STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185359	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robertson County Health Care Facility	1030 Kentontown Road Mount Olivet, KY 41064

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 - 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. 50442 Based on interview, record review, and review of the facility's investigation and policy, it was determined the facility failed to protect 2 of 15 sampled residents from resident-to-resident abuse, Resident (R) 2 and R5. 1. On 10/13/2024, R2 entered R5's room uninvited and R5 was heard by staff yelling get out of my room. R2 was care planned for wandering, cussing at staff, and physical behaviors. When the State Registered Nurse Aide (SRNA) 5 responded to R5's call for help, she found R2 with her foot on R5's wheelchair. R5 reported R2 swung at her and hit her on the arm causing a skin tear and a bruise. 2. On 10/21/2024, a second incident occurred between R2 and R5. Staff observed R5 following R2 earlier that day [on 10/21/2024] and told the resident to stop. Later that same day, R5 and R2 were observed in a physical altercation in which R5 grabbed R2's arm and two facility staff had to assist with separating the residents. R5 was observed to have twisted R2's arm which resulted in R2 sustaining a broken wrist. The findings include: Review of the facility's policy titled, Reporting Abuse to Facility Management, not dated, revealed the facility did not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the residents, family members, legal guardians, sponsors, other residents, friends or other individuals. Further review of the policy revealed it was the policy of the facility that each resident had the right to be free from abuse, neglect, misappropriation, and exploitation. In an interview with the Interim Administrator on 03/26/2025 at 10:45 AM, she stated the facility did not have a policy that addressed residents' behaviors. 1. Review of the Long-Term Care Facility Self-Reported Incident Form Initial Report (IR), dated 03/28/2023 [sic], revealed, on 10/13/2024 at 8:20 PM, the Administrator was notified that a staff member [Kentucky Medication Aide/State Registered Nurse Aide (KMA/SRNA)5] heard yelling coming from R5's room. Upon immediate investigation, she found R2 sitting facing R5 (both in wheelchairs), and R2 had her foot on the wheel of R5's wheelchair. Per the initial report, R5 reported to staff that R2 came into her room uninvited and swung at her, hitting her (R5) in the left upper extremity (LUE), which caused a linear shaped bruise and skin tear. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Long-Term Care Facility Self-Reported Incident Form 5-Day Follow-Up/Final Report (5 Day), dated 10/17/2024, revealed R5 was interviewed by the Administrator on 10/13/2024 at 9:00 PM, and R5 stated R2 entered her room via a wheelchair. R5 stated she told R2 to get out of her room, and R2 began swatting at R5. R5 stated she defended herself and swatted back. a. Review of R2's Face Sheet from her electronic medical record (EMR) revealed the facility admitted the resident on 02/07/2021 with diagnoses which included dementia and legal blindness. Review of R2's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 10/03/2024, revealed the facility assessed the resident to have a Brief Interview for Mental States [BIMS] score of three of 15, which indicated severe cognitive impairment. Review of R2's Comprehensive Care Plan [CCP], dated 07/09/2024, revealed she was care planned for the focus of behavior problems related to cursing at staff, having physical behaviors, and having frequent confusion regarding the location of her room. The goal was that R2 would have no further physical behaviors through the next review. Interventions placed included if reasonable, staff was to discuss R2's behavior and explain or reinforce why the behavior was inappropriate and/or unacceptable; staff was to minimize the potential for the resident's disruptive behaviors by offering tasks which diverted R2's attention; R2 was to have her behaviors monitored to determine the underlying cause, taking into consideration the time of day, persons involved, and situations that occurred, and the monitoring of the behavior was to be documented along with the potential cause. Review of R2's Nursing Progress Notes, dated 10/13/2024, revealed there was an Incident Note placed that stated a Kentucky Medication Aide (KMA) was in the hallway passing medications and heard R5 yelling get out. Per the note, the KMA noted R2 was sitting in her wheelchair facing R5, and R2 had her