STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185042	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grandview Nursing and Rehabilitation Facility	640 Water Tower Bypass Campbellsville, KY 42719

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42192 Based on interview, record review, and facility document and policy review, the facility failed to protect 1 (Resident #286) of 7 residents reviewed for abuse from resident-to-resident abuse. Specifically, the facility failed to protect Resident #286's right to be free from physical abuse perpetrated by Resident #284 on 08/19/2023. Findings included: The facility's Resident Protection Plan, dated 09/15/2022, included a policy titled, Reporting Abuse to Facility Management that indicated, It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. An Admission Record revealed the facility admitted Resident #284 on 02/17/2023. According to the Admission Record, the resident had a medical history that included diagnoses of moderate dementia with anxiety, need for assistance with personal care, depression, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/09/2023, revealed Resident #284 had a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident had severe cognitive impairment. According to the MDS, the resident had no physical, verbal, or other behavioral symptoms directed towards others and wandered one to three days during the assessment look-back period. Resident #284's care plan included a focus area, initiated on 02/17/2023, that indicated the resident exhibited physical and verbal behaviors, refused medications at times, and had a history of physical aggression towards others. Resident #284's Progress Notes revealed an Incident Note, dated 08/19/2023 at 8:13 PM, that indicated Resident #284 hit Resident #286 across the face and then in the leg as Resident #286 was propelling around them. Per the note, Kentucky Medication Aide (KMA) #21 witnessed the altercation. An Admission Record revealed the facility admitted Resident #286 on 02/13/2013. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, post-traumatic stress disorder (PTSD), major depressive disorder, and dementia in other diseases classified elsewhere with mood disturbance. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/13/2023 revealed Resident #286 had a Brief Interview for Mental Status (BIMS) score of 5, indicating the resident had severe cognitive impairment. According to the MDS, the resident had no physical, verbal, or other behavioral symptoms directed towards others and wandered daily during the assessment look-back period. Resident #286's care plan included a focus area, initiated on 10/17/2022, that indicated the resident's psychosocial wellbeing was at risk due to dementia, confusion, and a new environment. Resident #286's Progress Notes revealed an Incident Note, dated 08/19/2023 at 6:10 PM, that indicated Resident #286 was propelling themselves in their wheelchair on the North Unit when one of the residents on the unit (Resident #284) hit Resident #286 on the right side of their face and kicked their right leg. A Facility Investigation-5 Day Final Report, dated 08/23/2023, revealed on 08/19/2023 at approximately 6:10 PM, Kentucky Medication Aide (KMA) #21 notified Licensed Practical Nurse (LPN) #23 that Resident #284 struck and kicked at Resident #286 as they passed them in the hallway. Per the report, KMA #21 and State Registered Nursing Assistant (SRNA) #24 witnessed the altercation, and the facility concluded the incident was verified and that it did occur. On 07/11/2024 at 12:02 PM, a call was placed to KMA #21. A voicemail was left, but no return call was received. During a telephone interview on 07/11/2024 at 12:09 PM, SRNA #24 stated she no longer worked at the facility. She stated she witnessed the incident between Resident #284 and Resident #286. She stated Resident #284 was in their wheelchair next to the day room doors, and Resident #286 rolled by, close to Resident #284, who swung and hit Resident #286. She stated Resident #284 slapped Resident #286's shoulder, but she did not see Resident #284 kick at Resident #286. SRNA #24 stated she immediately separated the residents and the incident occurred at the nurse's station so she called for the nurse to report what happened. SRNA #24 stated she could not recall who she reported the incident to. She further stated she had received abuse training from the facility while she was employed there and covered the different types of abuse and whom to report to. During an interview on 07/11/2024 at 4:22 PM, Registered Nurse (RN) #1 stated she was the Director of Nursing (DON) between July 2023 and October 2023, and had been with the facility since 2016 and had held various roles. She stated the facility provided abuse training frequently, the most recent being a couple months ago. She continued to state she recalled the incident between Resident #284 and Resident #286 and she stated the Administrator completed most of the investigation. RN #1 stated Resident #284 was placed on increased monitoring after the incident, specifically 1:1 supervision for a few days following the incident, followed by every 15-minute checks for a week. She stated the behavior and incident was odd and out of character for Resident #284, who had never done anything similar prior to the incident. She stated the physician came to examine Resident #284 and reviewed their medications for possible adjustments and Resident #286 had not been involved in any type of incident prior to or since the incident with Resident #284. RN #1 further stated she expected staff to follow the facility's abuse policy, and the floor staff acted appropriately during this incident, and the management team met to discuss the incident after the investigation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/12/2024 at 3:27 PM, the Administrator stated Resident #284 was sitting in their wheelchair when Resident #286 passed by them, and Resident #284 smacked Resident #286. The Administrator further stated she expected staff to follow the facility's policy and abuse should be reported to the DON or herself immediately per policy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 28196 Based on interview, record review, and facility document and policy review, the facility failed to ensure a pharmacy recommendation was addressed by the physician in a timely manner for 1 (Resident #34) of 5 residents reviewed for unnecessary medications. In addition, once the physician responded to the pharmacy recommendation, facility staff failed to immediately implement the physician's recommendation. Findings included: A facility policy titled, Consultant Pharmacist Reports, dated 11/2021, revealed Documentation and Communication of Consultant Pharmacist Recommendations included Policy The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapies are communicated to those with authority and/or responsibility to implement the recommendations, and are responded to in an appropriate and timely fashion. Procedures A. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, prescribers, and the care planning team. This should include: 1) Documentation of the date each medication regimen review is completed and notation of the findings in the medical record or other designated manner. The policy revealed, 3) The consultant pharmacist documents potential or actual medication-related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review. The policy revealed, B. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review and C. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her within a reasonable time period, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director. An Admission Record revealed the facility admitted Resident #34 on 10/12/2019 and most recently readmitted the resident on 03/12/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of gastroesophageal reflux disease (GERD). An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/04/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #34's care plan revealed a focus area, initiated on 10/28/2019, that indicated the resident was at risk for malnutrition/dehydration related to multiple diagnoses, including the resident's diagnosis of GERD. An intervention initiated on 11/30/2021 and revised on 02/13/2024 instructed staff to administer medications for GERD as ordered by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Note to Attending Physician/Prescriber, with a medication regimen review (MRR) date of 10/02/2023, revealed a note that indicated, [Resident #34] receives two or more medications with similar mechanism of actions which may represent duplicate therapy. The note identified the medications in question as famotidine (a medication used to treat GERD) 20 milligram (mg), to be taken every night, and pantoprazole (a medication used to treat GERD) 40 mg, to be taken every day. The note recommended the physician consider discontinuing one medication if clinically appropriate due to risk of adverse effects and to avoid polypharmacy. A Consultant Pharmacist's Medication Regimen Review, dated 11/05/2023, revealed that a consultant pharmacist sent a pharmacy recommendation for Resident #34 the previous month regarding a possible duplication of therapy. The review indicated the consultant pharmacist was unable to find a response to the recommendation and requested the facility follow up. A Note to Attending Physician/Prescriber, with a MRR date of 12/03/2023, revealed a note that indicated, [Resident #34] receives two or more medications with similar mechanism of actions which may represent duplicate therapy. The note identified the medications in question as famotidine 20 mg, to be taken every night, and pantoprazole 40 mg, to be taken every day. The note recommended the physician consider discontinuing one medication if clinically appropriate due to risk of adverse effects and to avoid polypharmacy. Resident #34's MRR records revealed the physician's first documented response to these recommendations was dated 12/08/2024, over two months from the date of the pharmacist's original recommendation. Per documentation on the 12/03/2023 Note to Attending Physician/Prescriber, the physician agreed with the recommendation on 12/08/2023 and provided a verbal order to decrease Resident #34's pantoprazole to 20 mg every day. Resident #34's Order Recap [recapitulation] Report, reflecting all orders during the timeframe from 12/01/2023 to 07/31/2024, revealed the resident's order for pantoprazole 40 mg, one tablet by mouth one time a day for GERD, was not decreased to 20 mg per the physician's verbal order until 12/14/2023, five days after the physician provided the verbal order to decrease the dose. The order to decrease the dosage was entered on 12/13/2023 with a start date of 12/14/2023. Resident #34's medication administration record (MAR), for the timeframe from 12/01/2023 to 12/31/2023, revealed documentation that indicated staff did not implement the physician's verbal order to decrease the dose of Resident #34's pantoprazole until 12/14/2023. During an interview on 07/10/2024 12:36 PM, the Director of Nursing (DON) confirmed Resident #34's pantoprazole was not decreased until 12/13/2023 and it went unaddressed from the 10/02/2023 pharmacy recommendation until the new order was entered on 12/13/2023. She indicated that her expectation was for the pharmacy recommendations to come directly to her as soon as they were completed. She stated she reviewed and sorted the recommendations, had medical records staff take them to the prescribing physician that day, then sent the staff back the next day to pick them up and the responses were given back to her, and they were addressed immediately at that time. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/12/2024 at 9:03 AM, the Administrator stated she was the DON and the Administrator at the time Resident #34's pharmacy recommendation was not addressed by the prescribing physician in a timely manner. She stated that she did not know why there was a delay in addressing the recommendation. She indicated that all pharmacy recommendations needed to be addressed as soon as possible, but no longer than a week. During an interview on 07/12/24 01:25 PM with R# 34's Medical Provider, he/she stated typically the facility would bring the pharmacy rec. to his/her office once a month and he/she would go over them and fax them back to the facility with a reason for not agreeing with the recommendation or any medication and/or lab orders. He/she stated he would expect medication and/or lab orders be acted on within a day or two after receiving them. He/she continued to state the resident had some other medication changes back in Nov. of 2023 due to dealing with a DVT. The Medical Provider stated he/she did not know why there was a lag in responding to the pharmacy recommendation.