Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101301	A. BUILDING: _____ B. WING _____	R-C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOMINION SENIOR LIVING OF FRANKFORT	122 LEONARDWOOD DR FRANKFORT, KY 40601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments Based on the acceptable Plan of Correction (POC) received on 08/03/2024 and the on-site revisit survey concluded on 08/22/2024, it was determined the facility had achieved substantial compliance as of 08/19/2024.	{P 000}		

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

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P 000	Initial Comments A Re-licensure and Complaint Survey investigating Complaints KY00035990, KY00037161,KY00039807, KY00041391, KY00041662, KY00041687, KY00042598 and KY00042841 was initiated on 07/01/2024 and concluded on 07/05/2024. No deficient practice was identified associated with the Re-licensure survey or Complaints KY00035990, KY00037161, KY00039807,KY00041391,KY00041662,and KY00041687. However, regulatory violations were identified related to Complaints KY00042598 and KY00042841. A Type A Citation was issued to the facility on 07/05/2024 related to KY#00042841. On 06/21/2024, R2 exited the building without staff's knowledge, through a window in her room on the Memory Care Unit (MCU). Facility staff was unaware the resident was missing until R2's daughter notified the facility she had just received a call from R2, stating she was at the local retail store. R2 was located at a local retail store approximately three tenths (0.3) of a mile away from the facility, which was across a three (3) lane road. Observation of resident room windows on 07/05/2024 for the MCU, revealed there were no safeguards to hide screw heads on windows. Survey dates: 07/01/2024-07/05/2024 Survey Census: 51 Sample Size: 16	P000	902 KAR 20:036 3(1) (a-d) Section 3. Administration and Operation It is the policy of Dominion Senior Living to comply with all Applicable provisions of 902 KAR 20:036 3(1) (a-d) Section 3. Administration and Operations. Resident #8 was immediately discharged from the facility on 05/24/2024, after the incident occurred. Resident #7 was immediately sent out to Emergency Room for further treatment and returned to facility. To ensure deficient practice from reoccurring, Dominion Senior Living has developed a criterion for all new admissions and what historical Information is needed prior to admission. Education was provided to the Executive Director and Wellness Director by VP of Wellness on 07/19/2024 regarding the criteria for additional Historical information prior to admission. Executive Director/Designee will perform weekly audits of all new admissions to ensure historical Data is obtained prior to move in. These audits will start on 07/22/2024 and ongoing. Compliance Date 08/19/2024	
P 015	902 KAR 20:036 3(1)(a-d) Section 3. Administration and Operation (1) Licensee. The licensee shall be legally responsible for:	P 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Angie Dunn Executive Director 08/03/2024

TITLE

(X6) DATE

RECEIVED
AUG 3 2024
CHFS Office of Inspector General
Division of Health Care - EB
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Received by

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(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 015	Continued From page 1 (a) The operation of the PCH or SPCH; (b) Compliance with federal, state, and local laws and administrative regulations pertaining to the operation of the facility; (c) The development and implementation of policies related to administration and operation of the facility; and (d) If the licensee is an SPCH, the development and implementation of written transition procedures to ensure cooperation with an individual or entity that assists with transitioning residents with an SMI to community living arrangements. This requirement is not met as evidenced by: Based on interview, and review of facility policies, the facility failed to develop and implement policies related to the administration and operation of the facility. There was no documented evidence the facility created an Admissions Policy in order to define admissions criteria. On 05/22/2024, the facility admitted Resident (R)8 without reviewing the medical record and discharge summary from the previous facility. After admission, on 05/24/2024, R8 was the aggressor in an altercation with R7, resulting in	P 015	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services It is the policy of Dominion Senior Living to comply with all applicable Provisions of 902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services On 6/22/20244 the window was repaired in resident's room. On 06/22/2024 reeducation was provided to staff on Missing Resident Policy and Procedures, and Elopement Prevention Policy and Procedure. On 06/22/2024 elopement drills were conducted on all three shifts. On 06/23/2024 the Wellness Director Completed an updated elopement assessment on Resident #2. Dominion Senior Living of Frankfort will continue to conduct monthly elopement drills and elopement assessment quarterly for all residents. Resident #2 remains at facility. Resident has exhibited no further behaviors or desire to leave community. To ensure deficient practice from reoccurring, beginning 07/09/2024 Dominion Senior Living Team Leaders/and or designee will perform daily audits of MC Windows and ongoing.	

