

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/09/2024
NAME OF PROVIDER OR SUPPLIER  Owenton Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  905 Hwy 127 North Owenton, KY 40359	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30898</p> <p>The facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made for 3 of 23 sampled residents (R)2, R48, R86.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Resident Rights dated 01/02/2020, and revised 02/16/2024, revealed the facility ensured all staff were educated on the rights of residents and the responsibility of the facility to properly care for its residents. Further review of the policy revealed the resident had the right to be treated with respect and dignity.</p> <p>Review of the facility policy titled, Abuse, Neglect, and Exploitation reviewed/revised 08/2023, revealed the facility was to protect the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevented abuse. Continued review revealed the abuse prohibition plan included reporting of all alleged violations to the State Agency immediately, but not later than two hours after the allegation was made, if the event involved abuse. Further review revealed reports would not be made later than 24 hours if the allegation had not involved abuse and did not result in serious bodily injury.</p> <p>1. Review of the medical record for R48 revealed the facility admitted the resident on 01/13/2022, with diagnoses including dementia, depression, anxiety, and psychotic disorder with delusions.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R48 with a Brief Interview for Mental Status (BIMS) score of zero out of 15, indicating the resident was severely cognitively impaired.</p> <p>Review of the facility's investigation for an incident on 11/18/2023 at 7:50 PM, revealed staff witnessed R85 strike R48 on top of the head, with no assessed physical injury. Further review revealed the facility had not emailed the initial report to the State Survey Agency (SSA) until 11/20/2023 at 9:43 AM.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In interview on 08/09/2024 at 3:39 PM, the Administrator stated she was the only employee responsible to report abuse to the State Agency. She stated she had access from home to report on those occasions when she was not in the facility at the time of the allegation. The Administrator stated she had two hours to make the initial report of an allegation to the SSA. She stated she tried multiple times to email the SSA the initial report of the incident that occurred on 11/18/2023 at 7:50 PM; however it failed to send a couple of times. In continued interview she stated she did not have records of the failed email attempts. The Administrator additionally stated she was not aware she could fax the initial reports (to the SSA) as well.</p> <p>2. Review of the facility investigation for an incident that occurred on 10/25/2023 at around 11:45 AM, revealed R86 made an allegation of physical abuse against Certified Nursing Assistant (CNA) 8. Continued review revealed R86 reported the CNA hitting his/her leg. Further review revealed the facility had not emailed the initial report of the incident to the SSA until 10/25/2023 at 5:16 PM.</p> <p>In interview with the Administrator on 08/09/2024 at 3:39 PM, she stated R86 had not experienced any serious bodily injury and therefore, she had 24 hours to report to the SSA. She further stated she could not recall who told her she did not have to report incidents of abuse within two hours.</p> <p>50000</p> <p>3. Review of the facility face sheet for R2 revealed the facility admitted him on 05/08/2015, with diagnoses of traumatic brain injury, paraplegia, and aphasia.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R2 to have a BIMS score of 14 out of 15, indicating intact cognitive function. Further MDS review revealed the facility had not assessed R2 to exhibit any behavioral symptoms of physical, verbal or rejection of care and as dependent on staff for care needs.</p> <p>Review of the facility initial incident report dated 12/27/2023, for an incident that occurred on 12/26/2023 at 4:40 PM, revealed CNA 3 and CNA 4 witnessed CNA 2 using foul language and being verbally rude to R2 while providing his care. Per review, R2 had held onto his shirt and would not let go of it while CNA 2 was providing his care. Continued review revealed however, the allegation of abuse was not reported to the Administrator until 12/27/2023 at 10:30 AM. Further review revealed the Administrator had not submitted the initial report of the incident to the SSA until 12/27/2023 at 4:41 PM.</p> <p>Review of the facility's final report/5 day follow up investigation information revealed CNA 3's and CNA 4's witness statements dated 12/27/2023, which noted they overheard CNA 2 say to R2 you're not going to fucking hit me with that. Let go or I will break your fucking hand.</p> <p>Interview on 08/09/2024 at 2:57 PM with the Director of Nursing (DON) revealed she began employment with the facility on 12/04/2023. The DON stated suspected abuse was immediately reported to the Abuse Coordinator who was also the Administrator. She stated the Administrator was responsible to send information of abuse allegations to the State Agency.</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>In interview on 08/09/2024 at 4:00 PM, the Administrator stated the incident involving R2 occurred during an evening shift, and she was not notified until the following morning of the incident by the SSD. The Administrator stated after the SSD informed her an investigation was immediately initiated. She further stated she reported the incident to the required agencies within 2 hours of finding out about the incident. The Administrator additionally stated at the time she believed the facility was following the CMS guidelines for reporting due to there not being any physical injury or harm to R2.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>30898</p> <p>Based on interview, record review and review of facility policy, the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of 23 sampled residents (R), R86.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Abuse, Neglect, and Exploitation reviewed/revised 08/2023, revealed the facility was to protect the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prevent abuse. Continued review revealed instances of abuse of residents could cause harm, pain, or mental anguish, and the facility was to make efforts to ensure all residents were protected during an investigation.</p> <p>Review of the facility investigation for an incident involving R86 on 10/25/2023 at around 11:30 AM, revealed the resident alleged Certified Nursing Assistant (CNA) 8 hit his/her leg. Continued review revealed the facility sent the CNA home for the day. Further review revealed education for CNA 8 on resident rights, signed by the aide on 10/27/2023. Additional review revealed the facility's final report/5-day follow-up was signed on 10/28/2023 and emailed to the State Survey Agency (SSA) on 10/29/2023.</p> <p>Review of the facility's, Assignment Sheet dated 10/26/2023 and 10/27/2023 revealed CNA 8 was scheduled to work on the other unit in the facility, even though review of the facility's investigation revealed it was not completed until 10/28/2023.</p> <p>Review of the Timecard for CNA 8 revealed the aide clocked out of work at 12:06 PM on 10/25/2023 (The date of the incident). Continued review of the timecard revealed CNA 8 worked 12 hour shifts on 10/26/2023 and on 10/27/2023.</p> <p>In interview on 08/08/2024 at 4:19 PM and on 08/09/2024 at 10:43 AM, the Administrator stated CNA 8 was suspended the rest of her shift on the day the allegation was made. The Administrator also stated CNA 8 was then moved to the other unit in the facility to work. (However, review of the facility investigation revealed it was not completed until 10/28/2023.)</p> <p>In interview on 08/09/2024 at 11:11 AM, CNA 8 stated she went on break after changing R86 and was informed of the allegation when she returned from break. She further stated she was taken off R86's hall and came back to work the next day on the other unit.</p> <p>On 08/09/2024 at 2:57 PM interview with the Director of Nursing (DON) revealed if the facility received an allegation of abuse and the staff member was working, the employee was removed from the floor immediately and suspended during the investigation, usually for three days. She stated the purpose of the investigation was to find more evidence and determine if the abuse occurred. The DON further stated the staff member was suspended during the investigation to prevent the individual from continuing to abuse residents or retaliate against someone who reported. She also stated the Administrator was the facility's Abuse Coordinator.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In additional interview with the Administrator on 08/09/2024 at 3:39 PM, she stated when she received the abuse allegation she sent CNA 8 home for the day and initiated the investigation. She stated the investigation lasted three days from start to finish. The Administrator stated once the interviews for the investigation were completed the aide was allowed to return to work on the facility's other unit. She stated she did not feel CNA 8 abused the resident or anyone else. The Administrator further stated the facility investigation had not been completed when CNA 8 returned to work on 10/26/2024.</p>		