STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. Building B. Wing	03/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Nursing and Rehabilitation	1705 Stevens Avenue Louisville, KY 40205

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45914 Based on observation, interview, record review, and review of facility policies, the facility failed to ensure residents were: informed of their rights to conduct resident council meetings without staff present; and that visitors and/or other guests might attend resident council meetings only at the respective group's invitation. The facility failed to address and follow-up with Resident Council grievances, and further communicate the results to residents for seven (7) out of eight (8) sampled residents attending Resident Council meetings (Residents #5, #49, #55, #71, #101, #119, and #128). The findings include: Review of the facility's policy titled, Resident Council Meetings, undated, revealed the facility supported the rights of residents to organize and participate in resident groups. Per policy review, the meeting minutes were to include issues discussed and recommendations from the group. Further review revealed the facility was to act upon concerns and recommendations of the Resident Council by making attempts to accommodate recommendations to the extent practicable, and to communicate the decisions to the Council. Review of the facility's policy titled, Resident and Family Grievances, undated, revealed the facility was to make Prompt Efforts to Resolve resident grievances as defined by the facility's acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance. Further review revealed the Grievance Official or appointed staff member was to keep residents appropriately apprised of progress towards the resolution of the grievances. Review of the facility's policy titled, Resident Rights, undated, revealed the facility was to inform residents both orally and in writing, in a language the residents understood, of his or her rights, and all rules and regulations during their stay in the facility. Further review revealed residents had a right to voice grievances and the facility must make prompt efforts to resolve residents' grievances. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the Resident Council meeting, on 03/20/2024 at 2:30 PM, revealed eight (8) residents in attendance as well as a volunteer Ombudsman. Continued observation revealed Resident #101 called the meeting to order. During the Resident Council meeting, seven (7) out of eight (8) residents (Residents #5, #49, #55, #71, #101, #119, and #128) stated the facility had not made them aware of their right to hold meetings without staff present. Six (6) out of the eight (8) residents (Resident #5, #55, #71, #101, #119, and #128) stated during the interview that their grievances were not addressed and/or resolved; and, staff had not communicated the status or the outcome of their concerns with them. The residents stated they were confident that the Resident Council President had taken their grievances and concerns to the facility's administrative staff on their behalf. In an interview on 03/20/2024 at 2:45 PM, Resident #101 stated he/she had informed residents where they could obtain a copy of the resident's rights. However, he/she stated as Council President he/she had not known about conducting meetings without facility staff present. Resident #101 stated he/she had taken residents' grievances and concerns to the facility's administrative staff, but he/she had not received a response or resolution to those concerns. (a). Record review revealed the facility admitted Resident #5 on 03/24/2023. Review of Resident #5'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 twelve (12) out of fifteen (15) indicating no cognitive impairment. (b). Record review revealed the facility admitted Resident #49 on 06/21/2021. Review of Resident #49's Annual 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. (c). Record review revealed the facility admitted Resident #55 on 01/17/2020. Review of Resident #55'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. (d). Record review revealed the facility admitted Resident #71 on 08/05/2022 Review of Resident #71's Significant Change in Status (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. (e). Record review revealed the facility admitted Resident #101 on 08/29/2021. Review of Resident #101'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. (f). Record review revealed the facility admitted Resident #119 on 05/12/2023. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #119'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. (g). Record review revealed the facility admitted Resident #128 on 05/11/2023. Review of Resident #128's Quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS' score of eight (8) out of fifteen (15) indicating moderate cognitive impairment. In interview on 03/22/2024 at 11:40 AM, the Activities Director (AD) stated he did not recall if residents were aware of their right to meet in Resident Council meetings without facility staff being present. He stated they had previously been informed of their rights to invite staff and others to their council meetings though. He stated grievances discussed in Resident Council meetings were generally provided to the Social Services Director (SSD) to be logged, but if he had been aware of the concerns they would have been discussed in the Interdisciplinary Team (IDT) meetings. In continued interview on 03/22/2024 at 11:40 AM, the AD stated if he was notified of the resolution of residents' grievances he would notify the residents of the results. He stated whatever the residents' concerns were related to, determined the department or staff member who would be responsible for addressing the concern(s). Per the AD's interview, the department/staff member who addressed residents' concerns, would follow-up with the residents with any updates or resolution regarding their concern. He stated there was a Resident Council response form the facility had adapted, but had not utilized appropriately. The AD stated that form was to be implemented moving forward to assure residents' concerns were addressed by the correct department and/or staff member and a resolution was documented and signed off on. He further stated it was disheartening to learn residents had complained about unresolved concerns, lack of communication, and the direct care provided in the facility. In addition, the AD stated if residents were not informed of their rights, then they had no knowledge of how to exercise those rights which was potentially a violation of their rights. In an interview with the SSD on 03/22/2024 at 12:10 PM, she stated her expectations for resident grievances was for whoever was told of the concern would complete the facility's process and update the resident on the outcome. She stated she had not been invited to Resident Council meetings. During the interview, she stated a grievance form was to be completed depending on what the resident's concern was, and she determined if the concern could be resolved immediately. The SSD stated the facility's protocol was for staff who had resolved the resident's concern, to notify the resident of any updates or ensure resolution of a concern was communicated to the resident. She stated any staff member who resolved an issue for a resident, but did not want to make the notification to the resident, could ask her to contact the resident and she would update them. The SSD stated if residents believed they were not being communicated with regarding their concerns, or felt they were not notified about resolutions of their concerns, then the facility needed to make improvements to the grievance process to ensure residents were satisfied. Per interview, the SSD stated she ensured any resident concerns reported to her were addressed and followed-up on. She stated her expectation if a resident's concern was reported, was the staff should follow-up on that concern and notify the resident of the results, or ask someone else to do it. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview with the Director of Nursing Services (DNS) on 03/22/2024 at 5:40 PM, she stated she was uncertain about whether the right to choose to have no facility staff present during their Resident Council meetings was something the residents had been made aware of. She stated however, residents' rights were posted. The DNS stated the Resident Council grievance process occurred when their concerns were provided to the AD and then shared in the IDT meetings for discussion. She stated those resident concerns were divvied out to the relevant department during the IDT meetings in order for an investigation to be completed. The DNS stated all resident grievances were logged by the SSD. Per the DNS, during the investigation process, updates were to be made to the residents on the progress and/or resolution of the grievance as soon as possible. She stated the goal was to have a resolution to a grievance within five (5) days. The DNS stated the staff or department who received the resident(s') concern and investigated it, would generally be the person(s) to find the resolution. She further stated her expectations for the SSD and administrative staff, IDT members regarding grievances was for them to investigate the concern once identified and ensure resolution. In addition, the DNS stated family, residents or both were to be notified once a resolution was found for the grievance, or for them to at least be updated on the progress of the investigation to appropriate communication occurred. In an interview with the Executive Director (ED) on 03/22/2024 at 5:50 PM, he stated residents had been aware of their right to invite staff and/or others to their Resident Council meetings. He stated he recalled discussing the residents' freedom of choice to have no staff in their Council meetings in general conversation when discussing a resident's requests. He stated grievances were discussed with the IDT members and the concerns were given to the appropriate department or person, in order to find a resolution tailored to the resident's needs or desired outcomes within reason. The ED stated expectations for all facility staff was for all of them to work together to determine how to make things right for the residents and ensure their concerns were addressed immediately. He further stated expectations also included staff to find a resolution and communicate the finding to the residents involved. Additionally, he stated he believed by personalizing resident's needs and requests, the facility could create a safe and homelike environment for all residents.