			Compliance Date 08/19/2024	

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P 015	Continued From page 2	P015		

R7 sustaining injury. It was determined R8 had a history of a resident-to-resident altercation at a previous facility. (Refer to R805)

The findings include:

On 07/02/2024 at 8:05 AM and on 07/05/2024 at 12:05 PM, a copy of the facility Admissions policy was requested from the Executive Director (ED); however, she stated both times the facility did not have one.

Review of the facility's Investigation Summary, undated, revealed on 05/24/2024, R7 came out of her room into the hall where R8 was standing and it was witnessed R7 held her walker up toward R8. R8 then shoved R7's walker causing R7 to fall back into the door. Further review revealed first aid was applied to R7 and 911 was called immediately. Both residents were transported to the hospital emergency department, and families were notified. Continued review revealed R8 was admitted to a psychiatric facility and would not be returning to the facility. The Summary was signed by the Executive Director.

During an interview, with the Advanced Practice Registered Nurse (APRN), on 07/02/2024 at 12:17 PM, she stated R8 had a history of agitation and she was aware of one (1) incident of resident to staff abuse by R8 at another facility and this facility was aware. The ARNP further stated R8 had no history of resident-to-resident abuse. However, the ARNP then stated she did recall a resident-to-resident altercation between R8 and a female resident at the previous facility, but "it may have been pushed back to the cobwebs of my brain". In continued interview, the ARNP stated R8 was transferred from the previous facility for his repeated attempts at

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P015	Continued From page 3 elopement and the incident of resident to staff abuse. The ARNP further stated, after R8 was discharged from the previous facility he was at home with his daughter for less than a week before he was admitted to this facility. During a follow-up interview with the ARNP, on 07/05/2024 at 8:44 AM, she stated she did not review R8's medical record before she referred him to the facility because she cared for the resident while he was at the previous facility and knew her patients pretty well. The ARNP was questioned if a review of R8's medical record and discharge summary from the previous facility would have changed her decision related to recommending him for this facility. The ARNP stated even if she had reviewed his chart from the previous facility, she might have missed the report of the resident-to-resident incident involving R8. In an interview, on 07/02/2024 at 9:05 AM, with the Wellness Director Vice President (WDVP), she stated the ARNP had referred R8 to this facility as she thought he would be a good fit. The WDVP stated if she remembered correctly, R8 did have an incident where he may have hit a nurse at the previous facility on the arm, and was then discharged home with his daughter. The WDVP stated the ARNP would not have referred R8 for this facility if she felt he was a threat to others; however, the WDVP stated the safety of the residents in the facility had to be considered during the admission process. In an interview, on 07/05/2024 at 11:30 AM, with the Wellness Director (WD), she stated she was not employed at the facility when R8 was admitted. She stated the facility did not have an admissions policy and the admission process	P015		

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P 015	Continued From page 4 began with a referral either from family or from a facility. She further stated, if the resident was coming from another facility, she would review diagnoses, type of dementia if applicable, and if the resident had a history of any behaviors. The WD stated she would speak with the family and interview them about the resident and if a resident had a history of aggressive behaviors, physical behaviors towards self or others, increasing agitation, self-harm or sexual behaviors, they were not a good fit and would be excluded from admission at the facility. In an interview, on 07/05/2024 12:05 PM, with the Executive Director (ED), she stated she had been in the role of ED for one (1) year and the facility did not have an admissions policy. She stated the admission process began with a referral from family or a facility. The ED stated she performed the admission assessment on R8 on the morning of 05/22/2024 and he was moved to the facility later in the evening. The ED further stated RS was known to the ARNP, as she completed the history and physical on R8 on 05/22/2024, and highly recommended the resident for admission to the facility. The ED stated RS was admitted from home, and the facility did not obtain the discharge summary from the previous facility to review. She stated, in addition to other considerations for admissions, the safety of all the residents was important.	P 015		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including:	P 185		

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P 185	Continued From page 5 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on observation, interview, record review, facility policy review, and review of the facility investigation, the facility failed to have an effective system to ensure adequate supervision and monitoring to prevent elopement for one (1) of 16 sampled residents, Resident (R)2. On 06/21/2024, R2 exited the building without staffs knowledge, through a window in her room on the Memory Care Unit (MCU). Facility staff had last seen R2 at approximately 8:00 PM, and was unaware the resident was missing until R2's daughter notified the facility at approximately 9:00 PM, she had just received a call from R2, stating	P 185		

