R) 1) of 22 sampled residents. Abuse was substantiated when staff yelled at R1 and hooked a back scratcher on the resident's bottom lip to pull on the resident's mouth.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Abuse Prohibition Standard of Practice, revision date 07/2022, revealed abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Review of R1's admission record revealed the facility admitted R1 on 06/14/2022, with diagnoses of neurogenic bowel, neuromuscular dysfunction of bladder, other psychoactive substance abuse with unspecified psychoactive substance-induced disorder, and unspecified viral hepatitis C without hepatic coma.</p> <p>Review of R1's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/07/2025, revealed a Brief Interview for Mental Status (BIMS) score of 13/15, indicating R6 was cognitively intact. Per the MDS, R1 displayed no behaviors.</p> <p>Review of R6's Electronic Health Record (EHR) on 04/22/2025, revealed a Miscellaneous Note, dated 02/08/2025 at 3:17 AM, which stated that R6 displayed some aggression towards staff at 10 PM, with the note stating that R6 threw water on staff. Further review of the Miscellaneous Note revealed no information as to what might have led to this incident.</p> <p>Review of a facility investigation, dated 02/10/2025 at 10:00 AM and completed by the former Director of Nursing (DON), revealed that on the evening of 02/07/2025, R1 was asleep in his bed when he was abruptly awakened by two Certified Nursing Assistants ((CNA) 4 and CNA5), who were standing over his bed, talking loudly and attempting to wake him up. Per the investigation, CNA4 took R6's bamboo back scratcher from his over-bed table and lightly touched his lip. CNA4 may have also brushed R6's stomach with the back scratcher. R6 was startled, and when he felt the backscratcher on his lip, he threw a half-filled cup of water on CNA4.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 185352	If continuation sheet Page 1 of 4

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of the investigation revealed CNA4 then left R6's room and brought CNA5 into the room to scold him for the water he threw on CNA4. CNA4 told R6 she was going to report him for his actions. Licensed Practical Nurse (LPN) 3 was standing at R6's doorway during this time. Per the investigation, LPN3, CNA4, and CNA5 claimed they tried to wake R6 up because he appeared to be unresponsive. LPN3 told CNA4 and CNA5 to stop after R6 woke up. The facility's investigation showed that, based on the information provided by R6 regarding CNA4, the facility substantiated the allegation of abuse.</p> <p>During an interview on 04/22/2025 at 11:34 AM, R6 stated LPN3 came into his room [ROOM NUMBER] minutes prior to the incident because R6's roommate was on intravenous (IV) antibiotics, and while in the room, LPN3 said, hey to R6. R6 continued that, when the incident occurred, he had been asleep but woke up when CNA4 took his back scratcher and hooked it on the bottom of his lip, pulled at his mouth, and was hollering at him. Then, he woke up and slung the cup of water on CNA4. R6 stated when he woke up, CNA4 and CNA5 were on the left side of his bed with LPN3 at the foot of his bed. Further interview with R6 revealed CNA4's actions made him mad.</p> <p>During an interview with CNA5 on 04/22/2025 at 2:31PM, CNA5 stated R6's call light went off and CNA4 answered it. CNA5 stated CNA4 tried to ask R6 if he needed anything, but he would not wake up, and that's when CNA4 got me. We tried to scratch his belly and forehead, smacked the bed, hollered at him, and he still wouldn't wake up. CNA5 stated that when R6 did wake up, he threw water on CNA4. CNA5 indicated that when trying to wake a resident, she would normally say their name two to three times and rub on the resident's leg, and if that does not work, she will get another staff member.</p> <p>During an interview on 04/23/2025 at 3:38PM, LPN3 stated prior to the incident, she was hanging R6's roommate's IV and she woke R6 up while she changed the IV. LPN3 stated she was at the nurses' desk when CNA5 came to her and stated that they were unable to wake R6 up. When she got there, CNA4 had the back scratcher in her hand and R6 stated I'm tired of getting picked on by these girls.</p> <p>Attempts to contact CNA4 on 04/22/2025 at 2:27PM and 04/23/2025 at 12:36PM, were unsuccessful, as the call could not be completed as dialed. Attempts to contact the former Director of Nursing (DON) on 04/24/2025 at 9:29AM and 04/24/2025 at 2:09PM were also unsuccessful, as the voice mailbox could not accept any more messages.