STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185012	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Nursing and Rehabilitation Center	1500 Pride Avenue Madisonville, KY 42431

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47798 Based on observation, interview, and review of the facility's policy, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, for one (1) of six (6) sampled residents (Resident #1). Observation of Resident #1 on 04/03/2024, revealed the resident's catheter bag had no dignity cover in place. The findings include: Review of the facility's policy titled, Dignity, revised February 2021, revealed each resident was to be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Review of Resident #1s Admission Record revealed the facility admitted the resident on 08/21/2023, with diagnoses to include: urinary retention, myelodysplastic syndrome, and major depressive disorder, severe with psychotic symptoms. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. Review of Resident #1's Indwelling Foley (name brand) Catheter Comprehensive Care Plan, dated 06/08/2023, revealed an intervention initiated on 07/17/2023 to provide a privacy bag covering for the catheter bag. During an observation on 04/03/2024 at 4:34 PM, Resident #1's catheter bag was observed anchored to the bed frame facing the door. Further observation revealed the catheter bag did not have a dignity covering in place. During an interview with Resident #1 on 04/03/2023 at 4:40 PM, she stated she did not know her catheter bag should be covered. She stated it was embarrassing for her to know that visitors and other residents could see her urine. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with State Registered Nurse Aide (SRNA) #3 she stated Resident #1 should have had a covering on her catheter bag, as that was a dignity issue. During an interview with SRNA #10 on 04/05/2024 at 4:31 PM, he stated catheter bags should have a dignity cover on them at all times. He stated, We do not want other people to be able to see the resident's catheter bag. During an interview with SRNA #6 on 04/05/2024 at 5:13 PM, she stated any resident with a catheter bag should have a covering on it or that could be a concern for the resident's dignity. During an interview with SRNA #11 on 04/05/2024 at 5:25 PM, she stated catheter bags should be placed in a privacy bag. She stated privacy bags were meant to provide privacy and to be discreet. During an interview with Licensed Practical Nurse (LPN) #7 on 04/05/2024 at 5:56 PM, she stated catheter bags should be covered. LPN #7 stated it was an infection control and dignity issue. During an interview with the Director of Nursing (DON) on 04/05/2024 at 7:30 PM, she stated she expected staff to always use a dignity cover on catheter bags. The DON further stated if a dignity cover was not used, it could cause a dignity issue for a resident. During an interview with the Administrator on 04/05/2024 at 8:16 PM, she stated she expected staff to ensure catheter bags had a dignity cover on at all times to prevent a dignity concern for the resident.

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47567 Based on observation, interview, record review, document review, and facility policy review, it was determined the facility failed to ensure residents' comprehensive care plans were developed and implemented for three (3) of eight (8) sampled residents assessed for elopement risk (Residents #13, #40, #52, #53). 1. The facility assessed Resident #13 to be at risk for elopement and was care planned as at risk for elopement and exhibited exit-seeking behavior. However, the resident exited the facility undetected by staff on 03/14/2024 at approximately 4:10 PM and was outside unsupervised for approximately five (5) minutes. 2. Resident #40 stated in interview she had carpal tunnel syndrome in both hands. However, review of Resident #40's care plan revealed the facility failed to develop a care plan related to pain or the potential for pain, with necessary interventions for the resident. 3. The facility failed to develop a care plan for Resident #52 for his activity preferences. 4. The facility failed to develop a care plan for Resident #53's psychotropic medication use. The facility's failure to ensure residents' care plans were developed and interventions implemented to include ensuring residents received adequate supervision and monitoring to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 03/29/2024 and was determined to exist on 03/14/2024 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F 689 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of the Immediate Jeopardy on 03/29/2024. The facility provided an acceptable Immediate Jeopardy Removal Plan on 04/05/2024 alleging removal of the IJ on 03/24/2024. An Extended Survey was initiated on 04/02/2024, and the State Survey Agency (SSA) validated the facility had removed the immediacy of the Jeopardy on 03/24/2024, as alleged. Refer to F689. The findings include: Review of the facility's policy titled, Care Plans, Comprehensive and Person-Centered, revised 03/01/2022, revealed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was to be developed and implemented for each resident. The policy also stated assessments of residents were ongoing and care plans were to be revised as information about the resident and the resident's condition changed. Further review revealed when possible, interventions should address the underlying sources of the problem areas not just the symptoms or triggers. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the facility's policy titled, Safety and Supervision of Residents, revised 07/01/2017, revealed the facility strived to make the environment as free from accident hazards as possible. Per review of the policy, the care team was to target (residents') interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Review further revealed implementing interventions to reduce accidents and hazards was to include communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions (to appropriate staff); providing training as necessary; and ensuring interventions were implemented, documented, and monitored. Review of the facility's policy titled, Wandering and Elopements, revised 03/01/2019, revealed the facility was to identify residents who were at risk of unsafe wandering and to strive to prevent harm while maintaining the least restrictive environment for residents. Further review revealed if a resident was identified as at risk for wandering, elopement, or other safety issues, the resident's care plan was to include strategies and interventions to maintain the resident's safety. Record review revealed the facility admitted Resident #13 on 04/14/2023, with diagnoses which included dementia, anxiety disorder, and Alzheimer's Disease. Review of Resident #13's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) which indicated he/she was rarely or never understood. The interview was not conducted. Review of Resident #13's Elopement Assessment Risk dated 11/17/2023, revealed the facility assessed him/her as being at risk for elopement related to the resident's ability to self-propel in a wheelchair; agitation, restlessness, impulsiveness, and having a history of elopement and wandering. Review of Resident #13's Treatment Administration Record (TAR), revealed the resident's Wanderguard bracelet was to be checked twice a day; once on day shift and once on night shift. Continued review of the TAR revealed Resident #13's Wanderguard bracelet was last checked for placement on 03/13/2024 by the dayshift nurse, and noted as in place. Review of Resident #13's Comprehensive Care Plan (CCP) revised on 02/01/2024, revealed the facility care planned the resident as at risk for elopement related to Alzheimer's Disease, dementia, psychosis, and exit-seeking behavior. Per review, the interventions included redirecting Resident #13 as appropriate if near an exit or doorways, and diverting him/her by giving alternative objects or activities. Continued review revealed the interventions also included utilizing and monitoring a security bracelet as per facility protocol. Further review revealed no documented evidence the facility care planned Resident #13 for increased supervision (even though the facility assessed the resident to be at risk for elopement on 11/17/2023). Review of the facility's investigation documentation dated 03/19/2024 revealed at approximately 4:10 PM on 03/14/2024, Resident #13 eloped from the facility through the exit door on the 400 Hall without staff's knowledge. Review further revealed Resident #13 was located outside near the exit door on the 100 Hall and brought back into the facility by two (2) staff members. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/02/2024 at 11:26 AM, LPN #3 stated she worked day shift on 03/13/2024, Resident #13 had a Wanderguard bracelet in place to his/her left ankle and to the best of her knowledge it had not came off during the time she was working her shift. She stated she checked Resident #13's Wanderguard for placement that day, which she documented. Review of Resident #13's TAR revealed LPN #3 documented the Wanderguard was in place to Resident #13's left ankle as per interview. She further stated if a resident was found not to be wearing a Wanderguard bracelet as they were care planned for, she would replace the bracelet immediately, and check it's function. In an interview on 04/03/2024 at 3:10 PM, LPN # 4 stated he worked the night of 03/13/2024 on the 400 Hall; however, he could not recall if Resident #13 had a Wanderguard bracelet in place or not. He stated he also could not recall what he documented on Resident #13's TAR that day regarding his/her Wanderguard placement. The LPN stated he was not sure who was responsible for updating a resident's care plan. LPN #4 stated he had not thought Resident #13 would elope. He further stated if he found a resident without a Wanderguard bracelet in place as per their care plan, he would immediately notify the Director of Nursing (DON) and place a new Wanderguard bracelet on the resident. In an interview on 04/05/2024 at 11:55 AM, LPN #1 stated she had not received report that Resident #13 did not have a Wanderguard bracelet on from the nightshift nurse in report on the morning of 03/14/2024. She stated when Resident #13 was found after eloping and brought back to the unit he/she was noted to not have a Wanderguard device in place as care planned. LPN #1 stated someone put a Wanderguard bracelet on Resident #13 after the elopement; however, she could not recall who that person had been. She further stated day shift checked the placement of the Wanderguard devices and she could not recall if she had checked Resident #13 for Wanderguard placement before he/she eloped that day. In an additional interview on 04/05/2024 at 5:40 PM, LPN #1 stated she had provided increased supervision of Resident #13 on 03/14/2024, because of the resident's potential risk for falls, not due to the elopement. She stated she received no education in regards to developing residents' care plans with additional interventions which might be necessary. LPN #1 stated the MDS Nurse updated residents' care plans; however, she knew how to update them in the residents' electronic medical record (EMR). In an interview on 04/05/2024 at 6:36 PM, the Assistant Director of Nursing (ADON) stated she expected staff to follow each resident's care plan and if they saw something a resident needed, all they had to do was just add the necessary interventions. The ADON further stated that was something any licensed nurse at the facility could do, as the MDS Nurse worked remotely and was only at the facility two (2) days a week. She stated Resident #13 never gave any indication she would actually elope so she had not felt the need to update the resident's care plan with interventions that included increased supervision. The ADON stated there was no reason for nightshift not to have checked the function and placement of a resident's Wanderguard bracelet unless the resident was not physically in the building. She further stated the potential for harm for a resident was that they would get out of the building if their Wanderguard bracelet was not working properly or was not in place. In an interview on 04/05/2024 at 7:30 PM, the DON stated there was no logical explanation as to why staff would not follow a resident's care plan and check the placement and function of the Wanderguard bracelet as required. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/05/2024 at 8:15 PM, the Administrator stated she expected residents' care plans to be updated and interventions followed according to the facility's policy. She further stated staff should follow residents' care plans as written and she expected the MDS Nurse to code the residents' MDS assessments correctly because that was what drives the care plans. 44370 2. Review of the Admission Record for Resident #40 revealed the facility admitted the resident on 12/15/2023, with the following diagnoses: spina bifida, carpal tunnel syndrome bilateral upper limbs, and type 2 diabetes mellitus. Review of the Admission MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS' score of fifteen (15) out of fifteen (15) indicating no cognitive impairment. Review of Resident #40's Comprehensive Care Plan revealed no documented evidence the facility developed a focus problem related to pain or the potential for pain, with necessary interventions. In an interview on 04/03/2024 at 11:21 AM, Resident #40 stated she had been at the facility since December (2023). The resident stated she had been admitted to the facility from another long term care facility. She stated she wore splints when her hands hurt. Resident #40 stated she had pain medication ordered but had not used any since being at the facility. During interview on 04/05/2024 at 7:34 PM, the DON stated she expected the MDS Nurse to catch if a baseline care plan was not initiated on admission and make the necessary changes. She stated she expected all residents to have a care plan initiated for potential for pain even if they had no current issues with pain. The DON further stated her expectation was for the MDS Nurse to complete residents' comprehensive care plans in order to prevent potential problems from occurring. 47798 3. Review of Resident #52's Admission Record revealed the facility admitted the resident on 08/21/2023, with diagnoses to include: myelodysplastic syndrome, major depressive disorder, recurrent, severe with psychotic symptoms, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly MDS Assessment, dated 02/13/2024, revealed the facility assessed Resident #52 to have a BIMS' score of a fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. Continued record review revealed no documented evidence the facility developed Resident #52's care plan to include activities or the resident's preferences. During an interview with Resident #52 on 04/03/2024 at 10:27 AM, he stated he did activities in his room most of the time. Resident #52 stated staff did not permit him to go outside and sit in the sun; however, he did not know why. He stated they did not let anyone go outside, which made him feel non-human and like he was just a piece of livestock. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with State Registered Nurse Aide (SRNA) #3 on 04/05/2024 at 4:13 PM, she stated Resident #52 had asked to go outside before; however, had been stopped from doing so by the former Administrator. She stated she had never observed Resident #52 outside the facility. During an interview on 04/05/2024 at 10:03 AM, the Activities Director (AD) stated she was responsible for developing residents' activities/preferences care plans. The AD stated she was not sure why she had not developed Resident #52's care plan to include the resident's preferences related to activities. During an interview on 04/05/2024 at 7:30 PM, the DON stated she expected Activities to follow up with residents to find out what type of activities they enjoyed and to develop the residents' activities/preferences care plan. The DON stated if a care plan was not developed, staff would not know what a resident's activity preferences were unless they asked the resident. 4. Review of the Admission Record for Resident #53 revealed the facility admitted the resident on 01/10/2024, with diagnoses to include: acute or chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), and respiratory disorders. Review of the Significant Change MDS Assessment, dated 02/13/2024, revealed the facility assessed Resident #53 to have a BIMS' score of seven (7) out of fifteen (15) indicating the resident was severely cognitively impaired. Continued record review revealed no documented evidence Resident #53's care plan was developed and initiated regarding the resident's psychotropic medications. Review of Resident #53's Physician's Orders revealed the resident was on Clonazepam (a sedative medication) 1 milligram (mg) 3 times a day. During an interview with LPN #1 on 04/05/2024 at 5:39 PM, she stated the admitting nurse should have initiated Resident #53's baseline care plan to include use of a psychotropic medication. LPN #1 further stated the purpose of a resident's care plan was for staff to know how to provide the care a resident needed. During an interview with LPN #7 on 04/05/2024 at 5:56 PM, she stated a baseline care plan was to be initiated upon admission by any nurse. LPN #7 stated she would discuss comprehensive care plans development with the DON. She stated if the care plan was not developed, staff would not know how to provide the proper care for a resident. During an interview with the Assistant Director of Nursing (ADON) on 04/05/2024 at 6:36 PM, she stated staff were expected to follow resident's care plans and if they saw that a necessary care plan was not in place, they should correct the problem. The ADON stated any licensed nurse could initiate a care plan. (continued on next page)

