STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185400	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hearthstone Place	506 Allensville Road Elkton, KY 42220

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51642 Based on interview, record review, facility document review, and review of facility policy, the facility failed to report an allegation of abuse within the two (2) hour time frame for one (1) of three (3) residents reviewed for abuse prohibition, (Resident (R) 40. The findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation, revised 04/10/2023, revealed, It is the policy of this 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, neglect, exploitation and misappropriation of resident property. According to the policy, Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. The policy also revealed, under Reporting/Response, the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies including law enforcement when applicable, immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Review of R40's Admission Record revealed the facility admitted the resident on 07/20/2023 with diagnoses including Alzheimer's disease and anxiety. Review of R40's Comprehensive Care Plan included a focus area initiated 08/15/2023, which revealed the resident was at risk for increased behaviors, altered mood state, and altered psychosocial well-being related to diagnoses of anxiety and dementia. Interventions directed staff to be alert for expressions of mood indicators, behaviors, and/or altered psychosocial well-being (initiated 08/15/2023). Review of R40's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/10/2024, revealed the facility completed a Staff Assessment for Mental Status, which indicated the resident was severely impaired in cognitive skills for daily decision making. (continued on next page)

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [State Agency] Long Term Care Facility - Self-Reported Incident Form Final Report/5 Day Follow-up, dated 09/03/2024, revealed an incident allegedly occurred in the dining room on 08/24/2024 at approximately 7:00 PM, and R49 who had a BIMS score of 15, indicating intact cognition, was a witness to the incident. The report revealed R49 was sitting at a table talking to R40 when R34 rolled up in a wheelchair. R34 started to kick R40's foot and told R40 to move to another table. According to the report, there were no staff in the dining room at the time of the alleged abuse. R49 advised R34 to stop kicking R40's foot; however, R34 stated R49 was not the boss of them and continued to kick R40's foot. Per the report, R49 moved R40 away from R34 so R34 would not be able to kick R40. According to the facility's report, Registered Nurse (RN)9 stated R49 reported the allegation of abuse to her on 08/24/2024 at approximately 7:00 PM. However, the report revealed the Administrator was not aware of the allegation of abuse until 08/26/2024 at approximately 9:15 AM, when an investigation of the allegation of abuse was initiated. (According to the facility's Initial Report, dated 08/26/2024, the facility submitted the Initial Report to the state agency on 08/26/2024 at 10:50 AM, two (2) days after the alleged incident occurred.) Interview with the Administrator, on 09/11/2024 at 9:20 AM, revealed RN9 did not notify him of the allegation of abuse until 08/26/2024. The Administrator stated once he was notified, he started an investigation and submitted a report to the state agency on 08/26/2024. According to the Administrator, the facility was out of compliance for reporting time for the allegation of resident-to-resident abuse. Interview with RN #9, on 09/12/2024 at 11:55 AM, revealed R49 reported R34 was kicking at R40's foot with an open toed shoe and R49 separated the residents. RN9 stated any allegation of abuse was expected to be reported immediately to administration. However, RN9 further stated she did not report this incident immediately to administration on 08/24/2024 because she did not consider R34 kicking at R40's feet to be abuse. During a follow-up interview, on 09/12/2024 at 4:31 PM, the Administrator stated staff was expected to report allegations of abuse immediately and he would report the allegation of abuse to the state agency within two (2) hours.