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 _____	R-C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDERS RIDGE HEALTH CAMPUS	119 EAST SANDERS LANE MOUNT WASHINGTON, KY 40047

(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) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Desk Review Revisit Survey was initiated on 07/07/2025 and concluded on 07/10/2025. It was determined the facility had achieved substantial compliance on 06/17/2025 as alleged.	{F 000}		

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

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.

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

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SANDERS RIDGE HEALTH CAMPUS	119 EAST SANDERS LANE MOUNT WASHINGTON, KY 40047

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F 000	INITIAL COMMENTS	F 000		

A Recertification and Abbreviated Survey investigating KY00043385 was concluded on 05/15/2025. The facility was found not to be in compliance with 42 CFR 483 subpart B. Regulatory violations were cited at Scope and Severity of "D."

No deficiencies for cited for KY00043385.

Survey Dates: 05/12/2025 - 05/15/2025
Survey Census: 53
Sample Size: 15
Supplemental Residents: 0

F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		6/17/25

§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, the facility failed to assess a resident for their ability to self-administer medication for 1 of 15 sampled residents, (Resident (R)202).

The findings include:

Review of the facility policy titled, "Medication Administration- General Guidelines," revised 01/2018, residents were allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications.

The submission of this plan of correction does not indicate an admission by Sanders Ridge Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Sanders Ridge Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2025

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.

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F 554 Continued From page 1

Review of the "Resident Face Sheet" revealed the facility admitted R202 on 05/09/2025, with diagnosis of gastroesophageal reflux disease (GERD).

Review of R202's "Order History" revealed an order dated 05/09/2025, for Tums (an over-the-counter antacid medication) 200 milligrams (mgs) every eight hours.

During a concurrent observation and interview on 05/12/2025 at 9:55 AM, a medication cup was observed on R202's bedside that contained a Tums tablet inside. In interview, R202 stated staff gave him/her the Tums to take whenever he/she needed it.

In interview on 05/12/2025 at 11:12 AM, Licensed Practical Nurse (LPN) 6 stated R202 was able to keep his/her medications at bedside. LPN 6 confirmed R202 had no order to self-administer his/her medication or keep the medication at bedside.

In interview on 05/13/2025 at 12:36 PM, R202 stated he/she would like to be able to take his/her own medication without the nurse having to watch. R202 further stated he/she only got the Tums medication when he/she needed it, so nursing staff just left it for him/her to take.

During a follow-up interview on 05/13/2025 at 12:43 PM, LPN 6 confirmed R202 had not been assessed for his/her ability to self-administer his/her own medication.

In interview on 05/13/2025 at 1:33 PM, the Director of Health Services (DHS) stated her

F 554

It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.

F554 – Self Administration of Medications

1. Resident R202 was not affected adversely by the deficient practice. Resident R202 had the medication removed after being informed about the necessity of an assessment to ensure safety and the requirement for a physician's order to keep medications or over-the-counter medications at bedside and administer them as prescribed on 5/12/2025.

Resident R202 was evaluated using our Self-Medication Observation to ensure safe self-administration and storage of medications. A physician's order confirming the resident's ability to keep and use medication at bedside was obtained, and the care plan was reviewed and updated accordingly on 5/12/2025.

2. All residents residing at Sanders Ridge Health Center have the potential to be affected by the deficient practice. The Director of Health Services completed an audit at Sanders Ridge Health Center on 5/12/2025 to ensure unauthorized medications were not left at residents' bedsides. The audit reviewed to ensure that residents had been assessed for safe self-administration and storage of medications, and if there was a physician order permitting them to do so, in compliance with policy and procedures.