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P 185	Continued From page 6 she was at the local retail store. R2 was located at a local retail store approximately three tenths (0.3) of a mile away from the facility, which was across a three (3) lane road. Observation of resident room windows on 07/05/2024 for the MCU, revealed there were no safeguards to hide screw heads on windows. Based on the findings, it was determined the facility's failure to provide adequate supervision and monitoring to ensure a safe environment and prevent elopement presents an imminent danger and creates substantial risk that death or serious mental or physical harm to the resident (s) could occur. The findings include: Review of the facility policy titled "Elopement Prevention", undated, revealed communities are ensured safe, environments are secure, and elopement dangers will be identified with preventative interventions placed. All residents will be assessed for elopement risk factors completed at preadmission, admission, and quarterly, and significant changes in resident's condition. Continued review revealed residents who are assessed to be at risk for elopements will have preventative measures placed to reduce risks for elopement and injury. Review of the facility's Initial Report of Investigation, dated 06/24/2024, untimed, revealed R2 was at a local department store with no escort. Window audits were performed on the memory care unit on 06/21/2024 at 10:40 PM, which revealed all windows had the safety function in place to prevent the window from raising up too far, except the one in R2's room that appeared to have the screw removed, plastic	P 185		

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P 185	Continued From page 7 broken and window raised with screen removed from the window. The Investigation was signed by the Executive Director. Review of R2's medical record Face Sheet, revealed the facility admitted the resident on 09/08/2023 with diagnoses to include metabolic encephalopathy (brain condition caused by chemical imbalance), chronic obstructive pulmonary disease (group of lung diseases that block airflow), and dementia. Review of R2's Quarterly Elopement Risk Evaluation, dated 12/06/2023, revealed the resident was at high risk for elopement with a score of 26 out of 50. Per the Evaluation, a score of ten (10) to 50 indicated high risk for elopement. The criteria marked placing the resident at risk for elopement included: Mini Mental Exam score; history of wandering; status of ambulation; making personal choices; a recent life changing event; attempted to leave within the last 90 days; and expresses a desire to leave community. Review of the Service Plan (care plan), revised 04/14/2024, revealed a Psychosocial Category. The action plan included: R2 has minimal wandering issues which does not jeopardize health or safety to self or others. There were no interventions listed to prevent elopement. Review of R2's Quarterly Elopement Risk Evaluation, dated 05/06/2024, revealed a score of 26 out of 50, indicating the resident was at high risk for elopement. The criteria marked placing the resident at risk for elopement included: Mini Mental Exam score; history of wandering; status of ambulation; making personal choices; a recent life changing event; and attempted to leave within the last 90 days.	P 185		

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P 185	Continued From page 8 Review of R2's medical record revealed no psychiatric notes. Review of the Advanced Practice Registered Nurse (APRN) Notes, dated 05/01/2024, 05/08/2024, 05/22/2024, 05/28/2024, and 06/04/2024, under the section titled "Neurology review", revealed R2 complained of memory loss. Review of the Incident Report (IR), dated 06/21/2024 at 9:05 PM, revealed R2's daughter called the facility to let staff know R2 was at the local retail store. Further review revealed Licensed Practical Nurse (LPN)2 sent two (2) staff members to the local retail store in an attempt to bring the resident back to the facility, Emergency Services were activated and management was notified. Continued review revealed R2's room window was open, the plastic barrier from the top of the window was broken, with a screw missing, and the screen was removed. Additional review of the IR, revealed R2 refused to return to the facility. Staff stayed with the resident at the local retail store, restaurant and gas station. Continued review of the IR, revealed R2 was sent to the Emergency Room (ER), placed on alert charting, frequent checks for 72 hours was initiated, and staff was educated/inserviced. The IR was signed by LPN2. Review of the Police Report, dated 06/21/2024, revealed a 911 call was received at 9:20 PM and police were on the scene at 9:23 PM. Facility staff was with R2, but the resident was refusing to come with them and was very angry. Continued review revealed R2 walked to the restaurant and then on to the gas station. Review of the Emergency Medical Services	P 185		

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(EMS) Note, dated 06/21/2024 at 9:36 PM, revealed EMS was on scene and R2 was alert/oriented times three (3) and complaining of dizziness. Per the Note, R2 was transferred to the local hospital at 9:54 PM.

