STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185440	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care Center	2990 Riggs Avenue Erlanger, KY 41018

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 - Minimal harm or potential for 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. Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents were free from verbal and physical abuse. This deficient practice resulted in actual harm for 1 out of 4 sampled residents, Resident (R) 13.On 09/14/2025, R13 stated State Registered Nurse Aide (SRNA) 12 was mean and hurtful during care. R13 reported SRNA12 lifted her legs in the air and then dropped them onto the bed, which hurt her back. She further stated SRNA12 handled her roughly during care, causing pain in her arm. The findings include:Review of the facility policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy, dated 10/23/2024, revealed abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Per the policy, abuse also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being.Review of R13's admission Record revealed the facility admitted the resident on 09/03/2024 with diagnoses of pain in the right shoulder, adhesive capsulitis of right shoulder, contracture, right shoulder, anxiety disorder, other chronic pain, depression, polyneuropathy, muscle weakness, need for assistance with personal care, other abnormalities of gait and mobility, secondary osteoarthritis, right shoulder, and low back pain.Review of R13's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 08/24/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15, indicating R13 was cognitively intact.In an interview with R13 on 09/26/2025 at 9:12 AM, she stated SRNA12 hurt me every time she cared for me. R13 explained she did not initially report her concerns because she did not think anyone would believe her. R13 described an incident that occurred on 09/14/2025, when SRNA12 was rough during care, stating, She would lift my legs in the air and let them fall back in the bed, hurting my back. R13 said this occurred on more than one occasion and she feared SRNA12, describing her as having manhandled her during care. R13 stated she felt unsafe when SRNA12 cared for her. She further stated she felt safe after Registered Nurse (RN) 3 escorted SRNA12 from the facility following the resident's allegation and she had no further concerns regarding her care once SRNA12 left the facility.In an interview with Family Member (FM) 4 on 09/26/2025 at 2:00 PM, he stated R13 broke down and cried when telling him about her care. According to FM4, R13 stated SRNA12 was rough and had slammed her legs down on the bed. FM4 reported R13 told him she feared SRNA12. FM4 stated the Administrator later contacted him and informed him that SRNA12 would no longer care for his mother.Review of R40's admission Record revealed the facility admitted the resident on 08/22/2024 with type 2 diabetes mellitus, hypertension, muscle weakness, other abnormalities of gait and mobility, and anxiety disorder.Review of R40's comprehensive MDS, with an ARD of 07/19/2025, revealed the facility assessed the resident to have a BIMS score of 15, indicating R40 was cognitively intact.During an interview with R40 on 09/26/2025 at 9:00 AM, who was R13's roommate, she stated SRNA 12 had a terrible attitude and was nasty and short during care. R40 stated, It really upset me and made me cry. R40 reported she could hear SRNA12 pushing R13 over hard in the bed and heard SRNA 12 say, I'm not changing your bed. I'll change your diaper but not your bed. R40 stated after SRNA12 finished providing care, she heard R13 crying and went to her bedside (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	to comfort her. R40 reported she informed Licensed Practical Nurse (LPN) 6 of SRNA 12's behavior, and afterward, RN3 escorted SRNA12 from the facility.The State Survey Agency (SSA) Surveyor attempted to reach LPN6 and RN3 by telephone on 09/25/2025 and 09/26/2025, however, they did not answer the call.The SSA Surveyor was unable to interview SRNA12 as she was an agency employee who was no longer permitted to work in the facility following the allegation. The facility did not have a current contact telephone number for SRNA12.In an interview with the Director of Nursing (DON) on 09/26/2025 at 2:30 PM, she stated R13 had never previously made false allegations and emphasized that staff were to handle residents with care and speak to them respectfully, without aggression or a harsh tone.In an interview with the Administrator on 09/26/2025 at 2:44 PM, she stated the allegation was unsubstantiated by the facility because, although R13's roommate overheard part of the conversation, it could not be confirmed the incident occurred as reported. The Administrator emphasized she expects staff to treat all residents with dignity and respect, as if they were caring for their own grandparents.