foot on R5's wheel on her wheelchair. The note stated the KMA removed R2 from R5's room and noted that R5 had injuries to her arms. R2 was assisted to bed and placed on 15-minute checks. Review of R2's Nursing Progress Notes, dated 10/14/2024, revealed that an Acute Change in Condition Note was placed in R2's EMR stating that R2 had initiated physical aggression toward another resident (R5) and caused injury to R5. The note stated that R2 was in R5's room slapping and kicking at her, and this resulted in a skin tear to R5's left upper extremity. Further review of R2's CCP, dated 10/15/2024, revealed a focus of elopement and wandering, to monitor R2 for wandering and behavior indicators. Continued review of the resident's care plan revealed no documentation to support the resident's 15 minute checks were included on the care plan. Observation of R2 on 03/26/2025 at 3:23 PM revealed that R2 was sitting quietly and calmly in her wheelchair by the nurses' station. In an interview with R2 on 03/25/2025 at 11:00 AM she said that she had no problems other than getting those babies out. Resident (R)2 was unable to answer the State Survey Agency (SSA) Surveyor's questions. In an interview on 03/26/2025 at 11:25 AM with the guardian of R2, F10, he stated that he was made R2's guardian because she had no family. He also stated that he was notified of the incident that occurred on 10/13/2024. Per the interview, F10 stated that when he was contacted, the facility told him that they would have to find another placement for R2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	b. Closed record review of R5's Face Sheet from her EMR revealed the facility admitted the resident on 12/05/2022 with diagnoses which included cerebral infarction (stroke), mild cognitive impairment, and anxiety disorder. Review of R5's quarterly MDS, with an ARD of 08/23/2024, revealed the facility assessed the resident to have a BIMS score of 14 of 15, which indicated intact cognition. She was also assessed as having no physical or verbal behavioral symptoms. Review of R5's CCP, dated 02/02/2024, revealed a focus of agitation and an intervention of: before the agitation escalated, guide R5 away from the source of distress. Interventions placed to achieve these goals were for nursing staff to analyze key times, places, circumstances, triggers, and what de-escalated behaviors and to document. On 03/29/2024, R5 was care planned for behaviors of verbal aggression with interventions for staff to intervene before the resident's agitation escalated. Review of R5's Nursing Progress Notes, dated 10/13/2024, revealed there was an Incident Note placed that stated a KMA was in the hallway passing medications and heard R5 yell get out. The KMA noted R2 was sitting in her wheelchair facing R5, and R2 had her foot on R5's wheel on her wheelchair. Per the note, the KMA removed R2 from R5's room and noted that R5 had injuries to her arms, a skin tear on the left upper extremity and dark purple bruising above it. Review of R5's Nursing Progress Notes, dated 10/14/2024, revealed that an Acute Change in Condition Note was placed for R5 stating that R5 had received physical aggression from another resident (R2) that caused injury to R5. The State Survey Agency (SSA) surveyor could not interview R5 as she was discharged from the facility on 10/24/2024 and later passed away. In an interview on 03/26/2025 at 9:33 AM with F3, she stated she was notified of this altercation between R2 and R5. F3 stated the facility staff notified her that R2 went into R5's room and R2 caused R5 to have a skin tear on her arm with bruising. F3 stated the facility did not discuss with her what they were doing to keep both R2 and R5 safe after this incident. She stated she was not a part of the Interdisciplinary Team (IDT) meetings (a multi-disciplinary group where residents' care was discussed) to hear about the resident's care plan interventions. In an interview on 03/26/2025 at 7:49 PM with the Charge Nurse (CN), she stated that on the day the incident occurred, on 10/13/2024, there was adequate staff to supervise and care for the residents. 2. Review of the Long-Term Care Facility Self-Reported Incident Form Initial Report (IR), dated 10/21/2024, revealed that on 10/21/2024 at 3:05 PM, the Administrator was notified [by LPN2] that a staff member [SRNA5]was walking past the family room in the facility and witnessed an altercation between R2 and R5. The staff member [SRNA5] immediately called for assistance and separated R2 and R5. Review of the Long-Term Care Facility Self-Reported Incident Form 5-Day Follow-Up/Final Report (5 Day), dated 10/25/2024, revealed both R2 and R5 were interviewed by the Administrator, and both did not remember the incident. Per the report, R2 obtained an x-ray for her left wrist which showed a fracture, and an orthopedics consult occurred on 10/22/2024. (continued on next page)