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31383 Based on interview, record review and review of the facility's policy, the facility failed to develop a baseline care plan for one (1) of three (3) residents sampled related to elopement (Resident #642). Upon admission, the facility assessed Resident #642 as a high risk for wandering/elopement. However, the facility failed to care plan the resident for his/her high risk for wandering/elopement. Resident #642 exited through the front door and left the faciity on [DATE]. Resident #642 returned to his/her home located eighty-five (85) miles away. Resident #642 did not return to the facility. Immediate Jeopardy (IJ) was identified on 03/12/2024 and was determined to exist on 01/07/2023 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F 655; and 42 CFR 483.25 Quality of Care, F689 at a Scope and Severity (S/S) of an J. The facility was notified of the the Immediate Jeopardy on 03/15/2024. The facility provided an acceptable Immediate Jeopardy Removal Plan on 03/23/2024, alleging abatement of the IJ as past non-compliance on 01/13/2023. An Extended Survey was initiated on 03/22/2024. The SSA (State Survey Agency) validated abatement of the IJ on 03/23/2024 as past non-compliance as alleged on 01/13/2023. The findings include: Review of the facility's policy titled Baseline Care Plan, copyrighted 2023, revealed the facility was to develop and implement a baseline care plan for each resident that met professional standards of quality care. Per policy review, interventions were to be initiated that addressed a resident's current needs to include any health and safety concerns to prevent elopement, decline, or injury in a resident. Further review revealed the interventions were also to address any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. Review revealed once (the baseline care plan was) established, goals and interventions were to be documented in the designated format. Review of the facility's policy titled, Elopements and Wandering Residents, copyrighted 2023, revealed the facility was to ensure residents who exhibited the behavior of wandering and/or were at risk for elopement received adequate supervision to prevent accidents. Continued review revealed the facility was to ensure residents received care in accordance with their person-centered plan of care that addressed the unique factors contributing to the resident's wandering or elopement risk. Per policy review, the facility was equipped with door locks/alarms to help avoid resident elopements. Further review revealed the facility was to establish and utilize a systematic approach to monitor and manage residents at risk for elopement or unsafe wandering. The review revealed the facility's systematic approach was to include identification and assessment of a resident's risk; evaluation and analysis of hazards and risks; implementing interventions to reduce hazards and risks; and monitoring for effectiveness and modifying interventions when necessary. (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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed the facility admitted Resident #642 on 01/05/2023, with diagnoses which included alcohol psychosis dementia, vascular dementia with behaviors, major depressive disorder, and agitation. Continued review revealed the facility assessed Resident #642 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), which indicated the resident was cognitively intact. Further record review revealed facility staff noted Resident #642 refused to wear a Code Alert/Wanderguard device on admission. Review of the Wandering/Elopement Risk Scale dated 01/05/2023 at 9:34 PM, completed for Resident #642, revealed the facility assessed the resident with a score of fourteen (14), which indicated he/she was at high risk to wander. Record review revealed Resident #642 exited through the front door and left the faciity on [DATE]. Resident #642 returned to his/her home located eighty-five (85) miles away. Resident #642 did not return to the facility. Review of the Baseline Care Plan dated 01/06/2023, revealed the facility developed a care plan for Resident #642 to reside on a secured memory care unit due to his/her diagnosis of vascular dementia and for the benefits of specialized programming on that type of unit. Per review, the interventions included keeping Resident #642 involved in activities and/or socialization to divert behaviors; daily activity programming; encouraging the family to bring in photos and items to cue and alert the resident of past roles and lifestyle; and providing an activity calendar with reminders of daily events. However, further review revealed no documented evidence the facility addressed the Wandering/Elopement Risk Scale completed for Resident #642 which identified him/her as a high risk for wandering. Review of Resident #642 Progress Note, dated 01/06/2023 at 3:25 PM, revealed documentation noting the resident was refusing to let staff place a Wanderguard device on him/her for safety. However, further review of Resident #642's Baseline Care Plan revealed no documented evidence of interventions to be implemented regarding the level of supervision the resident required after he/she refused to have a Code Alert/Wanderguard bracelet