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F 554	Continued From page 2 expectation for the facility's self-administration of medication assessment process was for the resident to be assessed to assess for the appropriateness of being able to do that. The DHS further stated a resident's medication was not allowed to be left at his/her bedside if the resident had not been assessed as able to self-administer his/her own medication. During an interview on 05/15/2025 at 8:43 AM, the Executive Director stated he expected medication generally not to be left at bedside unless the resident had a self-administration assessment of medication completed.	F 554	This was completed on 5/12/2025. Residents authorized to self-administer medications had physician orders to keep and take their medication at bedside as prescribed. Their care plans were reviewed and updated to reflect their personalized medication plan. This was completed on 5/12/2025. 3. The Director of Health Services provided education to the nurses and the certified medication techs on 6/4/25 regarding our policy and procedures concerning Self-Medication Observation, Medication Storage, and Care Planning. On 6/4/25, the staff completed a posttest administered by the Director of Health Services, which required a 100% pass rate to verify retention of the provided education. After 6/4/2025, any newly hired staff will be educated through orientation by the DHS and ADHS. The campus does not use agency staff. 4. An "Ad Hoc" Quality Assurance meeting occurred on 6/13/2025, with the Medical Director to discuss the findings from the cited deficiency and our process for ensuring that residents with medications left at bedside have been assessed and determined to be safe to self-administer and store medications. Once it is determined to be safe, physician orders will be obtained indicating that the residents' medications	

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F 554	Continued From page 3	F 554		

may be kept at the bedside and administered by the resident as prescribed. The resident's care plan will also be reviewed and updated to reflect the resident's individualized provisions for medication administration.
Starting on 6/13/25 Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan.

Starting on 6/16/25, as part of the facility's ongoing quality improvement plan, the Director of Health Services or designee will perform an audit of 10 Residents; weekly times 4 weeks, then every other week times 4 weeks, then monthly times 1 month, to ensure that residents with medications left at bedside have a Self Administration of Medication Assessment completed.

The Director of Health Services or designee will present the findings from the audits to the monthly QAPI Committee. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction.

Facility alleges compliance on 6/17/2025

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F 689	Continued From page 4	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		6/25/25

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to ensure medications were secured to prevent potential accidents for 1 of 1 residents reviewed for accidents, out of the total sample of 15 (Resident (R) 102).

The findings include:

Review of the facility policy titled, "Medication Storage In The Facility," revised 11/2018, revealed, "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier."

Review of the "Resident Face Sheet" for R102 revealed the facility admitted the resident on 05/09/2025, with diagnoses of Alzheimer's disease and low back pain.

Review of R102's "Physician Order Report" for the timeframe of 04/15/2025 through 05/15/2025, revealed an order dated 05/09/2025, for Biofreeze gel, to be applied to the lower back twice daily.

F689 Accidents and Supervision
1. Resident R102 was not affected adversely by the deficient practice. Resident R102 had the medication removed after being informed about the necessity of an assessment to ensure safety and the requirement for a physicians order to keep medications or over-the-counter medications at bedside and administer them as prescribed on 5/12/2025.

The medication left at bedside in the room of Resident R102 was removed on 5/12/25.

2. All residents residing at Sanders Ridge Health Center have the potential to be affected by the deficient practice. The Director of Health Services completed an audit of the skilled memory care unit at Sanders Ridge Health Campus to ensure that potentially hazardous materials/items were not left in resident care areas. This was completed on 6/18/2025.

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F 689	Continued From page 5	F 689		

Review of R102's "Care Plan" revealed the facility identified a problem statement initiated on 05/12/2025, that indicated the resident was at risk for lower back pain. Further review revealed the interventions noted staff where to administer medications as ordered.

Review of R102's "Observation Detail List Report" completed 05/12/2025, revealed the resident had severe cognitive impairment.

In a concurrent observation and interview on 05/12/2025 at 10:09 AM, the State Survey Agency (SSA) Surveyor observed a clear medication cup in R102's room with the resident's room number on the cup. In interview, Licensed Practical Nurse (LPN) 3 stated she placed the medication in the resident's room and assumed since the resident received Biofreeze for their lower back, that was what was in the cup. She reported medication was not to be left at a resident's bedside and said the unit had residents who wandered. LPN 3 further stated the cup of medication should not have been left on R102's nightstand, and she was embarrassed the medication had been left there. LPN 3 additionally stated she was unsure who left the medication on the nightstand.

In interview on 05/12/2025 at 10:16 AM, Certified Resident Care Associate (CRCA) 4 stated she served R102 breakfast and had not seen the medication at the resident's bedside. The CRCA further stated if she had seen the medication at R102's bedside she would have removed the medication and taken it to the nurse.

In interview on 05/14/2025 at 1:29 PM, the

3 The Director of Health Services provided education to Facility Staff in all Departments on 6/18/25 on how to identify, and what to do if you find, potentially hazardous materials/items in a resident care area.
On 6/18/25, Facility Staff in all Departments completed a posttest administered by the Director of Health Services, which required a 100% pass rate to verify retention of the provided education.