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(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 - Actual harm Residents Affected - Few	a. Review of R2's Face Sheet from her electronic medical record (EMR) revealed the facility admitted the resident on 02/07/2021 with diagnoses which included dementia and legal blindness. Review of R2's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 10/03/2024, revealed the facility assessed the resident to have a Brief Interview for Mental States [BIMS] score of three of 15, which indicated severe cognitive impairment. Review of R2's Comprehensive Care Plan [CCP], dated 08/27/2024, revealed that she was care planned for the focus of elopement risk related to wandering and attempting to open a door. The goal for this care plan focus was that R2 would not leave the facility unaccompanied by staff or family. Interventions to achieve this goal was that staff were to provide diversional activities for wandering such as offering coffee, encouraging R2 to go to activities, and providing one to one socialization. Further review revealed R2 was to be monitored for wandering and behavior indicators. Review of the results of R2's mobile x-ray of her left wrist, dated 10/21/2024, revealed a nondisplaced radial styloid (a broken bone near the wrist) fracture of the left wrist. Review of R2's Nursing Progress Notes, dated 10/21/2024, revealed a Behavior Note that stated R2 was in a physical altercation in the television lounge with R5. Resident (R)2 and R5 were separated by staff. Review of R2's Nursing Progress Notes, dated 10/21/2024, revealed an Acute Change in Condition note that detailed the incident in which R5 twisted R2's wrist and broke it. Further review of the note revealed R2 had an abrasion on her left upper lip, top of left hand, and left side of her neck. Review of R2's Orthopedic Specialist Note, dated 10/22/2024, revealed R2 presented to the office with left wrist pain from an altercation with another resident who twisted her arm. Per the note, X-rays were taken at the nursing home the day prior but were retaken at the orthopedic office. The note stated R2 had a nondisplaced radial styloid fracture of the left wrist. Per the note, R2 presented to the orthopedic office wearing a wrist brace since the previous day, 10/21/2024, and had decreased range of motion and discomfort in the left wrist. The note stated there was tenderness with palpation to the left wrist, particularly to the radial styloid. Per the note, the physician placed her into a thumb spica cast for six weeks, at which time there was to be a follow-up and repeated x-rays. In an interview on 03/25/2025 at 11:00 AM, R2 was unable to answer the SSA surveyor's questions. In an interview on 03/26/2025 at 11:25 AM with R2's Guardian (F10), he stated he was notified of the incident that occurred on 10/21/2024. He stated that after this incident, the facility told him the other resident (R5) was the one that had to be moved to a different facility. b. Closed Record Review of R5's Face Sheet from her closed EMR revealed the facility admitted the resident on 12/05/2022 with diagnoses which included cerebral infarction (stroke), mild cognitive impairment, and anxiety disorder. Review of R5's quarterly MDS, with an ARD of 08/23/2024, revealed the facility assessed the resident to have a BIMS score of 14 of 15, which indicated intact cognition. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R5's CCP, dated 02/02/2024, revealed a focus of agitation and an intervention of: before the agitation escalated, guide R5 away from the source of distress. Interventions placed to achieve these goals were for nursing staff to analyze key times, places, circumstances, triggers, and what de-escalated behaviors and to document. On 03/29/2024, R5 was care planned for behaviors of verbal aggression with interventions for staff to intervene before the resident's agitation escalated. On 10/22/2024 the focus of behavior symptoms related to an altercation with another resident and having made negative statements was added to her care plan with goals of R5 demonstrating effective coping skills, and demonstrating no further physical behaviors, both through the next review date. Review of R5's Nursing Progress Note, dated 10/21/2024, revealed a Behavior Note that stated R5 was in a physical