applied on that date. Review of Resident #642's Kardex, which was utilized by the State Registered Nurse Aides (SRNAs) as a care plan tool to guide the resident's care revealed no documented evidence of interventions placed regarding strategies for SRNAs to use to prevent elopement of the resident. In interview with the Minimum Data Set (MDS) Nurse on 03/17/2024 at 10:36 AM, she stated she had not met Resident #642 and had not completed the Baseline Care Plan for the resident. She stated the admission nurse had initiated Resident #642's Baseline Care Plan, as the resident was admitted on [DATE] at 9:34 PM. However, the MDS Nurse stated she had reviewed Resident #642's Baseline Care Plan, and had not increased the resident's supervision. Telephonic (phone) attempts were made to reach Resident #642's admission nurse on 03/17/2024 at 11:47 AM and 11:51 AM, and on 03/18/2024 at 8:43 AM. However, all attempts were unsuccessful, with no way to leave a voicemail. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Registered Nurse (RN) #4 on 03/14/2024 at 4:07 PM, she stated Resident #642 had resided on the facility's Memory Care Unit. The RN stated she had received report of Resident #642 being a new resident, and that he/she refused to have a Wanderguard placed. She stated Resident #642 stated he/she did not need to be in the facility, and kept saying he/she wanted to leave. In further interview, RN #4 stated Resident #642's supervision was not increased after he/she refused the Wanderguard (device). In an interview with the DNS on 03/17/2024 at 12:29 PM, she stated a staff member called her on 01/07/2023 at dinner time which was around 5:00 PM. She stated the staff member told her Resident #642 was not located on the unit or in the facility, and staff had found the resident's bed covers lumped up. The DNS stated she contacted the ED (Executive Director), and all the department heads and managers were called in to help search for Resident #642, inside and outside the facility. She stated Resident #642 was admitted to the facility from a sister facility because it had been determined the resident needed to be in a secured building. Per the DNS, she was not notified when Resident #642 refused to have a Code Alert/Wanderguard device placed after his/her admission to the facility. She stated her expectation was for staff to implement another intervention to be initiated after Resident #642 refused to wear the (Code Alert/Wanderguard) bracelet. The DNS stated Resident #642's supervision had not been increased. She stated a resident's Baseline Care Plan was to be developed with necessary interventions to keep the resident safe. In interview with the current ED on 03/23/2024 at 1:19 PM, he stated it was his expectation for staff to be vigilant in making sure resident care was provided according to the facility's policy. He stated he expected staff to take the best possible care of all facility residents.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31383 Based on observation, interview, record review, review of facility policy, and Internet Google Maps, the facility failed to ensure all residents were in a safe and supervised environment to prevent elopement for one (1) of three (3) residents sampled for elopement (Resident #642). The facility admitted Resident #642 on 01/05/2023 and he/she eloped from the facility on 01/07/2023 and did not return. The resident exited out the facility's front door when the receptionist, not knowing he/she was a resident, opened the door to let him/her out. Resident #642 was located 85 miles away from the facility. The facility failed to increase the resident's supervision to promote his/her safety, after learning the resident was at high risk for elopement. The facility's failure to ensure its policies were implemented related to elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 03/12/2024, and was determined to exist on 01/07/2023 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F 655; and 42 CFR 483.25 Quality of Care, F689 at a Scope and Severity (S/S) of an J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of the the Immediate Jeopardy on 03/15/2024. The facility provided an acceptable Immediate Jeopardy Removal Plan on 03/23/2024, alleging removal of the immediate jeopardy on 01/13/2023. An Extended Survey was initiated on 03/22/2024, and the SSA validated the facility's IJ Removal Plan on 03/23/2024, and determined the immediate jeopardy had been removed and the deficient practice was corrected as alleged on 01/13/2023, prior to initiation of the investigation. Therefore, the IJ was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy titled, Elopements and Wandering Residents. copyright 2023, revealed the facility would ensure residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to their risk. Continued review revealed elopement was when a resident left the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Per policy review, the facility was equipped with door locks/alarms to help avoid resident elopements. Review of the policy revealed adequate supervision was to be provided to help prevent accidents or elopements of residents, and the charge nurses and unit managers were to monitor the implementation (of residents') interventions, their response to the interventions, and document that information accordingly. Further review revealed the facility was to establish and utilize a systematic approach to monitor and manage residents at risk for elopement or unsafe wandering. Record review revealed the facility's systematic approach was to include identification and assessment of a resident's risk; evaluation and analysis of hazards and risks; implementing interventions to reduce hazards and risks; and monitoring for effectiveness and modifying intervention when necessary. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Elopement (Risk and Missing Resident), dated October 2019, revealed the Care Team Members who had residents under their care were responsible for knowing the location of those residents at all times. Further review revealed in the case of a missing resident, the Care Team Members were to ensure appropriate action was taken. Record review revealed the facility admitted Resident #642 on 01/05/2023, with diagnoses which included vascular dementia with behaviors, major depressive disorder, agitation, and alcohol psychosis dementia. Continued record review revealed the facility assessed Resident #642 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14), which indicated he/she was cognitively intact. Further review of the record revealed it was noted the resident refused a Code Alert/Wanderguard (devices alerting staff when residents were near exit doors) on admission. Review of the facility's document titled, Wandering/Elopement Risk Scale, for Resident #642, dated 01/05/2023 at 9:34 PM, revealed the facility assessed the resident as a high risk for elopement with a score of fourteen (14). Further review of the document revealed the scoring key for the document was noted as: 0-8 as a low risk for elopement; 9-10 as at risk for elopement; and 11 and above as a high risk for elopement. Review of the Progress Note dated 01/06/2023 at 3:25 PM, revealed Resident #642 refused to let staff place a Wanderguard device on him/her for safety. Review of Resident #642's Care Plan dated 01/06/2023, revealed the facility developed a care plan for the resident to reside on a secured memory care unit due to his/her diagnosis of vascular dementia, and for the benefits of the specialized programming. However, further review revealed no documented evidence of interventions specific to Resident #642's high risk for elopement. Record review revealed Resident #642 exited through the front door and left the faciity on [DATE]. Resident #642 returned to his/her home located eighty-five (85) miles away. Resident #642 did not return to the facility. Review of the facility's investigation dated 01/07/2023, and reported by the facility's former Executive Director (ED), revealed the summary of the investigation noted Resident #642 was (located) at his/her home after leaving the facility, and the police performed a wellness visit with him/her. Per review, Resident #642 told police he/she was fine. Continued review revealed Adult Protective Services (APS) was to be notified to follow up. Review of the Internet weather history for 01/07/2023 for the facility's location revealed the day temperature was 48 degrees Fahrenheit (F) and the night temperature was 37 degrees Fahrenheit. Review of the Internet Google Maps application revealed Resident #642's home was located eighty-five (85) miles from the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with Resident #642's daughter on 03/13/2024 at 3:52 PM, she stated she had not been made aware of the incident until 7:00 PM on 01/07/2023. She stated Resident #642 should not have been allowed to leave because he/she had a state guardian. The daughter stated she found out that a truck driver had picked Resident #642 up from the side of the road after he/she left the facility, and took the resident to his/her home. Resident #642's daughter stated after the resident got home, he/she started a fire in his/her home. She stated Resident #642 was taken to an acute care facility, where he/she was admitted for smoke inhalation from the fire. In addition, she stated Resident #642 was admitted to another long-term care facility. In an interview with Resident #642's State Guardian on 03/13/2024 at 9:45 AM, he stated he had not given permission for the resident to leave the facility. During an interview with State Registered Nurse Aide (SRNA) #4 on 03/14/2024 at 3:55 PM, she stated Resident #642 had not wanted to be at the facility and told staff he/she did not want to be there. SRNA #4 stated the resident appeared angry all the time while at the facility. She further stated she heard that Resident #642 left the facility Against Medical Advice (AMA) and went back to his/her home. In addition, SRNA #4 stated the process at the time was to have the wandering binders at each nurse's station as well as at the front receptionist desk for staff to refer to regarding residents at risk for wandering or elopement. In an interview with Registered Nurse (RN) #4 on 03/14/2024 at 4:07 PM, she stated Resident #642 had resided on the facility's Memory Care Unit. RN #4 stated it was reported to her that Resident #642 had been a new patient and had refused to wear a Wanderguard alarm. She stated Resident #642 said he/she did not need to be there at