After 6/18/2025, any newly hired Facility Staff in any department will be educated through orientation by the DHS or designee. The campus does not use agency staff. After 6/18/2025, any Facility Staff in any department that have not received the education, will be educated before working at Sanders Ridge, and complete a post test administered by the Director of Health Services, which required a 100% pass rate to verify retention of the provided education.

4. An "Ad Hoc" Quality Assurance meeting occurred on 6/19/2025, with the Medical Director to discuss the findings from the cited deficiency and our process for ensuring that potentially hazardous materials/items are not left out in resident care areas.
Starting on 6/19/25 a Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above

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F 689	Continued From page 6 Director of Health Services (DHS) stated when giving residents medications she expected the nurses to follow the rights of medication administration, which included the right resident, right time, right dose, and the right medication. She reported medications were not to be left at a resident's bedside. The DHS said the danger of leaving medications at a resident's bedside in a dementia unit was a resident could get a medication not prescribed for them. She stated there were residents in the dementia unit where R102 lived that wandered, but had not recently wandered into others' rooms. The DHS further R102 might have the dexterity to apply the Biofreeze; however, did not have the mental capacity to administer the medication independently. In interview on 05/15/2025 at 8:36 AM, the Executive Director (ED) stated he did not expect medication to be left at a resident's bedside unless the resident had been assessed and deemed appropriate for self-administration and a physician's order had been obtained.	F 689	stated plan. Starting on 6/24/25, as part of the facility's ongoing quality improvement plan, the Director of Health Services or designee will perform an audit of 10 Resident Rooms; weekly times 4 weeks, then every other week times 4 weeks, then monthly times 1 month, to ensure that potentially hazardous materials/items are not left in resident care areas. The Director of Health Services or designee will present the findings from the audits to the monthly QAPI Committee. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance on 6/25/2025	

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F 000	INITIAL COMMENTS A Recertification and Abbreviated Survey investigating KY00043385 was concluded on 05/15/2025. The facility was found not to be in compliance with 42 CFR 483 subpart B. Regulatory violations were cited at Scope and Severity of "D." No deficiencies for cited for KY00043385. Survey Dates: 05/12/2025 - 05/15/2025 Survey Census: 53 Sample Size: 15 Supplemental Residents: 0	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		6/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/16/2025

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.

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: 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,	F 609	F609 Reporting of Alleged Violations 1. No Residents were affected. The allegation was not substantiated, with Resident R152 unaffected by the alleged incident. 2. All residents had the potential to be affected. The Clinical Support or designee will provide education to the Administrator and Director of Health Services regarding the facilitys policy on Abuse Reporting and the importance of verifying the time that the allegation is made to facility staff to ensure compliance with timely reporting, on or before 6/4/2025. On 6/4/25, the Executive Director and Director of Health Services completed a posttest administered by the Trilogy Health Services Campus Clinical Support, which required a 100% pass rate to verify retention of the provided education. 3. As a measure of ongoing compliance, beginning on 6/16/25, the Clinical Support or designee will monitor weekly times 4 weeks, then every other week times 4 weeks, then monthly times one month,	

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F 609	Continued From page 2 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. 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	F 609	reports of allegations to ensure timely reporting as it relates to the time that the allegation was reported to facility staff in accordance with timely reporting guidelines. This will be monitored using an audit tool, which will compare within the investigation, the time stated in initial witness statements, that the facility staff was made aware of the allegation, with the time that the initial report was made to the Office of the Inspector General. 4. An "Ad Hoc" Quality Assurance meeting occurred on 6/13/2025, with the Medical Director to discuss the findings from the cited deficiency and our process for ensuring ongoing compliance with said deficiency. Starting on 6/13/25, Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan. As a quality measure, starting on 6/13/25, the administrator or designee will review any findings and corrective action weekly for 4 weeks, then monthly in the campus Quality Assurance Performance Improvement meetings, as stated above. The plans will be revised as warranted. Facility alleges compliance on 6/17/2025	

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(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) COMPLETION DATE
F 609	Continued From page 3	F 609		

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

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 _____	C 05/15/2025

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F 609	Continued From page 4	F 609		

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

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F 609	Continued From page 5 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. 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.	F 609		