Review of the Emergency Room (ER) records from the local hospital, dated 06/21/2024 with admit time of 9:54 PM, revealed patient presented to Emergency Room (ER) by EMS from Dementia memory unit for medical exam. Patient reportedly did not want to be there any more so she climbed out the window and walked to the gas station. The physical examination revealed the patient was awake, alert, with no acute distress. Further, in review of the re-evaluation note dated 06/21/2024 at 10:22 PM, patient is hemodynamically stable and pending pick up by daughter.

Observation on 07/02/2024 at 7:30 AM, revealed R2's window was approximately 50-60 feet from the sidewalk and a three (3) lane road. Additional observation revealed there were no cameras in that area.

Observation of the odometer on 07/01/2024, revealed it was approximately three tenths (0.3) mile to the local retail store from the facility.

Review of the Weather app, revealed temperature at 8:53 PM on 06/21/2024 was 84 degrees Fahrenheit (F) with no precipitation or winds in Frankfort, Kentucky (location of incident). Continued review revealed temperature on 06/21/2024 at 9:53 PM. to be 80 degrees F with no precipitation or winds at location of incident.

Observation on 07/05/2024 beginning at 2:45 PM, accompanied by the Executive Director (ED), of

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P 185	Continued From page 10 the windows in rooms 129 through 143, revealed the screws and window guards were intact. However, all screw heads of both star heads and four (4) way screws and bolt heads were visible. There were no safeguards to hide screw heads on the windows. Additionally, observation of R2's room window during this tour (room number 139), revealed the room was located on the road side of the building. During an interview with RA1, on 07/01/2024 at 2:00 PM, she stated she was working the MCU the day R2 left the facility. She stated R2 ate dinner at approximately 6:00 PM, then went to her room. Further, RA1 stated she last saw R2 at approximately 8:00 PM, when she was sitting in the recliner in her room talking on the cell phone. When questioned about preventative measures to protect R2 from elopement prior to this incident, she stated she had received elopement training and was to notify the nurse if a resident exhibited exit seeking behaviors such as checking doors and shaking door knobs; however, she was unaware of R2 having exit seeking behaviors prior to this incident. During an interview with RA?, on 07/02/2024 at 3:19 PM, she stated she was working the Memory Care Unit (MCU) on 06/21/2024, the day R2 left the facility. She stated on that date, she last saw R2 at approximately 6:00 PM around mealtime. She further stated, during her two (2) hour rounding, maybe around 8:00 PM, she noted R2 was not in her room, and the window in her room was open. In continued interview, RA? stated R2's daughter called the facility and notified LPN2, that R2 was at the local retail store. RA? stated, to her knowledge, R2 had not exhibited exit seeking behavior and had never attempted to leave the facility before 06/21/2024.	P 185		

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P 185	Continued From page 11 When questioned what preventive measures were in place to protect R2 from elopement prior to this incident, she stated staff performed rounds on the residents every two (2) hours and if a resident exhibited exit seeking behaviors such as trying to leave, or shaking a door knob, she would notify the nurse. During an interview with RA6, on 07/02/2024 at 3:00 PM, she stated on 06/21/2024, she was on the personal care unit when LPN2 informed her and RA9, that R2 was at the local retail store. She stated they immediately exited the facility through the front door and located R2. who was at the local retail store. RA6 stated they tried to convince R2 to return to the facility with them, but R2 refused. R2 then walked to the restaurant across the street and then on to the gas station. RA6 stated she and RA9 stayed with R2 the whole time. She further stated the police arrived by the time the resident got to the gas station, and the police obtained a drink for the resident. Further, R2 became short of breath and EMS transferred the resident to the hospital. In continued interview, RA6 stated prior to R2's elopement she had been trained on elopement and knew to re-direct a resident who was exit seeking and notify the nurse. Per interview, she performed rounds every two (2) hours. During an interview with RA9, on 07/03/2024 at 3:00 PM, she stated when she and RA6 got to local retail store, R2 was sitting at the garden center on a bench with a store employee. Per interview, RA9 and RA6 were unable to convince R2 to return to the facility. RA9 stated R2 had never had any elopement behavior prior or any behaviors prior to this incident. During an interview with LPN2, on 07/02/2024 at	P 185		