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	185012	A. Building B. Wing	04/05/2024

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During continued interview on 04/05/2024 at 7:30 PM, the DON (who had previously been an MDS Nurse) stated if a necessary care plan was not initiated during a resident's comprehensive assessment (MDS Assessment) she expected the MDS Nurse to catch that and make the necessary changes. The DON stated the admitting nurse was to initiate a baseline care plan for new residents and the MDS Nurse should initiate the Comprehensive Care Plan based on the MDS Assessment findings. She stated she expected the MDS Nurse to complete residents' comprehensive care plans to prevent potential problems from occurring. She stated her expectations were for her staff to follow residents' care plans and carry out the interventions because that was what the care plans were for, to provide direction of care of the resident. During an interview with the Administrator on 04/05/2024 at 8:16 PM, she stated if a care plan was not developed, staff would not know what a resident's care needs were. The Administrator stated she expected staff to develop residents' care plan based on their assessed needs.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on interview, record review and review of facility policy, the facility failed to ensure each resident had an active Advance Directive order in place for five (5) of 25 sampled residents (Residents #8, #9, #22, #28, and #61). The findings include: Review of the facility's policy titled, Advance Directives, dated 09/2022 revealed residents had the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Further review revealed Advanced Directives were to be honored by state law and facility policy. Review of the facility's policy titled, Do Not Resuscitate Order, dated 03/2021 revealed Do Not Resuscitate (DNR) orders must be signed by the resident's attending physician on the physician's order sheet and maintained in the resident's medical record. Further review revealed the DNR order form must be completed and signed by the attending Physician and the resident or the resident's legal surrogate as permitted by state law. 1. Review of Resident #8's Admission Record revealed the facility admitted the resident on 03/06/2024, with diagnoses to include chronic diastolic congestive heart failure, chronic pain syndrome, and chronic atrial fibrillation unspecified. Review of Resident #8's Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating he/she was cognitively intact. Review of Resident #8's Admission Orders dated 03/06/2024 revealed no documented evidence of an order in place indicating whether the resident was a Do Not Resuscitate (DNR) or a Full Code status. Review of Resident #8's Comprehensive Care Plan dated 03/18/2024 revealed the resident had established an advanced directive and had chosen a full code status. Review of a document titled, Advanced Directives Policy and Record, signed by Resident #8 on 03/07/2024 revealed the resident had not executed an advanced directive, even though his/her care plan noted a full code status. 2. Review of Resident #9's Admission Record revealed the facility admitted the resident on 05/03/2023, with diagnoses to include, Parkinson's Disease without dyskinesia (involuntary neurological movement disorder), Type 2 diabetes mellitus with diabetic polyneuropathy and acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissue). Review of Resident #9's Quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS score of twelve (12) out of fifteen (15) indicating he/she had moderate cognitive impairment. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's Physician's Orders dated 04/05/2024, revealed no documented evidence of a Physician's Order indicating whether the resident had a DNR or a Full Code Status. Review of Resident #9's Comprehensive Care Plan dated 05/03/2023, revealed the facility care planned the resident as a DNR. 3. Review of Resident #22's Admission record revealed the facility admitted the resident on 02/09/2017, with diagnoses to include, quadriplegia C5 to C7 complete, chronic pain syndrome and protein calorie malnutrition. Review of Resident #22's Quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15) indicating no cognitive impairment. Review of Resident #22 Physician's Orders dated 04/05/2024, revealed no documented evidence of an order in place to indicate whether the resident had a DNR or a Full Code Status. Review of Resident #22's Comprehensive Care Plan revealed on 6/19/2019, the facility developed a DNR care plan. 4. Review of Resident #28's Admission Record revealed the facility admitted the resident on 10/13/2022, with diagnoses to include, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, severe protein calorie malnutrition, and type 2 diabetes mellitus. Review of Resident #28's Quarterly MDS assessment dated [DATE] revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15) indicating he/she was cognitively intact. Review of Resident #28's Physician's Orders dated 04/05/2024, revealed no documented evidence of a Physician's Order to indicate whether the resident had a DNR or Full Code status. Review of Resident #28's Comprehensive Care Plan dated 10/25/2022, revealed the facility care planned the resident to have established an advanced directive and was a full code. 5. Review of Resident #61's Admission Record revealed the facility admitted the resident on 03/11/2024, with diagnoses to include: chronic obstructive pulmonary disease, Type 2 diabetes mellitus, and heart failure unspecified. Review of Resident #61's Admission MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS score of fourteen (14) out of fifteen (15) indicating no cognitive impairment. Review of Resident #61's Physician's Orders dated 03/15/2024, revealed no documented evidence of an order to indicate whether the resident was a DNR or Full Code Status. Review of Resident #61's Comprehensive Care Plan dated 03/20/2024, revealed the facility had care planned the resident to have established an advanced directive and was a full code. (continued on next page)