altercation in the television lounge with R2. The note stated staff separated both residents. Review of R5's Nursing Progress Note, dated 10/22/2024, revealed an IDT Root Cause Analysis Note that stated R5 had a history of aggressive behaviors and confusion and was able to independently ambulate with a wheelchair. Per the note, R5 was separated from R2, placed on one-on-one supervision, and moved to another hallway. The note stated R5 had an immediate BIMS assessment and a head-to-toe assessment after she and R2 were separated. Per the note, R5 could not remember what happened. The State Survey Agency (SSA) Surveyor was unable to observe or interview R5 as she no longer resided at the facility. In an interview on 03/26/2025 at 9:33 AM with Family Member (F) 3, she stated she was notified of the 10/21/2024 altercation between R2 and R5. She stated R5 was moved to a different room on a different hallway after this second altercation between R2 and R5, in which R2's wrist was broken. F3 stated the former Administrator told her that one of the residents had to leave the facility, and it ended up that her family member (R5) was made to leave the facility. F3 stated, after the second incident, R5 had someone with her all the time. In an interview on 03/25/2025 at 3:54 PM with SRNA2, she stated she did not see the altercation between R2 and R5 because she was bathing another resident at that time. She stated, the following day, R2 was sent to the physician due to complaints of wrist pain and came back with a cast on her wrist. SRNA2 stated that R2 was confused and wandered. She stated R5 had been following R2 earlier in the day, and she told R5 to stop. In an interview on 03/26/2025 at 2:46 PM with SRNA4, she stated, on 10/21/2024, she was in the shower room with another SRNA getting a resident out of the whirlpool with the Hoyer Lift when she heard screaming. She stated she could not leave the other SRNA alone with the resident in the lift. She stated she heard yelling for the third time and told the other SRNA she was going to go find out what was going on. She stated she peered into the family room and saw R2 and R5, both in their wheelchairs, hitting each other and fighting. She stated she attempted to separate the two residents but was unable, so she ran to get the nurse (unnamed). She stated she and the nurse got R2 and R5 separated. She stated both residents were upset, and they had experienced previous issues in the past. She stated, earlier that day, the nurse told R5 to stop following R2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 03/26/2025 at 10:26 AM with Licensed Practical Nurse (LPN) 2, she stated on 10/21/2024, R2 was going into the day room, and R5 followed R2 into the room, causing a physical altercation. She stated the residents were separated, and the Charge Nurse (CN) assessed the residents and reported the incident to the former Administrator. She stated this time R5 was the aggressor (unlike the first incident several days earlier when R2 was the aggressor). LPN2 stated she was not at the facility when the first incident occurred but heard about it. She stated, with the second incident, she did not remember R5 having any injury, only R2 having scratches and a broken wrist. She stated R2 complained of wrist pain and an outside company came to the facility, took the wrist x-ray, splinted it, and then she went to the orthopedics doctor the next day. She stated she could not remember, prior to these incidents, either R2 or R5 being aggressive or abusive to each other or anyone else. She stated, after the first incident, the facility put stop guards on the door to R5's room. She stated she was not sure about R2's supervision level. She stated the incident occurred later in the day, and she was not sure if staff did any further interventions to keep both residents safe. In an interview on 03/26/2025 at 7:49 PM with the Charge Nurse (CN), she stated she was one of the two nurses at the facility when the altercation occurred on 10/21/2024. The CN stated R5 had gone into the quiet room/family room and grabbed R2 by the arm. She stated, after this incident, R2 complained of arm pain. She stated after she helped the other nurse (LPN2) and SRNA4 separate the two residents, R5 was placed on one-on-one supervision. She stated R2 wandered the facility and tended to call others (staff and residents) names. She stated, earlier in the day, she redirected R5 to stay away from R2. In continued interview with the CN, on 03/26/2025 at 7:49 PM, she stated she did not move R5 to another hallway after the first incident that occurred on 10/13/2024 