STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185175	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treyton Oak Towers	211 West Oak Street Louisville, KY 40203

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. (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	Based on interview, record review, and review of facility policy, the facility failed to ensure allegations of abuse were reported to the Administrator and State Agencies immediately, but not later than 2 hours after an allegation of abuse was made for 2 of 4 residents reviewed for abuse prohibition, Resident (R)23 and R201. The findings include: Review of the facility policy titled, Resident Abuse, revised 06/30/2023, revealed, any alleged violations involving mistreatment, neglect, exploitation or abuse, including injuries of unknown source and misappropriation of resident property, must be reported to the employee's supervisor or directly to the Administrator 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. The policy revealed, When an alleged violation, suspected case of mistreatment, exploitation or neglect is reported, or there is a substantial investigation of mistreatment or abuse, the facility Administrator, or his/her designee, will notify the following persons or agencies within the time frames specified above of such incident . 2. State Licensing and Certification Agency. 1. Review of R23's Resident Face Sheet revealed the facility admitted the resident on 01/06/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a cerebral infarction affecting the left and right side. Review of R23's Care Plan, included a problem statement dated 02/08/2024, revealing the resident had limited mobility and needed assistance related to impaired balance, weakness, and poor safety awareness/judgement. Interventions directed staff to utilize a mechanical lift for transfers from chair to bed and bed to chair transfers (initiated 02/22/2024). Review of R23's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/03/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of nine out of 15, indicating moderate cognitive impairment. Further review of the MDS, revealed the facility assessed the resident as dependent on staff for chair to bed and bed to chair transfers. Review of the facility Initial Report revealed on 06/21/2024 (time not documented), a resident reported that Certified Nursing Assistant (CNA)12 slammed R23 into a wheelchair when providing care. The Initial Report revealed the facility failed to notify the Administrator of the allegation until 06/23/2024 at 2:31 PM, two days after the alleged incident. A Facsimile report revealed the facility sent the initial report of alleged abuse to the State Survey Agency (SSA) on 06/23/2024 at 4:29 PM. Review of the typed facility statement for CNA15, dated 06/24/2024, revealed on Saturday (06/22/2024), R23's roommate stated CNA12 changed R23 and when the CNA transferred the resident to a wheelchair, she slammed the resident into the seat and the resident yelled loudly. Per the statement, CNA15 stated there was a lot going on that morning and she forgot to tell the nurse. It slipped my mind. During a telephone interview on 07/02/2025 at 1:42 PM, CNA15 stated a resident told her, that on Friday (06/21/2024), CNA12 was rough with R23 and had grabbed the resident's arms when she moved the resident from the bed into a wheelchair. CNA15 stated the resident told her about the incident on Saturday (06/22/2024), when the CNA was delivering a meal, and she forgot to tell anyone about the allegation. CNA15 further stated, on Monday morning (06/24/2024), the Assistant Director of Nursing (ADON) asked her about the incident, and she told the ADON that she failed to report the allegation. Review of CNA14's written statement, dated 06/23/2024, revealed a resident told her, CNA12 slammed R23 into a wheelchair on Friday (06/21/2024). During a telephone interview on 07/02/2025 at 8:35 PM, CNA14 stated, on 06/23/2024, another resident told her about an incident that happened on Friday (06/21/2024) and she immediately notified the Assistant Director of Nursing (ADON). CNA14 stated the resident told her CNA12 was rough with R23 when the resident was transferred from the bed to the wheelchair. During an interview on 07/03/2025 at 9:47 AM, the ADON stated CNA15 failed to report the allegation to anyone on Saturday (06/22/2024), after a resident told her about the incident. The ADON stated CNA15 should have reported the allegation to the nurse immediately. During an interview on 07/03/2025 at 2:12 PM, the Director of Nursing (DON) stated it was not acceptable for staff to fail to report an allegation of abuse. She stated she expected staff to report allegations immediately to the Administrator, who was also the abuse coordinator. 2. Review of R201's Resident Face Sheet revealed the facility admitted the resident on 10/04/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of osteoarthritis of the right hand, other osteoarthritis without a current pathological fracture, psychotic disorder with behavioral disturbance, and dementia, Review of R201's Care Plan, included a problem statement dated 04/25/2022, indicating the resident had limited

