Department of Health & Human Services
Centers for Medicare & Medicaid Services

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185483 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/19/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Radcliff Veterans Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 Veterans Drive Radcliff, KY 40160 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document and policy review, the facility failed to report an allegation of physical abuse to the State Survey Agency (SSA) within the required timeframe for one (Resident (R) 1) of three sampled residents reviewed for abuse. Staff witnessed an allegation of abuse at approximately 10:00 AM on 07/22/2025; however, the facility did not immediately (in no more than two hours, per regulation) notify the SSA.The findings include:Review of the facility's policy titled, Reporting Abuse to State Agencies, effective 09/11/2023, revealed all alleged violations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, and misappropriation of resident property were to be reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury. The policy further revealed verbal or written notice to the appropriate agencies was to be made within two hours when an occurrence involving abuse was reported, and a written report of the findings of the investigation was to be provided within five working days of the occurrence.Review of the facility's policy titled, Reporting Abuse to Facility Management, effective 09/11/2023, revealed employees were to immediately report any observed or suspected abuse or incident of abuse to the on-duty supervisor, who in turn was to immediately report it to the Administrator or Assistant Administrator. The policy further revealed the Administrator or Assistant Administrator was to be immediately notified of suspected abuse or incidents of abuse and suspected or confirmed abuse was to be immediately reported to facility management regardless of the time lapse since the incident occurred.Review of a facility document titled, admission Record, revealed the facility admitted R1 on 05/15/2023 with diagnoses including Alzheimer's disease with late onset, cognitive communication deficit, chronic kidney disease, and hypertension. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/02/2026, revealed R1 was assessed as severely cognitively impaired. Review of a facility document, titled, Initial Report, dated 07/22/2025, revealed the facility reported an allegation from Nurse Aide State Registered ([NAME]) 2 that she witnessed NASR1 physically abuse R1. The Initial Report documented the date and time of the incident as 07/22/2025 at 12:35 PM. Review of email correspondence revealed the facility submitted the Initial Report to the Department for Community Based Services (DCBS), the ombudsman, and the Office of Inspector General (OIG-SSA) on 07/22/2025 at 2:32 PM. Review of another facility document, titled, Final Report/5 Day Follow-Up, dated 07/25/2025, revealed that no abuse was substantiated. However, review of this document revealed the alleged abuse actually occurred on 07/22/2025 at 10:00 AM (not 12:35 PM as initially reported). Based on the times listed on the Final Report/5 Day Follow-Up, the initial abuse allegation was not reported for over four hours and did not meet the immediate reporting requirement of no more than two hours required by regulation and facility policy. Review of personnel records revealed a written counseling memorandum issued by the Director of Nursing (DON) to NASR2, which documented NASR2 reported to Licensed Practical Nurse (LPN) 1 on 07/22/2025 at 12:27 PM that she had observed NASR1 inappropriately pull on R1's arm while providing a shower at approximately 10:00 AM that same day. The memorandum further documented NASR2 was counseled<br>(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 |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to report all allegations of abuse or neglect immediately in the future.Review of a letter from the Department of Veterans Affairs, dated 07/22/2025, revealed NASR1 was placed on special leave with pay pending further investigation. The letter documented NASR2 reported to LPN1 that NASR2 observed NASR1 in the bathroom with R1 at approximately 10:00 AM on 07/22/2025 and reported NASR1 allegedly inappropriately pulled on R1's arm while providing a shower.Review of an untitled facility document outlining the investigation timeline confirmed that the abuse allegation on 07/22/2025 was not immediately reported within two hours of NASR2 witnessing suspected abuse of R1 at 10:00 AM. Per this document, NASR1 remained in resident direct care until 12:32 PM, the Administrator was notified at 12:33 PM, the investigation was initiated at 12:50 PM, and the allegation of physical abuse involving R1 was reported to the OIG/SSA at 2:32 PMIn an interview on 03/19/2026 at 2:41 PM, NASR2 stated allegations of abuse or neglect were to be reported to the charge nurse or nurse on the hall as soon as possible, and the facility had two hours to report abuse to [OIG]. NASR2 stated at approximately 10:00 AM on 07/22/2025, NASR1 was pulling on [R1's] arm, R1 was trying to pull away, and she told NASR1 to sit R1 down because that was what worked to keep R1 calm. NASR2 stated she thought about it and then reported the incident to LPN1. NASR2 further stated, I know I didn't report it right then and there, and explained she was nervous about reporting because others who had reported concerns had felt retaliated against. In an interview on 03/18/2026 at 1:32 PM, LPN1 stated NASR2 reported around lunchtime that NASR1 had been rough with R1. LPN1 stated when he assessed R1, there were marks on his arm that were consistent with grabbing. LPN1 stated the incident was then reported to the nurse supervisor or Assistant Director of Nursing (ADON), and NASR1 was removed from the hallway and did not return to the floor that day.In interview with NASR1, on 03/19/2026 at 12:27 PM via telephone, NASR1 stated she recalled the incident in question but denied anything out of the ordinary occurred and there was nothing going on with the resident.In an interview on 03/19/2026 at 3:29 PM, the ADON stated incidents of alleged abuse were to be reported immediately and there was a two-hour timeframe to report abuse to [OIG]. The ADON stated LPN1 reported the incident to her, and at the time of the report, she was told the incident had occurred earlier, around 10:00 AM. The ADON stated NASR1 was then removed from the unit and placed in the Director of Nursing's (DON) office. In an interview on 03/19/2026 at 3:43 PM, the DON stated abuse allegations were to be reported immediately and the required timeframe for reporting allegations of abuse to OIG was two hours. The DON stated the ADON reported the allegation involving R1 to her after lunch, sometimes in the afternoon, and she understood the incident had happened around 10:00 AM. The DON stated when asked why the report was delayed, NASR2 said she was not sure it was abuse. The DON stated she reiterated to NASR2 to always report the allegation and allow management to determine whether abuse had occurred. In an interview on 03/19/2026 at 4:10 PM, the Administrator stated allegations of abuse were to be reported immediately. The Administrator stated notification to OIG was required within two hours if bodily injury was involved and within 24 hours if there was no bodily injury. The Administrator stated that, for this incident, she believed the report was timely because there was no injury. However, the Administrator failed to note that the regulation and facility policy also required that all allegations must be reported within two hours if the event that caused the allegation involved abuse. |