because R2 wandered the facility, and R5 was often in the hallway and in activities, so they were bound to pass and interact. She stated the day and time of the incident, there were four SRNAs and two nurses working [on 10/21/2024]. She stated she felt this was adequate staff to supervise and care for the residents. In an interview on 03/27/2025 at 10:23 AM with the former Assistant Director of Nursing (ADON), she stated she was not working at the time of the incident on 10/21/2024 when R5 broke R2's wrist. She stated she expected staff to remove a resident from the situation if the resident was exhibiting behaviors and place the resident on one-on-one monitoring. She stated staff was educated on abuse frequently. She stated she expected staff to immediately inform the supervisor if they heard or witnessed abuse. The former ADON stated she expected staff to always know the location of residents that wandered. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 03/27/2025 at 10:46 AM, she stated her expectation was for any abuse allegation, staff should make sure the resident(s) were safe and report it immediately. The DON stated R2 wandered and was legally blind. She stated, for this reason, they had to place pink tape around her door after the first incident with R5, to prevent her from entering the wrong room. She stated R2 had accidentally entered R5's room on 10/13/2024, and an altercation occurred where R5 had bruising and a skin tear on her left arm. She stated, when the second altercation occurred on 10/21/2024, staff separated R2 and R5. The DON stated after the first event, she did not think R5 would do anything to R2. She stated she did not know that R5 had been following R2 around the facility earlier on the day of 10/21/2024 when R5 broke R2's wrist. She stated she expected if staff had to redirect R5 multiple times to keep her from pursuing R2, something other than redirection should have been done. She stated staff was educated on abuse upon hire, annually, and in between when needed. She stated it was her expectation that staff kept a close eye on residents that wandered. In an interview on 03/28/2025 at 10:35 AM with R2's Physician, he stated he was notified of both incidents between R2 and R5 (10/13/2024 and 10/21/2024). He stated for the incident on 10/21/2024, he was told R2 and R5 got into a heated argument, and R5 grabbed R2's wrist and broke it. He stated the facility staff told him they separated both residents and put measures in place to keep them apart and safe. He said that R2 later complained of arm pain, and a mobile x-ray came to the facility and found that she had a broken wrist. He stated R2 was splinted at the facility on 10/21/2024, and the following day (10/22/2024), she was sent to an appointment with an orthopedic specialist, who placed her in a spica cast. In an interview on 03/25/2025 at 9:19 AM with the former Administrator, she stated earlier in the week, R2, who was blind and had dementia, had entered R5's room accidentally, prior to the second incident on 10/21/2024. She stated the residents had adjoining rooms. She stated R5 was heard screaming, and when they entered R5's room, she had bruises and scratches on her arm. She stated, a week later, R2 entered the day room and R5 followed her. She stated R5 grabbed R2's arm and twisted it, breaking her wrist. She stated R5 was sent to a psychiatric hospital for medication review and never returned to the facility. In an interview on 03/25/2025 at 10:45 AM with the Interim Administrator, she stated the facility did not have a policy on behaviors, dementia care, supervision or wandering. She stated the reason the facility did not have these policies was that behaviors, dementia care, and supervision was different for each resident, and a policy could not encompass all those differences. She stated she was not the Administrator of the facility at the time of both incidents and had only been the Administrator since the day of the interview [on 03/25/2025]. In another interview with the Interim Administrator on 03/28/2025 at 8:36 PM, she stated it was her expectation that staff report any abuse allegation to her immediately so she could report it to the State Survey Agency (SSA) immediately. She stated staff did abuse training upon hire, annually, and when the need arose (with any allegation of abuse). She stated she expected that SRNAs should report any behaviors to their nurse each time it occurred. She stated she expected nursing staff to implement existing interventions or develop new interventions if those in place did not work to combat the resident's behaviors.