</p> <p>Interview with the former Administrator on 04/24/2025 at 9:33AM, revealed he was the Administrator at the time of this incident. The former Administrator described the incident in which abuse was substantiated as, It was just one aide aggravating a resident, also stating that There was no injury at all. Continued interview with the former Administrator revealed his statement that CNA4 and R6 had some playfulness prior to that incident, and I think they thought it was funny. He did not elaborate on what playfulness was or what his expectations were. Further interview with the Administrator revealed that the facility failed to report the incident to the State Survey Agency or other required agencies (Refer to F609.)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>51174</p> <p>Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure an alleged violation involving abuse was reported immediately, but not later than two hours, for one (Resident (R)1) of four residents reviewed for abuse, out of a total sample of 22 residents. Staff failed to immediately report an allegation of abuse to the Administrator, as well as the State Survey Agency (SSA) and Adult Protective Services (APS).</p> <p>The findings include:</p> <p>Review of the facility's policy titled Abuse Prohibition Standard of Practice, revision date 07/2022, revealed alleged violation(s) will be reported to the Administrator and/or designee immediately. Further review revealed alleged violations were to be reported to the SSA and APS. However, the policy did not include the time frames specified in the regulation.</p> <p>Review of a facility investigation dated 02/10/2025 at 10:00 AM, and which was completed by the former Director of Nursing (DON), revealed that on the evening of 02/07/2025, R1 was asleep in his bed when he was abruptly awakened by two Certified Nursing Assistants ((CNA) 4 and CNA5), who were standing over his bed, talking loudly and attempting to wake him. Per the investigation, CNA4 took R6's bamboo back scratcher from his over-bed table and lightly touched his lip and may have also brushed R6's stomach with the back scratcher. R6 was startled, and when he felt the backscratcher on his lip, and he threw a half-filled cup of water on CNA4.</p> <p>Continued review of the investigation revealed CNA4 then left R6's room and brought CNA5 into the room to scold the resident for the water he threw on CNA4. CNA4 told R6 she was going to report him for his actions. The facility's investigation concluded, that based on information provided by R6 regarding CNA4, abuse was substantiated. (Refer to F600.).</p> <p>Further review of the facility investigation revealed the initial allegation of abuse was not received by the Administrator until 02/10/2025 at 10:00 AM, three days after the incident occurred. In addition, once the Administrator was notified of the allegation, the facility failed to immediately notify the SSA, as the Office of Inspector General was not notified until 02/10/2025 at 2:57 PM.</p> <p>During an interview with CNA5 on 04/22/2025 at 2:31PM, she said that after the incident on 02/07/2025, she texted Unit Manager (UM)1 about the incident. CNA5 stated she no longer had the texts, and did not remember specifically what she texted to UM1. However, she indicated that the report to the UM was more about the resident throwing water on CNA4, rather than the suspected abuse in which the CNA pulled the resident's lip with the backscratcher and yelled at him.</p> <p>During an interview with LPN3 on 04/23/2025 at 3:38PM, she confirmed that CNA5 texted UM1 what happened, and UM1 said OK, figure out what's going on in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with UM1 on 04/24/2025 at 10:41AM, UM1 stated CNA5 texted her in the middle of the night, and she did not see the text until she woke up the next morning. Further interview with UM1 revealed that she sent a message to the former DON, and he said the resident was just mad, that's not anything. Continued interview with UM1 revealed she expected her staff to call her and keep calling until she was awake.</p> <p>During an interview with the former Administrator on 04/24/2025 at 9:33AM, he confirmed that he did not receive the report until a couple days after the incident. The former Administrator stated, It was just one aide aggravating a resident. The former Administrator stated that once he was aware of the allegation, he had two hours to report it to OIG, However, the SSA was not notified of the abuse allegation until almost five hours after the Administrator was made aware of it. The Administrator confirmed that the facility had not reported the abuse allegation to APS, saying that he was under the impression OIG informed APS. Continued interview with the Administrator revealed staff were supposed to notify the Administrator or the Director of Nursing (DON) immediately, and that was specified in the abuse policy of the facility.</p>		