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and review of facility document and policy, there was no documented evidence alleged violations were thoroughly investigated for 2 of 4 residents reviewed for abuse prohibition, Resident (R)42 and R201.The findings include: Review of the facility's policy titled, Resident Abuse, dated 06/30/2023, revealed, Each resident has the right to be free from abuse, mistreatment, neglect, and misappropriation of property. The policy revealed the section titled, V. Investigation, included, D. The investigation shall consist of: 1. Review of witness statements; 2. Interview with the person(s) reporting the incident; 3. Interviews with any witnesses to the incident; 4. Interview with the resident; 5. Interview with the resident's attending physician; 6. Review of the resident's medical record; 7. Interviews with the staff members on all shifts having contact with the resident during the period of the alleged incident. The policy revealed, Documentation of interviews: It is necessary for all interviews to document the name and title of the person being interviewed, the date and time of the interview as well as the information provided by the interviewee. 1. Review of R42's Resident Face Sheet revealed the facility admitted the resident on 12/05/2023. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of dementia. Review of R42's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2025, indicated the resident had severe impairment in cognitive skills for daily decision-making and had both short and long-term memory problems. The MDS further revealed R42 required substantial/maximal assistance with activities of daily living, and the resident also received hospice services. Review of the facility Long Term Care Facility - Self Reported Incident Form Initial Report, dated 07/12/2024, revealed R42's family member contacted the facility, notifying the facility the resident's credit card had unauthorized use. The facility investigation included three transactions for which the credit card had been used. The transactions included a local liquor store, ride share, and automated teller machine (ATM) withdrawal, with locations. The information provided to the facility reflected the card had not been used for over two years. The report revealed the police theft department was notified, and a full investigation was underway. According to the report, the facility planned to interview staff members to determine whether they heard or saw anything and planned to review video footage. Review of the Police Incident Report, dated 07/12/2024, revealed The victim's [R42] wallet was stolen from their purse at listed location [facility location]. Victim [R42] in skilled nursing section at listed location. The incident report documented five items that were stolen, which included a wallet, two credit cards, personal identification, and a social security card. The incident report did not include information regarding the three unauthorized transactions and the locations of the transactions.During an interview on 07/03/2025 at 7:37 AM, the Administrator stated he did not recall the details reported to the police; however, the three transactions should have been reported to the police. After a review of the police incident report, he stated it did not appear the transactions were communicated to the police. Review of the facility Long Term Care Facility - Self Reported Incident Form Final Report/5 Day Follow Up, dated 07/17/2024, revealed staff did not notice anything that could help with the investigation and did not see anyone taking anything that belonged to another resident. The report revealed the facility was unable to determine the perpetrator. Per the report, the resident's credit card was cancelled. The report revealed the facility's investigation was inconclusive with respect to identifying who may have taken or used the resident's credit card. According to the report, the police department report was not available, but the facility hoped to hear from the bank or police department with any information and make any corrective action necessary. Further review of the facility's complete investigation revealed no documented evidence of facility staff interviews. Further, the facility's report revealed no documented evidence the facility interviewed the hospice staff assigned to R42 during the alleged theft of the credit card. During an interview on 07/02/2025 at 10:10 AM, R42's Responsible Party (RP) (RP17), revealed unauthorized purchases had been made using the resident's credit card. Per interview, RP17 reported the issue to both the nursing supervisor and the social worker. According to RP17, R42 who had memory impairment and had required full-time care since 2023, typically kept a pocketbook in a drawer accessible to caregiving staff. RP17 denied filing a police report because the facility was to conduct a thorough investigation and notify law enforcement. RP17 stated, despite expectations and assurances from staff, the outcome of the investigation was never discussed and staff responses when questioned about the outcome were vague or dismissive. Per RP17, R42 had no other visitors. Per interview, although R17 sought accountability, there was no resolution. During an interview on 07/02/2024 at 11:30 AM, the Unit Secretary stated she became aware of the incident involving R42's missing