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	185012	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Nursing and Rehabilitation Center	1500 Pride Avenue Madisonville, KY 42431

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Licensed Practical Nurse (LPN) #1 on 04/05/2024 at 4:54 PM, she stated a resident's code status was noted in their electronic record and in the front of their hard chart. LPN #1 stated if a resident did not have a DNR order then they would be a full code even if the DNR had been signed by the resident. She stated a signed Physician's Order was required for a resident's code status. In an interview with LPN #7 on 04/05/2024 at 5:08 PM, she stated she could see if a resident was a DNR or Full Code on their resident profile in the computerized Point Click Care (PCC) system. She stated a resident's code status was also noted in the physical chart. LPN #7 stated a signed Physician's Order was required for a resident's code status. During an interview with the Director of Nursing (DON) on 04/05/2024 at 7:34 PM, she stated she expected Physicians to provide orders for residents' DNR or Full Code status. She stated the resident's code status should have orders entered in the PCC computerized system, and also noted on the resident's physical chart as well. The DON stated a resident's code status was to be obtained on admission. During an interview with the Administrator on 04/05/2024 at 8:16 PM, she stated she expected a resident's code status to be obtained on admission and the order entered in the resident's electronic record.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47798 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure an ongoing program of activities was developed to meet the resident's individual needs for four (4) of six (6) sampled residents (Residents #15, #38, #52, and #53). The facility failed to provide individualized activities based on residents' comprehensive assessments, care plans, and personal preferences. The findings include: Review of the facility's policy titled, Activity Programs, revised June 2018, revealed an activity program was to be designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. Continued review revealed the activities offered were to be based on the comprehensive resident-centered assessments and the preferences of each resident. 1. Review of Resident #15's Admission Record revealed the facility admitted the resident on 03/27/2023, with diagnoses to include: traumatic brain injury, major depressive disorder, anxiety disorder, and paraplegia. Review of Resident #15's Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. During an interview with Resident #15 on 04/05/2024 at 11:29 AM, she stated staff did not take the residents outside and did not even ask if they wanted to go outside. Resident #15 stated she would like to go outside if the weather was okay. She stated it bothered her so much not to be able to go outside because it got boring staying inside the facility and when it was nice weather she would like to go outside. 2. Review of Resident #38's Admission Record revealed the facility admitted the resident on 09/12/2022, with diagnoses to include: vascular dementia, with other behavioral disturbance, major depressive disorder, severe with psychotic symptoms, and generalized anxiety disorder. Review of Resident #38's Quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. During an interview with Resident #38 on 04/05/2024 at 8:30 AM, she stated staff always said they did not have time to take us outside, even though the residents would like to outside. 3. Review of Resident #52's Admission Record revealed the facility admitted the resident on 08/21/2023, with diagnoses to include: myelodysplastic syndrome, major depressive disorder, severe with psychotic symptoms, and chronic obstructive pulmonary disease (COPD). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #52's Quarterly MDS assessment dated [DATE] revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. During an interview with Resident #52 on 04/03/2024 at 10:27 AM, he stated he did activities in his room most of the time. Resident #52 stated staff did not permit him to go outside and sit in the sun and he did not know why. He stated they did not let anyone go outside, which made him feel non-human and like he was just a piece of livestock. 