the facility. Per RN #4, Resident #642 kept saying he/she wanted to leave the facility and had moved his/her bed against the wall so it would be less visible from the doorway. The RN stated Resident #642 had been oriented and therefore, she had not increased supervision of the resident. She stated around 1:00 PM (on 01/07/2023), staff noticed the resident was not in bed; however, his/her covers had been piled up on the bed to appear as if someone was lying there asleep. According to RN #4, they discovered Resident #642 was not in the facility at 1:00 PM. She further stated the resident exited the facility when a family was leaving. RN #4 stated there had been Elopement binders at the nurse's station and receptionist's desk for staff to refer to for residents at risk for elopement. In an interview on 03/14/2024 at 3:39 PM, Receptionist #1 stated she was the person responsible for opening the door that allowed Resident #642 to exit the facility some time between 12:00 PM to 3:00 PM on 01/07/2023. She stated she had let Resident #642 out the door because she did not know he/she was a resident. Receptionist #1 stated Resident #642 was not wearing any type of a code alert bracelet. She stated she found out the person she let out the door was Resident #642 when the Director of Nursing Services (DNS) came to her desk about an hour later, and showed her a picture of the resident. Receptionist #1 further stated she told the DNS she had seen the person and opened the door to let him/her out. She stated there had been a wandering notebook at the receptionist desk at the time she let Resident #642 out the door; however, she had not referred to it. The Receptionist stated she was not supposed to allow people to leave without checking the wandering notebook. Review of the facility's list of residents who were at risk for elopement revealed thirty-five (35) residents' names noted as at risk. (continued on next page)

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	185039	A. Building B. Wing	03/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Nursing and Rehabilitation	1705 Stevens Avenue Louisville, KY 40205

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DNS on 03/17/2024 at 12:29 PM, she stated she received a call from a staff member on 01/07/2023, at dinner time which was around 5:00 PM. She stated the staff member told her Resident #642 was not located on his/her unit or in the facility, and staff had found the resident's bed covers lumped up. The DNS stated she then contacted the Executive Director (ED), and all of the department heads and managers were called in to help search for Resident #642. The DNS stated they searched inside and outside the facility, and also searched in the community, in homeless shelters, and bars for one (1) to two (2) hours. She said the former ED contacted the police; however, she could not recall if the police came to the facility or not, and there was no copy of the police report available. The DNS stated Resident #642 had been admitted to their facility from a sister facility because the resident needed to be in a secured building. She said she was not notified when Resident #642 refused to have a Code Alert/Wanderguard bracelet placed on him/her. The DNS further stated her expectation was for another intervention to be initiated after the resident refused to wear a Code Alert/Wanderguard bracelet. She additionally stated wandering binders were located at all the nurse's stations and the front reception desk for staff to have as a reference for residents at risk for wandering. In interview with the ED on 03/23/2024 at 1:19 PM, he stated it was his expectation staff were vigilant in making sure residents were provided care according to the facility's policy and ensured the best care possible was provided for them. In interview on 03/13/2024 at 3:25 PM, the former ED stated there had been an investigation completed. She stated Resident #642 ended up (being found) in his/her hometown which was eighty-seven (87) miles away from the facility. She said Resident #642 had a high Brief Interview for Mental Status (BIMS) score (and therefore had been cognitively intact). She stated she had called the police who did a wellness check of the resident with no problems noted; however, they would not do anything because the resident was alert and could make his/her own decisions. The former ED stated she was not aware Resident #642 had a state guardian, and then stated she had tried to call the state guardian several times with no success. She also stated Resident #642 clearly planned to leave the facility, and had even left his/her phone in his/her room on purpose so he/she could not be tracked. In an interview with the facility's Medical Director on 03/20/2024 at 3:15 PM, he stated he was notified of Resident #642's elopement after it happened and had participated in the facility's Quality Assurance Performance Improvement (QAPI) meetings. He stated it was important for staff to have meetings to receive education on residents at risk for elopements, and felt staff needed to be re-educated after the elopement. The Medical Director stated he was very involved in the life of the facility, and thought the exit door keypad codes should be changed and not shared with residents or others.