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	101301	A. BUILDING: _____ B. WING _____	C 07/05/2024

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P 185	Continued From page 12 1:13 PM, she stated on 06/21/2024, she was working the personal care side passing medications and had not made it over to the MCU, adding she was the only nurse in the building at that time. LPN stated she received a phone call on the facility phone from R2's daughter around 9:00 PM, stating R2 had just called her and stated she was at the local retail store. LPN1 stated she immediately sent two (2) staff to the store, activated 911, called management, and initiated a head count to ensure all other residents were in the building. She stated she went to R2's room, and noted the resident was not there and the window was open. Per interview, R2 had never exhibited exit seeking behavior prior to this incident. During interview with R2's daughter1, who was the resident's Power of Attorney, on 07/02/2024 at 7:40 PM, she stated she had spoken with R2 four (4) times the day of elopement. She stated the resident was not upset and did not voice wanting to leave the facility. When asked why R2 was on the MCU, she stated the resident was having hallucinations when last hospitalized. She further stated R2 "does not have any sense and will walk right into traffic". During interview with R2's daughter2, on 07/03/2024 at 7:58 PM, she stated her mother had called her around 9:00 PM and stated, "I'm out, come and get me". She stated at first she did not believe R2, but she could tell the resident was out of breath and she could hear the sound of traffic. Per interview, she told R2 to go back to the facility, but R2 immediately hung up the phone. Daughter2 stated she then immediately called the facility and informed LPN2. She stated she had spoken with R2 throughout the day on 06/21/2024 and she was not upset.	P 185		

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P 185	Continued From page 13 During interviews with RA2, on 07/05/2024 at 1:34 PM; RA/MedTech13, on 07/05/2024 at 12:10 PM; RA11, on 07/05/2024 at 11:45 PM; and RA12, on 07/05/2024 at 11:50 PM, they stated window checks were performed on the MCU but were not recorded. Further.they all stated window checks were performed at the beginning of the shift and consisted of checking locks and window stops. During interview with LPN1, on 07/05/2024 at 12:05 PM, she stated window checks were performed and she thought they were recorded on the Medication Administration Record (MAR). However, review of R2's June 2024 MAR, revealed no entries were noted related to window checks. LPN1 stated window checks consisted of physically trying to raise windows and performing a visual of the window. During an interview with the Wellness Director (WD), on 07/05/2024 at 3:45 PM, she stated her job description included oversight of nursing staff, policies, trainings and drills. She stated LPN2 called her and reported the elopement incident on 06/21/2024. She further stated the process to follow when a resident was missing, was to perform a head count and search the facility and grounds and that process was followed on 06/21/2024. When asked if windows were audited, she stated "Yes", but she was unsure if the window audits were documented. She stated there were no safeguards to hide screw heads on windows. When asked what process was in place to prevent elopement for R2 prior to the incident, she stated the facility provided elopement trainings, and elopement drills. The WD stated it was a safety concern for a resident to leave the facility without staff's knowledge.	P 185		

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P 185	Continued From page 14 During an interview with the Executive Director (ED), on 07/01/2024 at 8:00 PM, she stated she received a call from LPN2 around 9:15 PM, telling her R2 left the facility and was at the local retail store. She stated R2 had managed to remove screws, window stops,and a screen from the window in her room, adding the facility was unable to determine how the screws had been removed. When questioned what process was in place to prevent elopement prior to R2 exiting the building unaccompanied on 06/21/2024, she stated all residents on the locked MCU were elopement risks and the unit was secured by a security key to enter and exit. She further stated all windows on the locked unit were secured with the window stops which prevented the window from being raised over three-four (3-4) inches. In continued interview, the ED stated, she herself had placed extra star head screws in the window frame to prevent residents from raising windows over the three-four (3-4) inches. She added she had chosen the star head thinking a resident would have a harder time finding a tool to fit that type of screw. In further interview with the Executive Director (ED), on 07/01/2024 at 8:00 PM, she stated after the incident, R2's window was repaired and window audits were performed for all windows on the MCU, although there was no documented evidence of the audits. She stated a window audit consisted of ensuring the windows were locked, and if unlocked they were unable to be raised over three to four (3-4) inches. She further stated the facility had offered another room on the courtside of the building, but R2 had refused. In continued interview, on 07/05/2024 at 2:55 PM, the ED stated the facility did not have maintenance staff at this time and she had placed	P 185		

