STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185069	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 50990 Based on observation, interview, record review, review of the facility's policies, and review of the audit findings from Kentucky Protection and Advocacy, the facility failed to protect Resident (R) 15 from exploitation of personal funds. The facility did not keep adequate accounting documentations to ensure R15 was safeguarded from misappropriation of funds. The findings include: Review of the facility's policy titled, Resident Rights, revised 09/15/2023, revealed all residents had the right to be treated with respect and dignity, and all residents would be treated in a manner and in an environment that promoted maintenance or enhancement of quality of life. Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, revised 09/15/2023, revealed exploitation as taking advantage of a resident for personal gain by using manipulation, initiation, threats or coercion. The policy also defined misappropriation of resident property as the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review of the letter to the facility from Kentucky Protection and Advocacy, dated 03/19/2024, revealed the facility met with them for a representative payee review on 11/02/2023. Per the letter, the audit found recordkeeping corrections were needed because the facility had inadequate controls for safeguarding residents' funds; was missing receipts for large and unusual purchases; and had records not being retained for two years. The letter stated the facility had to submit a POC by 04/18/2023 (should be 04/18/2024) to correct the deficiencies. Review of the facility's response with a POC to Kentucky Protection and Advocacy, undated, revealed the facility implemented an updated Resident Trust Fund policy, reeducation of staff on the Resident Trust Fund policy and resident payee system, enhanced monitoring of expenditures, and resident personal needs spending compliance. Specifically, the POC stated the facility's Social Services Director (SSD) undertook additional training to ensure documentation and accounting practices met the highest standards of accountability and care. Review of the letter to the facility from the SSA, dated 05/20/2024, revealed the SSA had reviewed the facility's POC and determined the facility, with implementation, of the POC, fulfilled their duty as representative payee. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R15's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 12/17/2019 with diagnoses that included stroke, anemia, and anxiety disorder. Review of R15's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/17/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident's cognition was intact. Review of the R15's checking deposit slip, dated 12/12/2023, revealed R15's account was credited for $18, 594.15 on 12/13/2023 for money given to family, friends, and taken with and without her consent. Review of the former SW's personnel file revealed she was suspended while the investigation was ongoing and then was allowed to return to work with no disciplinary action. She resigned in 12/2023. During an interview with R15 on 07/14/2024 at 2:30 PM, she stated she asked for an investigation by the SSA on the use of personal funds when they were in the facility preforming a random audit. R15 stated she felt like her account balance was low, and she could not figure out why. R15 stated the SSA looked over everything in her room for items listed on the facility reports of items the Social Worker (SW) had listed as purchased. Per the SSA audit, she stated it revealed that R15 should have lotions, clothing, and jewelry that were not in her possession at the time. R15 stated after the investigation she was told by the SSA that the former SW had stolen her money. R15 stated she would give the former SW money to buy things for her such as clothes, jewelry, lotion, and gifts cards. R15 stated she gifted $21,950 to family and friends in the form of gift cards and cash. R15 stated she never paid the former SW any money for the services she performed for her. R15 stated the facility did reimburse her for the money given out to family and friends in the form of cash and gift cards. R15 did not agree that her money should be used for her personal use only, as R15 stated, It's my damn money. I can use it how I want. R15 stated she currently had no communication with the former SW. R15 stated, after the investigation, the former SW no longer came around to her room to visit or to assist her with care. During a telephone interview with R15's representative, her son, on 07/17/2024 at 8:03 PM, he stated his mother was paralyzed on the left side from a stroke. He stated he agreed with the facility that R15 needed 24-hour care at home if she was released from the facility. He stated R15 would give lots of money to the grandchildren in forms of gift cards and cash. He stated he was no longer able to receive money from R15 as he had been told the money was for R15's personal use only. He denied using R15's money for his personal use or opening any credit card accounts in R15's name, but stated he was under investigation for exploitation, and nothing came from it. He stated he was currently living out-of-state, but at one time was living in R15's home when she was on the rehabilitation side of the facility. He stated R15's home was currently empty because he could not pay the bills once the financial assistance agency stopped assisting with paying the utilities. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with Adult Protective Services worker (APS) on 07/22/2024 at 1:38 PM, she stated she worked for the local government Adult Protective Services. The APS stated she was the payee for R15's personal money starting in 2017. The APS stated R15 entered a financial assistance program to help with her financial debt (medical). The APS stated she helped get R15's finances in order and assisted in paying her bills. She stated a goal she worked on with R15 was keeping her family from her personal funds and giving allowances. The APS worker stated she believed R15's son was her power of attorney (POA). However, no documentation had ever been presented for verification. She stated multiple meetings were scheduled for plans for R15 to go home to family once R15 was able to be discharged from the facility. However, she stated R15's son and her ex-husband failed to show up for the last meeting for R15 to return home. The APS worker stated she documented on 02/04/2020 that R15's son told R15, Mom you can't come home right now. At this point, she stated R15's son was living in R15's home while an assistance agency was paying the utilities. The APS worker stated she had all the utilities cut off, and R15 got mad. The APS worker stated she explained to R15 that her funds were for her personal use only. On 02/19/2020, the APS worker stated the Business Office Manager (BOM) and APS discussed the facility taking over as payee for R15. The APS worker stated she did not have any issues with the former SW; however, it was hard to get to the bottom of the payee transition and the plan moving from rehabilitation to home. In continued interview with the APS worker on 07/22/2024 at 1:38 PM, she stated she had a discussion with the former SW about keeping funds from R15's son and him being reported for exploitation. She also stated he had been arrested many times for selling drugs, and he never worked. Further, she stated she had asked R15 many times about the role of her son. The APS worker stated that R15's son had opened a credit card in R15's name, and the amount of the card was $1000. She stated the card was activated and on the same day maxed out at a local gaming store. The APS worker stated she called the credit card company and was told R15's son applied for the card. She stated she asked R15 if she authorized the credit card, and R15 stated, No. The APS worker stated she asked R15 if she wanted to press charges, and R15 stated, No. The APS worker stated R15 had a pension with the local school system, and there was a possibility that it could have been taken by R15's son. Observation and in an interview on 07/18/2024 at 1:23 PM, R15 stated she had no issues, complaints, or concerns on how her money was being handled at this time. R15 stated she was using her money for her own personal use. Observation revealed R15 got a soda out of the vending machine, using her own money. R15 stated her personal funds were used to purchase phone cards to add minutes to her cell phone by the Business Office. During an interview with Social Service Director (SSD) on 07/26/2024 at 1:15 PM, she gave a brief job description of her roles in the facility which included care plan meetings, observations, providing basic information needed for short or long-term stays, setting up rehabilitation, setting up transportation, and scheduling for meals on wheels. The SSD stated she did not handle personal funds, but the business office did. The SSD was asked, if a resident was trying to give her money or asked her to cash a check, would she be willing to take the money or cash the check? The SSD stated she would not touch the cash or check, and she would escort the resident to the business office. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the BOM on 07/26/2024 at 3:15 PM, she stated no resident was allowed to give a check or cash for deposit or to request to buy any items outside of the facility. The BOM stated she had no direct contact with the former SW and had never given her any money. The BOM stated if residents wanted money, they came to her. She stated she gave the resident the cash and had them sign a receipt. She stated a check was made out to the Chief Executive Officer (CEO), who would cash the check and reimburse the resident's trust fund account. During an interview with the CEO on 07/26/2024 at 2:53 PM, she stated she had been with corporate since 2020 and had received many of the trainings on residents rights and abuse, neglect, and exploitation. The CEO stated the facility had a check and balance system where they were able to check to verify the residents were receiving and the facility was performing at the highest level of care. The CEO stated the BOM allocated the funds to other employees to go outside the facility to purchase any items a resident requested. During an additional interview with the CEO on 07/30/2024 at 4:31 PM, she stated every resident should be free from abuse, neglect, and exploitation due to the facility being their home. The CEO stated residents would be allowed to spend their money per the rules and regulations of the SSA and CMS. During an interview with the Regional Nurse Consultant (RNC) on 07/30/2024 at 4:02 PM, she stated it was very important to have all things documented such as with accounting and to have effective checks and balances within the facility to make sure everything was correct.