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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. 46651 Based on observation, interview, review of the facility's policy, and review of the manufacturer's drug package insert, the facility failed to ensure all drugs and biological agents were properly labeled and stored in accordance with current accepted professional principles. Observation of the Unit 1B storage room revealed one (1) vial of Tuberculin (TB) Purified Protein Derivative five (5) milliliters (ml) with an open date of 02/12/2024 that had not been discarded after thirty (30) days per facility policy. Additionally, a pink jacket and pink polka dotted bag were observed on the counter on top of the pharmacy medication return tote. The findings include: Review of the facility's policy titled Storage of Medications, revised 08/2020 revealed medications and biologicals were stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier. Review of the policy under the Procedures/General Guidance section, item eight (8) revealed outdated medications were immediately removed from inventory, disposed of according to procedures for medication disposal and re-ordered from the pharmacy if a current order existed. Review of item nine (9) revealed medication storage areas were kept clean, well-lit and free of clutter. Review of the policy under the Expiration Dating (beyond-use dating) section, item 5a revealed the nurse shall place a date opened sticker on the medication and record the date opened and the date of expiration. The expiration date of the vial or container would be thirty (30) days from the opening date unless the manufacturer recommended another date or regulations/guidelines required different dating. Review of the manufacturer's package insert for Tuberculin Purified Protein Derivative (PPD) dated 10/2021 from Sanofi Pasteur, Incorporated under the storage section revealed an opened vial of PPD which had been entered and in use for thirty (30) days should be discarded. Observation on 03/21/2024 at 9:10 AM during the inspection of Medication Room Unit 1B with Registered Nurse #7 (RN #7)/Unit Manager (UM) revealed one (1) vial of Tuberculin Purified Protein Derivative (PPD) five (5) milliliters (ml) had been opened on 02/12/2024. Additionally, a pink jacket and pink polka dotted bag were observed on the counter on top of the pharmacy medication return tote. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN #7/UM she stated she did not know how long the opened vial of PPD could be used before being discarded but she could ask someone and find out. She also stated the nurses were responsible for the inventory of the medication room and the removal of expired or discontinued medications, but it was never done. RN #7/UM stated the pink jacket and pink polka dotted bag should not have been in the medication room. RN #7 asked Licensed Practical Nurse (LPN) #1 if the items belonged to her. LPN #1 stated they did and she knew they did not belong there. During an interview on 03/21/2024 at 10:25 AM with Registered Nurse (RN) #2/Unit Manager (UM) she stated she did her own medication room and cart audits, usually every Monday, She stated she pulled all discontinued and expired medications and placed them in a tote for return to pharmacy. RN #2/UM stated pharmacy made deliveries to the facility two to three times a day but the drivers preferred to take expired or discontinued medications back on nights when their vehicles were not as full of medications. She stated pharmacy also performed random cart and med room audits for expired medications but she could not say how often. RN #2/UM stated it was the responsibility of nursing to monitor the carts for expired and discontinued medications and remove them. During an interview on 03/22/2024 at 9:50 AM with the Director of Nursing Serviced (DNS) she stated the unit managers were responsible for doing a weekly medication room and medication cart audit. She stated expired medications and medications left from discharged residents were placed in the return to pharmacy tote to be taken back to the pharmacy. The DNS also stated the medication storage room was for medication storage only and personal items should not be kept in the medication room. During an interview on 03/22/2024 at 10:10 AM with the Executive Director (ED) he stated medication storage areas were for medication storage only not for personal items. He stated he deferred to his DNS for the maintenance of the medication rooms and the removal of expired medications and of course he expected for the medication rooms to be for medications only and free of expired medicines.