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P 185	Continued From page 15 extra screws in the windows herself. When asked if policies had been updated since the event she stated they had not, but those revisions would not be made at the facility level.	P 185	It is the policy of DSL to protect our residents against abuse or negligence. It is our goal to provide a safe and healthful environment for all.	
R805	KRS 216.515(6) PATIENTS' RIGHTS Every resident in a long-term-care facility shall have at least the following rights: (6) All residents shall be free from mental and physical abuse, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in writing by a physician for a specified and limited period of time and documented in the resident's medical record. This requirement is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to ensure residents were protected from physical abuse for two (2) of 16 sampled residents, Resident (R)7 and RB. On 05/24/2024, R7 exited her room into the hallway where RB was standing. R7 held her walker up between she and RB. RB then shoved	R805	Resident #8 was immediately discharged from the facility on 05/24/2024, after the incident occurred. Resident #7 was immediately sent out to Emergency Room for further evaluation. All residents at the community have the potential to be affected. To ensure deficient practice from reoccurring, Dominion Senior Living has developed a criterion for all new admissions and what historical Information is needed prior to admission. Education was provided to the Executive Director and Wellness Director by VP of Wellness on 07/19/2024 regarding the criteria for additional historical information prior to admission. On 05/24/2024 education was provided by the Wellness Director to staff on resident rights and abuse policy and procedures. Executive Director/Designee will perform weekly audits of all new admissions to ensure historical	

			Data is obtained prior to move in. These audits will start on 07/22/2024 and ongoing. DSL will provide ongoing abuse education through Relias Training and/or monthly in-services. Compliance Date 08/19/2024	

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R 805	Continued From page 16	R805		

R7's walker causing R7 to fall back into the door. R7 was immediately transferred to the hospital Emergency Room (ER). Review of R7's hospital Discharge Summary, dated 05/28/2024, revealed she was treated for an assault resulting in multiple bruises, generalized pain with movement, and a laceration to the skull requiring six (6) sutures.

The findings include:

Review of the facility's policy titled, "Long Term Care Abuse Reporting Act", dated 2021, revealed its purpose was to provide guidelines to protect not just the senior living community and staff, but more importantly to protect residents and former residents against abuse or negligence and to provide a safe and healthful environment for all. Further review of the policy revealed abuse was defined as any intentional act or series of acts which caused injury to a resident which included physical assault or sexual harassment.

Review of the facility's policy titled, "Resident Rights", undated, revealed all residents shall be free from mental and physical abuse.

Review of the facility's Investigation Summary, undated, revealed on 05/24/2024, R7 came out of her room into the hall where R8 was standing and it was witnessed R7 held her walker up toward RS. R8 then shoved R7's walker causing R7 to fall back into the door. Further review revealed first aid was applied to R7 and 911 was called immediately. Both residents were transported to the emergency department, and families were notified. Continued review revealed R8 was admitted to a psychiatric facility and would not be returning to the facility. The Summary was signed by the Executive Director.

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R 805	Continued From page 17 Review of R?'s medical record "Face Sheet", revealed the facility admitted the resident on 10/25/2022 with diagnoses including dementia, diabetes and hypertension. Review of R?'s Cognition/Care Plan, dated 06/05/2024, revealed the facility assessed the resident as mildly impaired for communication, and moderately impaired for long term and short term memory. The goal stated the resident would maintain and/or maximize current level of function for communication, and long and short term memory. There were no interventions listed. Review of R?'s Progress Note, dated 05/24/2024 at 8:05 PM, written by Licensed Practical Nurse (LPN)4, revealed she was notified by Resident Assistant (RA)8, that R8 pushed R7 causing her to fall backwards and hit her head on the door. Upon entering the hallway, LPN4 noted R7 lying on the floor at the end of the hall with blood coming from her lip and her head; and there was a skin tear on her left elbow. Emergency Medical Services (EMS) was called immediately. Review of R?'s Hospital Discharge Summary, dated 05/28/2024, revealed during her hospitalization she was treated for an assault resulting in multiple bruises, generalized pain with movement, a laceration to the skull requiring six (6) sutures, and a Urinary Tract Infection. Review of R8's medical record "Face Sheet", revealed the facility admitted the resident on 05/22/2024 with diagnoses including vascular dementia, anxiety, history of alcohol abuse and type 2 diabetes. Review of R8's Cognition Service/Care Plan,	R805		