4. Review of Resident #53's Admission Record revealed the facility admitted the resident on 01/10/2024, with diagnoses to include: acute or chronic diastolic (congestive) heart failure, COPD, and respiratory disorders in diseases classified elsewhere. Review of the Significant Change MDS assessment dated [DATE], revealed the facility assessed Resident #53 to have a BIMS score of seven (7) out of fifteen (15) indicating the resident was severely cognitively impaired. During an interview with Family Member (FM) #5, Resident #15's FM, on 04/04/2024 at 5:38 PM, he stated the resident had complained about not getting to go outside. FM #5 stated he would like for Resident #52 to be able to go outside and thought it would be good for the resident. During an interview with Resident #53 on 04/05/2024 at 8:40 AM, she stated staff did not let her go outside. She stated it did not do any good to ask because they (staff) were too busy or would say they did not have time. Resident #53 further stated it made her feel like she was in prison when not allowed to go outside. During an interview with the Activities Director (AD) on 04/05/2024 at 10:03 AM, she stated she did take residents out occasionally if the weather was nice outside. The AD further stated the facility was waiting on the wheelchair ramps and deck to be repaired to make it easier to take residents out who were in wheelchairs or used a walker. During an interview with State Registered Nurse Aide (SRNA) #3 on 04/05/2024 at 4:13 PM, she stated the facility did not offer many activities for residents and never took the residents outside. She stated Resident #52 had asked to go outside before, but the former Administrator had stopped him from being able to go outside. SRNA #3 stated however, she did not know why the former Administrator had done that. She further stated she had never seen Resident #52 outside. During an interview with SRNA #11 on 04/05/2024 at 5:25 PM, she stated activity staff seldom took the residents outside. During an interview with Licensed Practical Nurse (LPN) #1 on 04/05/2024 at 5:39 PM, she stated activities were not being done at the facility. She stated she had never seen residents being taken outside. LPN #1 stated she did not think there was a place the residents could be taken outside safely. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 04/05/2024 at 7:30 PM, she stated she expected the facility's Activity department to be following up with residents to find out what type of activities the residents enjoyed. The DON further stated she had not been made aware of any residents complaining about not being able to go outside. During an interview with the Administrator on 04/05/2024 at 8:16 PM, she stated she had only been at the facility for three (3) weeks. She further stated she wanted the facility to have a very robust activity program where residents could go outside.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47567 Based on observation, interview, record review, and facility document and policy review, the facility failed to implement procedures that addressed and monitored the safe storage and handling of medications. Review of one (1) of two (2) medication storage refrigerator's, Refrigerator and Freezer Temperature Logs documentation revealed the facility failed to record temperatures for that refrigerator for three (3) days. The findings include: Review of the facility's policy titled, Storage and Expiration Dating of Medications and Biologicals, revised 08/07/2023, revealed the facility was to inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. Continued review revealed the facility was to ensure medications and biologicals were stored at the appropriate temperatures according to the United States Pharmacopoeia guidelines for temperature ranges. Review further revealed the facility should monitor the temperature of medication storage areas at least once a day, and the temperature of vaccines twice a day. Observation on 04/04/2024 at 10:25 AM of two (2) medication refrigerators revealed they contained various diabetes medications and different types of insulins. Review of the facility's Refrigerator and Freezer Temperature Logs revealed one Log had not been completed for the dates of 04/02/2024, 04/03/2024, and 04/04/2024. Continued review revealed the Log was dated with the incorrect month (March 2024). In an interview with Licensed Practical Nurse (LPN) #4 on 04/04/2024 at 10:30 AM, he stated he was an agency nurse and only worked at the facility as needed. He stated he was not sure what the protocol was for checking the refrigerator temperatures. In an interview with the Assistant Director of Nursing (ADON) on 04/05/2024 at 6:36 PM, she stated medications that required refrigeration were to be stored in a designated refrigerator and temperatures were to be checked by licensed staff at least once a day. She stated that task was primarily the responsibility of the nightshift nurse. However, the task could be completed on any shift. The ADON stated the medications could be ruined if the temperature was out of range and not monitored by staff. She stated there was no reason why staff were not checking the medication refrigerator temperatures as a part of their daily tasks. In an interview with the Director of Nursing (DON) on 04/05/2024 at 7:30 PM, she stated medication storage refrigerator temperatures could be checked on either shift. The DON stated medications could be negatively affected if the refrigerator temperatures were out of range. She stated she expected staff to check the temperatures daily as required. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 04/05/2024 at 8:15 PM, she stated she expected staff to monitor and record refrigerator temperatures per the facility's policy.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47567 Based on observation, interview, review of facility policy, and review of the Kentucky Food Guide 2013 Food Code guidance, the facility failed to provide food at a palatable temperature for two (2) residents (Resident #1 and Resident #52). In addition, the facility failed to ensure point of service temperatures (temps) were within acceptable levels. Observation of the 400 Hall lunch meal on 04/02/2024 revealed the hot foods were below the acceptable levels for the point of service temps. The cold food/beverages were above the acceptable levels for the point of service temps. The findings include: Review of the Kentucky Food Guide 2013 Food Code guidance revealed hot foods should be 135 degrees Fahrenheit (F) or greater and cold food/beverage products should be 41 F degrees or less. Review of the facility's policy titled, Food Preparation and Service, revised November 2022, revealed food and nutrition services employees were to prepare, distribute and serve food in a manner that complied with safe food handling practices. Continued review revealed,Danger Zone meant temperatures above 41 degrees Fahrenheit (F) and below 135 degrees (F). 