STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185487	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanders Ridge Health Campus	119 East Sanders Lane Mount Washington, KY 40047

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. Based on interview, record review, facility document and policy review, the facility failed to timely report an allegation of physical abuse to the State Survey Agency (SSA) for 1 of 1 resident reviewed for abuse, out of the total sample of 15 (Resident (R) 152). The findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation Procedural Guidelines, revised 12/16/2024, revealed its purpose was to develop and implement processes, which strived to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Per review, the Executive Director (ED) and Director of Health Services (DHS) were responsible for the implementation and ongoing monitoring of abuse standards and procedures. Continued review revealed the facility was 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 no later than two hours after the allegation was made. Review revealed the facility was to ensure reporting was completed no later than 24 hours if the events causing the allegation did not involve abuse and did not result in serious bodily injury, to the Administrator of the facility and to other officials (including the SSA and adult protective services [APS] where state law provided for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the Resident Face Sheet for R152 revealed the facility admitted R152 on 04/01/2021, with a diagnosis of dementia. Review of the Significant Change in Status Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 06/12/2024, revealed the facility assessed R152 to have a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident had severe cognitive impairment. Review of R152's Care Plan revealed the facility identified a problem statement initiated 04/22/2021, that noted the resident had a diagnosis of arthritis and was at risk for pain. Further review revealed the interventions included for staff to provide assistance with activities of daily living (ADLs) as needed. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Investigation Summary dated 08/16/2024, which noted Certified Resident Care Associate (CRCA) 1 had been assisting R152 to bed utilizing the stand assist to lift to transfer the resident from recliner to bed. Per review, R152 told the CRCA she was hurting him/her during the transfer, and swatted at the CRCA to stop. Continued review revealed CRCA 1 blocked R152's hand from hitting her by putting her hand on the resident's left forearm. Review revealed the CRCA removed the lift equipment, ensured R152's safety in the recliner, and left the room to inform the nurse of the resident's complaints of pain with transfer and to get additional assistance. Further review revealed when CRCA 1 left R152's room, the nurse was in another room providing care, so she proceeded to the next resident's room to provide care. Review revealed the nurse, (Registered Nurse (RN) 2), exited the room she was providing care in and heard R152 yelling for help. Further review revealed when the RN entered the room, she asked R152 what he/she]needed and the resident reported the CRCA hit his/her hand. According to the Internal Investigation Log Timeline/Chronology of Events and Communication, on 08/16/2024 at 8:20 PM, R152 informed RN 2 that CRCA 1 hit him/her on the hand. In interview on 05/14/2025 at 11:32 AM, CRCA 1 stated on the day of the incident, she went into R152's room to see if the resident wanted to go to bed and the resident said yes. CRCA 1 said that was between 8:00 PM and 9:00 PM on 08/16/2024. She reported as she pulled R152 up, the resident complained of pain, so she sat the resident back down and asked if he/she was being pulled too hard, and the resident said yes. The CRCA said R152 told her he/she felt like his/her shoulder was being ripped off. She stated she asked R152 if he/she felt comfortable with her trying to assist again and R152 said no and started complaining about his/her hand. CRCA 1, reported R152 swatted at her and she put up her hand to prevent the resident from hitting her. She said she removed the sit-to-stand lift, made sure R152 was safe, and left the resident's room so that the incident would not escalate. CRCA 1, stated as she was going to tell RN 2, a resident's call light was on, she went to answer the call light and while she provided care for that resident, the nurse informed her of the allegation made by R152. She further stated she had been asked to write a statement and leave the facility. CRCA 1 additionally stated she had not hit or abused R152 in any way. In interview on 05/14/2025 at 1:14 PM, RN 2 stated she heard R152 yelling, so she went to the resident's room. RN 2 said she entered R152's room around 8:00 PM on 08/16/2024, and asked R152 what she could do. She stated R152 told her, that girl hit me, and she made sure the resident was safe and went to find CRCA 1, who had been in another resident's room. RN 2 reported she escorted CRCA 1 to the nurses' station, so she could write a statement and then had the CRCA leave the facility. She stated she went back to check on R152 and the resident said he/she had no pain. RN 2 stated R152 told her CRCA 1 tried to get the resident up out of his/her chair and the resident swatted at the CRCA, who put her arm up to keep the resident from hitting her. She said CRCA 1 denied hitting R152 and R152 told her CRCA 1 was wonderful and very friendly. RN 2 further stated she then reported the incident to the Director of Health Services (DHS). In interview on 05/14/2025 at 2:01 PM, the DHS stated she did not remember the time she was notified of the incident involving R152, by RN 2. She said RN 2 informed her R152 stated CRCA 1 hit him/her on the hand. The DHS reported she had been informed CRCA 1 had been asked to write a statement and was removed from the facility. She stated she then notified the Executive Director (ED), who completed the mandatory reporting and investigation. The DHS explained staff had to report any allegation of abuse immediately and to the SSA within two hours. She said the two-hour reporting began when the allegation was made, and she expected any allegations of abuse to be reported within the two-hour reporting timeframe. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 05/14/2025 at 2:25 PM, the ED stated he had been notified of the incident on 08/16/2024 at 9:00 PM, by the DHS. He said he reported the incident to the SSA on 08/16/2024 at 10:48 PM. The ED further stated the facility had two hours to report allegations of abuse to the SSA. He also stated he expected all allegations of abuse to be reported within the two-hour timeframe. In a follow-up interview on 05/15/2025 at 10:58 AM, the ED stated the allegation of abuse involving R152 was reported to him around 9:00 PM on 08/16/2024. He reported he assumed the incident happened shortly before that so he placed 8:50 PM, as the time the allegation occurred. The ED stated however, once the investigation was started, he realized RN 2 had been made aware of the allegation at 8:20 PM on 08/16/2024.