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R 805	Continued From page 18 dated 05/22/2024, revealed the facility assessed the resident as having mild impairment for communication; mild impairment for long term and short term memory, as well as mild cognitive impairment. The goal stated the resident would maintain and/or maximize current level of function for communication, long and short term memory, and cognitive impairment. There were no interventions listed. Review of R8's Behavior Service/Care Plan, dated 05/22/2024, revealed the resident had occasional behavior issues, a current or history of occasional disruptive, aggressive, or socially inappropriate behavior, being either verbally or physically improper. The goal stated R8 would maintain and or maximize current level of functioning. There were no interventions listed. Review of R8's Progress Note, dated 05/24/2024 at 8:11 PM, written by LPN4, revealed she was notified by RA8, that R8 pushed R7 causing her to fall backwards and hit her head on the door. RA4 witnessed the altercation between R8 and R7 and she stated she saw R8 walking down the hall toward R7's room. R7 was exiting her room, and saw R8 coming toward her. R7 raised her walker up to protect herself and R8 grabbed the walker and pushed it, causing R7 to fall backward. Review of a written Witness Statement, dated 05/24/2024 at 6:30 PM, signed by RA4, revealed she witnessed R8 walking down the hall toward R7's room/apartment. When R7 saw RS coming toward her, R7 raised her walker to protect herself. RS then grabbed the walker and pushed it causing R7 to fall backwards. During an interview, on 07/02/2024 at 9:41 AM,	R 805		

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R 805	Continued From page 19 with RA4, she stated on the evening of the incident between R7 and RB, she was cleaning tables from supper when she saw R7 coming out of her room with her walker. RA4 stated she noted RB was down at the end of the hall near R7. RA4 stated she heard RB yell, "leave me alone" and "get away from me", and then she observed RB grab the walker and push R7 into the door. RA4 stated *RAB* left to find the nurse while the staff tried to calm R7 down and put pressure on her head which was bleeding. RA4 stated RB was yelling, "I didn't do that!" RA4 then stated the ambulance transported R7 to the hospital. During an interview, on 07/02/2024 at 9:30 AM, with *RAB*, she stated she had gone to the Memory Care Unit {MCU} to finish medication pass and noticed RB came out of his room in a t-shirt, boxers, socks and shoes with a belt in his hand. *RAB* observed RB walk to the end of the hall, and when R7 tried to go around him, RB blocked R7 in each direction. R7 then picked up the walker and went toward him. *RAB* stated she and RA4 were walking towards them when RB grabbed R7 and pushed her into the door. *RAB* stated R7 fell to the floor and she went to get a nurse. When she returned to the MCU with LPN4, R7 was hollering out in pain, bleeding from her head and lip, complaining of back pain and had a skin tear on her arm. RA4 stated staff applied pressure to R?'s head wound and LPN4 called EMS while other staff directed RB away. She stated EMS transported R7 to the local hospital. RAB further stated after the incident, RB calmed down and he told her he "didn't do it", and he walked away. During an interview, on 07/02/2024 at 9:24 AM, with LPN4, she stated on the night of the incident	R805		

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R 805	Continued From page 20 between R7 and R8, RA8 came to the Personal Care side, and told her to come to the MCU because R7 was on the floor near the exit door bleeding from her head. LPN4 stated RA8 informed her R8 had pushed R7. In further interview, LPN 4 stated 911 was immediately called and RA4 wrote a witness statement. LPN4 stated to her understanding, R7 walked out of her room and RS was standing there. R7 stopped, but RS ended up pushing R7 causing R7 to hit her head on the wall. LPN4 stated R7 was admitted to the hospital. During an interview, on 07/02/2024 at 11:10 AM, with LPN1, she stated RS was "fidgety and liked to go go go all the time". She further stated, R8 had a Physician's order for a PRN (as needed) sedative, which she would give to him when he seemed hyper and fidgety to help him calm down a little. LPN1 further stated RS would occasionally make sexual comments to her about her breasts and she would tell him that kind of talk was not allowed and redirect him. LPN1 stated she had never seen RS bothering R7. On 07/01/2024 at 2:00 PM, the State Agency Representative attempted to interview R7, and asked if she felt like talking. She stated "No". During an interview, on 07/02/2024 at 12:17 PM, with the Advanced Practice Registered Nurse (APRN), she stated she could not be sure R7 did not provoke R8 by raising up her walker toward him. However, she stated this action by R7 could have been self-defense. The APRN stated RS had a history of agitation and she was aware of one (1) incident of resident to staff abuse by RS at another facility and this facility was aware. The APRN further stated RS had no history of resident-to-resident abuse. However, the APRN	R 805		