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46651 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure the call system was accessible to residents while in their bed, chair or other sleeping accommodations for two (2) of seventy-five (75) sampled residents (Resident #22 and Resident #76). Observation on 03/21/2024 revealed Resident #22's and Resident #76's call lights were attached to the wall behind the head of their beds, out of their reach. The findings include: Review of the facility's policy titled, Call Lights: Accessibility and Timely Response, undated, revealed the purpose of the policy was to assure the facility was adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights would directly relay to a staff member or centralized location to ensure appropriate response. Review of the Policy Explanation and Compliance Guidelines, revealed staff would ensure the call light was within reach of the resident and secured as needed. 1. Review of the clinical record revealed the facility admitted Resident #22 on 03/30/2023. The resident's diagnoses included cerebral infarction, tracheostomy, vascular dementia, anticoagulant therapy, thrombocytopenia, gastrostomy tube (G- tube), epilepsy, malnutrition and hepatomegaly and chronic thrombosis. Review of Resident #22's Minimum Data Set (MDS) Admission Assessment, dated 04/04/2023 revealed a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15) which indicated moderate cognitive impairment. Observation on 03/21/2024 at 9:40 AM revealed Resident #22 lying in his/her bed with his/her eyes closed. Further observation revealed Resident #22's call light was attached to the wall behind the head of the bed, out of the resident's reach. During an interview on 03/21/2022 at 3:00 PM with Resident #22 it was discovered Resident #22 was non-verbal but could indicate yes or no by nodding his/her head. Resident #22 utilized a communication board for indicating his/her basic needs or spelling out sentences. 2. Record review revealed the facility admitted Resident #76 on 09/17/2019 with diagnoses of Alzheimer's, adult failure to thrive, need for assist with personal care and psychotic disorder with hallucinations. Review of Resident #76's MDS Significant Change of Condition assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) which indicated severe cognitive impairment. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/21/2024 at 9:40 AM revealed Resident #76 was sitting up beside the bed in a high back wheelchair with the over the bed table in front of him/her. Resident #76 was observed to be eating breakfast. Resident #76's call light was attached to the wall behind the head of the bed, out of the resident's reach. During an interview on 03/21/2024 at 9:40 AM with Resident #76 when asked how would you get staff in the room to help you if you needed it, Resident #76 stated, I don't know, it's my first day here. During an interview on 03/21/2024 at 9:42 AM with State Registered Nurse Aide (SRNA) #6 she stated it was important for the resident to have a call light in reach for safety and so he/she could get staff help if he/she needed it. During an interview on 03/21/2024 at 9:43 AM, Licensed Practical Nurse (LPN) #1 stated it was important for all residents to have access to their call light for safety. During an interview on 03/22/2024 at 9:50 AM with the Director of Nursing Services (DNS) she stated it was important for call lights to be within reach of all residents while in bed or in a chair so the residents would have their needs met and able to alert staff if they needed help. The DNS stated call bells assessments were completed for residents on admission and if their needs changed. Lastly, the DNS stated all staff were trained on call light use and the importance of answering the call lights timely. During an interview on 03/22/2024 at 10:10 AM with the Executive Director (ED) he stated his expectation for the call lights was staff placed them near the resident at all times so the resident could communicate with staff when they needed anything. He stated all staff were trained on call light use, placement and the importance of the call lights being answered timely.