1. Observation during tray line on 04/03/2024 at 11:50 AM, revealed temperature reading obtained by the cook were as follows: salisbury steak at 165 degrees F; green beans at 168 degrees F; and macaroni and tomatoes at 155 degrees F. Observation of a lunch meal test tray on 04/03/2024 at 12:53 PM, revealed the temperature readings taken by dietary staff were as follows: salsibury steak entree at 118.3 degrees F; hot coffee at 102.9 degrees F; iced tea at 62.1 degrees F; pineapple at 63.1 degrees; green beans at 110.6 degrees F; and macaroni and tomatoes at 116.2 degrees F. Observation revealed the test tray was placed on the food cart at 12:41 PM to be transported to the 400 Hall. During an interview with State Registered Nurse Aide (SRNA) #3 on 03/27/2024 at 10:34 AM, she stated when the facility was short on staff a resident was guaranteed to get a cold meal tray due to the trays being passed out late. In an interview with SRNA #6 on 04/05/2024 at 5:20 PM, she stated residents had complained to her that their meals were cold before, and when that happened she would go warm the meal in the microwave for the residents. SRNA #6 further stated a resident could potentially become sick from eating meals served cold. In an interview with Licensed Practical Nurse (LPN) #1 on 04/05/2024 at 5:40 PM, she stated she thought meals arrived hot to the unit initially. However, they would get cold because it took staff a long time to serve the residents. She further stated it took so long to serve the meal trays because staff were having to care for high acuity residents at the same time. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Dietary Manager on 04/05/2024 at 4:59 PM, she stated the point of service temperatures were off. She stated the coffee should have been 160 degrees F. In an interview with the Administrator on 04/05/2024 at 8:15 PM, she stated she was not aware of cold food complaints by residents. She stated she had tested a tray during her second week of working at the facility and the food temps had been in range at that time. She stated depending how long food was kept at the wrong temperature, residents could acquire a food-borne illness as a result. 47798 2(a). Review of Resident #1's Admission Record revealed the facility admitted the resident on 06/07/2023, with diagnoses to include: venous Insufficiency, cognitive communication deficit, and anxiety disorder, unspecified. Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #1 dated 02/15/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. During an interview with Resident #1 on 04/03/2024 at 4:23 PM, she stated her food on her meal tray was not hot when it arrived at her room. 2(b). Review of Resident #52's Admission Record revealed the facility admitted the resident on 08/21/2023, with diagnoses to include: myelodysplastic syndrome, major depressive disorder, severe with psychotic symptoms, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly MDS Assessment for Resident #52 dated 02/13/2024, revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. During an interview with Resident #52 on 04/03/2024 at 10:41 AM, he stated he was one (1) of the last residents to receive a tray and his food was always cold. During an interview with SRNA #3 on 04/05/2024 at 4:13 PM, she stated residents had complained before about food being cold during all meal times. SRNA #3 stated she would take the meal tray to the employee break room and warm it up in the microwave. She stated she had notified kitchen staff; however, it did not do any good and the kitchen did not offer to prepare another tray for the residents. SRNA #3 stated residents could get sick if they ate cold food. She further stated administration staff did not help with passing hall trays. SRNA #3 stated if the administration staff would assist with passing trays, she thought the resident's may get their food in a more timely manner and it may not be cold. During an interview with SRNA #10 on 04/05/2024 at 4:31 PM, he stated residents did sometimes complain of the food on their meal trays being cold. He stated he took the tray to the microwave and warmed it up. During an interview with LPN #1 on 04/05/2024 at 5:39 PM, she stated residents had complained of food being cold and she re-heated their food in the microwave. She further stated the kitchen was well aware of the issue. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with LPN #7 on 04/05/2024 at 5:56 PM, she stated when residents complained of their food being cold, she warmed food up for them or offered to get them a new meal tray. She stated if food was not served at the correct temperature, it could make the resident have stomach issues, diarrhea, or even food poisoning. LPN #7 further stated she made the kitchen aware of the cold food and had them fix a new tray. During an interview with the Dietary Manager on 04/05/2024 at 4:59 PM, she stated some residents had voiced concerns about food being cold. The Dietary Manager stated she had noticed some of the hall cart doors were not being closed between tray removal and she had provided education to staff to ensure they were closing the doors. The Dietary Manager stated if a resident complained about cold food, the kitchen staff should warm their tray, prepare a new tray, or fix the resident something else. The Dietary Manager stated if a resident ate something in the danger zone temperature