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R 805	Continued From page 21 then stated she did remember a resident-to-resident altercation between R8 and a female resident at the previous facility, but "it may have been pushed back to the cobwebs of my brain". In further interview with the APRN, on 07/02/2024 at 12:17 PM, she stated R8 was discharged from the previous facility for his repeated attempts at elopement and the incident of resident to staff abuse. The APRN stated, after RB was discharged from the previous facility he was at home with his daughter for less than a week before he was admitted to this facility. Per interview, the APRN stated the resident's daughter had tried to get R8 into a geriatric psychiatric facility, but was unsuccessful, so she (APRN), recommended he come to this facility. She stated she ordered a PRN (as needed) sedative after staff reported his restlessness and anxiety. Further, she stated she ordered an antidepressant medication for his promiscuity after staff reported he was being "too friendly" with the younger female staff. During a follow-up interview, on 07/05/2024 at 8:44 AM, with the APRN, she stated she did not review R8's medical record before she referred him to the facility because she cared for the resident while he was at the previous facility and knew her patients pretty well. When asked if a review of R8's chart would have changed her decision related to recommending him for this facility, the APRN stated even if she had reviewed his chart or discharge summary, she might have missed the report of the resident-to-resident incident involving R8 from the other facility. During an interview, on 07/02/2024 at 9:05 AM, with the Wellness Director Vice President	R805		

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R 805	Continued From page 22 (WDVP), she stated the APRN had referred R8 to this facility as she thought he would be a good fit. The WDVP stated theAPRN, told her there had been no prior behavioral incidents with R8. However, the WDVP then stated, if she remembered correctly, R8 had an incident where he may have hit a nurse at the other facility on the arm, and was then discharged home with his daughter and had been home with her for about a month prior to being admitted to this facility. The WDVP stated she felt the APRN would not have referred R8 for this facility if she felt he was a threat to others. However, she stated based on R8's altercation with R7, the facility would not take R8 back as a resident, because they had to consider the safety of all the residents. During an interview, on 07/05/2024 at 11:30 AM, with the Wellness Director (WD), she stated she was not employed at the facility when R8 was admitted. The WD stated if a resident was coming from another facility, she would review diagnoses, type of dementia if applicable, and if the resident had a history of any behaviors. The WD stated she would also speak with the family and interview them about the resident and ask if the resident had a history of aggressive behaviors, physical behaviors towards self or others, increasing agitation, self-harm or sexual behaviors. She stated if the resident had a history of these behaviors they would not be a good fit and would be excluded from admission to the facility. During an interview, on 07/02/2024 at 8:05 AM, and on 07/05/2024 at 12:05 PM, with the Executive Director (ED), she stated she had been in the role of ED for one (1) year. She further stated the facility did not have an admission policy, but the admission process began with a	R 805		

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DOMINION SENIOR LIVING OF FRANKFORT	122 LEONARDWOOD DR FRANKFORT, KY 40601

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 805	Continued From page 23 referral from family or a facility. In continued interview with the ED, she stated she performed the admission assessment on RS on the morning of 05/22/2024 and he moved to the facility later that evening. She stated RS was known to the APRN, as she completed the history and physical on the resident on 05/22/2024, and had highly recommended him for admission to the facility. The ED further stated the APRN had cared for RS at another facility, and stated he had no behavioral issues at the other facility. Further, the ED stated the **APRN** told her she thought RS would be a good resident for this facility. During further interview with the ED, on 07/02/2024 at S:05 AM, and on 07/05/2024 at 12:05 PM, she stated RS had been with his daughter at home for about a month prior to the resident being admitted to this facility. Per interview, the daughter brought him to the facility on 05/22/2024 in the afternoon. The ED further stated RS's daughter told her the resident was not aggressive at home. Per interview, in addition to other considerations for admissions, the safety of all the residents was important.	R805		