range, they could become really sick or get food poisoning. In an interview with the Dietary Manager on 04/05/2024 at 4:59 PM, she stated she had talked to the DON about reminding staff to serve residents their meals as soon as possible when the meal carts arrived on the units. She stated she had educated dietary and nursing staff on keeping the meal cart doors closed and not to let the trays sit on the cart for extended periods of time before they were served. She further stated a resident could contract food poisoning if they ate cold food especially if the temperatures were in the danger zone. During an interview with the Assistant Director of Nursing (ADON) on 04/05/2024 at 6:36 PM, she stated she was not aware of any complaints about residents receiving cold food. The ADON stated she expected residents to only be served cold food if it was supposed to be cold and for residents to receive their trays timely and their food to be hot. During an interview with the DON on 04/05/2024 at 7:30 PM, she stated if a resident complained of cold food on their meal tray, she would make sure it was warmed up. The DON stated she had not received any complaints about cold food from residents; however, she had only worked at the facility for six (6) weeks. During an interview with the Administrator on 04/05/2024 at 8:16 PM, she stated she had not been made aware of any resident complaints related to food not being at the appropriative temperatures. She stated she expected dietary to continue to test trays to ensure the temperatures were appropriate. The Administrator stated depending on how long food was kept at the wrong temperature, bacteria could build up and a resident could contract a food-borne illness.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 44370 Based on interview, and facility's policy review, Resident Matrix, and staff personnel files review, the facility failed to provide at least twelve (12) hours of required in-service training for nurse aides including dementia management training and resident abuse prevention training for 5 of 5 State Registered Nurse Aides (SRNA). (SRNA's #4, #9, #10, #12 and #13). This had the potential to affect the facility's fifty-eight (58) residents. The findings include: Review of the facility's policy titled, Staffing, Sufficient and Competent Nursing, dated 08/2022, revealed the facility was to provide a sufficient number of nursing staff. Continued review revealed the nursing staff were to have appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility's assessment. Per policy review, Competency was a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needed to perform work, roles, or occupational functions successfully. Further review revealed all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements as defined by state law. Review of the Facility Assessment Tool dated 03/01/2024, Staff training, Education and Competencies revealed, the section had been left blank and had no information related to how the facility would educate or train staff. Review of the facility's Resident Matrix completed on 04/03/2024, revealed the facility's census was 58. Continued review revealed 28 of the 58 residents had a diagnosis of Alzheimer's or dementia. Review of personnel files revealed: State Registered Nurse Aide (SRNA) #4 had a date of hire of 02/14/2024; SRNA #9 had a hire date of 03/29/2024; SRNA #10 had a hire date of 08/27/2019; SRNA #12 had a hire date of 02/15/2024; and SRNA #13 had a hire date of 11/21/2023. However, further review of the personnel files for the SRNA's revealed no documented evidence competency checks had been completed as per the facility policy. In an interview with SRNA #8 on 04/04/2024 at 4:08 PM, she stated she had been a SRNA for five (5) years and was a new employee at the facility. She stated it was her first day working on the floor. SRNA #8 stated she had watched some videos and completed a post test. She stated when she took the post test the answer key was provided with it. During an interview with SRNA #10 on 04/05/2024 at 4:33 PM, he stated he thought he had completed inservice education in the last year. He stated the former company (owners) used an online service for education and that most of the inservices and education had been completed on that site. The SRNA further stated he could not recall the last time he completed any competency checks. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with SRNA #11 on 04/05/2024 at 5:24 PM, she stated she had been at the facility for two (2) years. She stated she completed education on hire as well as competency checks. However, she had not completed any since that time. SRNA #11 further stated the facility had random in-services a lot. In an interview with the Director of Nursing (DON) on 04/05/2024 at 7:34 PM, she stated she had been at the facility for about six weeks. She stated the facility was trying to obtain records. She stated she was aware SRNA's required twelve hours but was unsure if the facility had conducted annual in-service training. In an interview with the Administrator on 04/03/2024 at 3:18 PM, she stated the facility had recently changed ownership and the previous owners came in and packed everything up. She stated the facility's Regional [NAME] President of Operations was working on obtaining records and getting access to Vital Learn (an online education portal). During an additional interview with the Administrator on 04/05/2024 at 8:16 PM, she stated she was new to the facility; however, her expectation was that all staff would receive the required information and training required during their orientation period. She stated competency checks should be completed for nursing staff. The Administrator further stated the facility was in process of obtaining in-service and education records from the previous owners.