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide a safe, clean, comfortable, and home like environment for all of the 77 current residents. Observation throughout the survey dates, 07/15/2024 to 07/30/2024, revealed gnats were in the building and observed in resident rooms [ROOM NUMBERS], the conference rooms, hallways in the North and South Wings, the kitchen, the day room on the North Wing, and in the dining room. Interviews with residents and staff revealed gnats had been an ongoing concern in the facility. The findings include: Review of the facility's policy titled, Resident Rights, revised 09/15/2023, revealed all residents would be treated in a manner and in an environment that promoted maintenance of enhancement of quality of life. Review of the pest control company's contract revealed the facility contracted with the service on 06/01/2015 to provide monthly and as needed pest control. Review of the pest control company's invoices service documentation revealed the company noted that sanitation issues in the kitchen could cause pest problems as follows: 1) the invoice dated 01/11/2024 revealed the floor under the cook/steam line was in need of cleaning, and the dishwasher area and under the shelves needed to be scrubbed; 2) the invoice dated 02/28/2024 noted trash cans in the kitchen area needed cleaning to reduce pest attraction and source of breeding and, to help prevent pest breeding sites, the facility needed to clean regularly in and around the cook line and floor drains where food debris and build up was found; 3) the invoice dated 03/18/2024 noted, to prevent the pest breeding sites, the area around the floor drains needed to be cleaned; 4) the invoice dated 04/25/2024 revealed there were structural concerns that could cause pest problems in the kitchen to include loose or missing floor tiles, baseboards, and floor grout lines, which were worn in the dish room area allowing water and food debris to accumulate and providing a breeding location for small flies which contributed to pest problems, and food debris found under the shelves and in the cook line and floor drains were in need of cleaning and was going to be a bad issue if we don't get the drains cleaned with flies - grease build up in/on/by and by residue and film build up on the kitchen floor and by dishwasher area. Please clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additional review of the pest control company's invoices service documentation revealed 5) the invoice dated 06/12/2024 noted small flies in the kitchen area underneath the counter and sink where dishes were washed with food materials and excess water found on the floor and in the dish area under the sink which were a breeding ground for fruit flies, and instructions included, Please clean to reduce pest attraction and source for breeding; 6) the invoice dated 06/19/2024, revealed the facility requested an as needed service to address small flies. According to the service report its purpose was to provide and identify sanitation deficiencies contributing to pest infestations. Per the comments, the kitchen was the source of the infestation, and the facility needed to address sanitation concerns in the kitchen to control pests. The report cited under the sink, underneath the counters, and the dishwashing area needed to be scrubbed and cleaned to prevent small flies feeding off of the biofilm on the walls and the undersides of the stainless steel equipment. It stated, It's unlikely the problem will get better if this issue isn't resolved first. 1. Observation of room [ROOM NUMBER] on 07/15/2024 at 2:10 PM, revealed there were several gnats flying around the room. The State Survey Agency (SSA) Surveyor attempted an interview with Resident (R) 2, who resided in room [ROOM NUMBER], on 07/15/2024 at 2:10 PM; however, the resident was uninterviewable. In an interview with R2's daughter on 07/16/2024 at 4:30 PM, she stated, There are gnats everywhere. She stated she had made complaints to the Director of Nursing (DON) and the Chief Executive Office (CEO), but stated, Nothing is done about it [the gnats]. 2. Observation of room [ROOM NUMBER] on 07/15/2024 at 2:25 PM, revealed there were several gnats flying around the room. Also, gnats were observed on R1's food, which was left over from lunch. In an interview with R1, who resided in room [ROOM NUMBER], on 07/15/2024 at 2:25 PM, she stated she had gnats in her room all the time, and they bothered her when she ate. R1 stated she did not remember anyone coming in her room to treat bugs. 3. Observation in the front hall on the South Wing on 07/16/2024 at 2:56 PM revealed there were gnats, and there were no food carts in the hallway at the time of the observation. 4. Observation in the front hall of the North Wing on 07/17/2024 at 12:56 PM revealed there were gnats. Further observation revealed that gnats were in the day area and near the nurse's station. Also, residents were eating lunch in their rooms, and meal carts were out in the hall. 5. Observation of the North Wing nurse's station on 07/22/2024 at 5:30 AM revealed there were gnats present . During an interview with R3 on 07/15/2024 at 2:15 PM, she stated she had observed gnats in her room on multiple occasions. R3 further stated gnats had been a problem in the facility for at least several months. She stated the gnats were annoying, especially when she was trying to eat her meals. R3 stated she did not remember anyone coming in her room to treat bugs. During an additional interview with R3 on 07/22/2024 at 1:45 PM, she stated gnats were flying in the building. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with R9 on 07/22/2024 at 1:30 PM, R9 stated there were gnats flying around when eating meals. During an interview with Certified Nurse Aide (CNA) 4 on 07/22/2024 at 7:12 AM, she stated gnats were seen everywhere. She stated uncovered food contributed to the problem, and a particular resident liked to leave her food out in her room for an extended amount of time. During an interview with CNA5 on 07/22/2024 at 7:40 AM, she stated there were gnats everywhere, but there were not as many as she had noticed in the past. She stated that if residents saw gnats, they could report it to the nurse or maintenance. During an interview with CNA20 on 07/24/2024 at 4:34 PM, she stated she noticed gnats in the facility during the summertime. During an interview with Licensed Practical Nurse (LPN) 5 on 07/24/2024 at 11:00 AM, she stated gnats were a problem in the facility. During an interview with LPN9 on 07/26/2024 at 4:00 PM, she stated there were gnats in the facility. She stated the problem was from residents who kept food in their rooms. LPN9 further stated staff would check resident rooms for open containers or food left out and encourage residents to put food away or discard. She stated that if staff saw gnats, she could report it to maintenance. During an interview with the Director of Maintenance (DOM) on 07/17/2024 at 2:10 PM, he stated the facility had a full service contract with a pest control company. He stated the pest control company provided routine and as needed pest control services to the facility. The DOM stated, The gnats are bad. He further stated the pest control company had been out to treat for gnats, but they were not controlled. He stated the most recent routine service was on 07/08/2024, and at that time, no issues of concern were noted. The DOM further stated some residents kept food in their rooms, contributing to the gnat problem. During an interview with the Regional Nurse Consultant (RNC) on 07/30/2024 at 4:05 PM, she stated it was her expectation the facility was clean and maintained in such a manner to promote a homelike environment within the guidelines. She stated it was important because this was the residents' home. During an interview with the Chief Executive Officer (CEO) on 07/30/2024 at 4:30 PM, she stated she was aware of gnats but was unaware of where they were coming from. She stated the DOM was responsible for overseeing the contract with the pest control company. She stated she had the pest control company out multiple times whenever there was a concern with gnats. Per interview, the CEO stated it was her expectation for departmental leadership to ensure staff followed facility policies to provide a homelike environment and enhance the quality of life for all residents. She stated it was essential to maintain a pest control program and adhere to cleanliness to inhibit insects in the building to ensure residents were safe and to maintain a happy, healthy, and comfortable environment. 51155

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50990 Based on interview, record review and review of the facility's policy, the facility failed to document grievances related to reported missing items for 2 out of 39 sampled residents, Resident (R) 21 and R28. R21 and R28 reported missing items to staff. However, these items were not documented on the grievance log, found, or replaced by the facility. The findings include: Review of the facility's policy titled, Grievance/Complaints, revised 07/19/2024, revealed the resident had a right to voice grievances to the facility or other agency or entity that heard grievances without discrimination or reprisal and without fear of discrimination or reprisal. This policy was to ensure the prompt resloution of resident grievances. Review of the Grievance Logs, dated for 07/01/2023 to 07/31/2023, revealed no documentation of R21's and R28's missing items logged on the sheet. 1. Review of R21's electronic medical record (EMR) revealed the facility admitted the resident on 05/23/2023 with diagnoses that included diabetes type 2, depression, and bipolar disorder. Review of R21's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/11/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six out of 15, indicating he had severe cognitive impairment. Review of the facility's Investigative Report, dated 07/10/2023 at 3:47 PM, revealed R21 stated concerns regarding missing items left at the facility when she had been discharged and stated she had concerns about the former Social Worker (SW). Per the report, the nurse (not identified) reported that R21 did leave a box of belongings and a cane. The nurse stated the items remained in R21's room until taken to the therapy gym. Per the report, the nurse stated she told this to the Social Services Assistant. The housekeeper for that hall recalled the belongings being in the therapy gym at the time of the deep clean on 06/26/2023. The items were no longer there. An investigation was initiated, and the former SW was suspended pending the investigation. In an interview with R21 on 07/23/2024 at 5:28 PM, she stated the former SW put her to the street. R21 stated the SW told R21 she would keep her clothes in the SW's office, but when R21 called to retrieve her box of clothes and pink cane, they were not able to be located. R21 stated the Social Services Director (SSD) told her she needed to leave the facility because her insurance was not going to cover her stay at the facility. R21 stated staff at a housing program rented a room for her so she could have a place to stay. R21 stated the SW told her the facility would replace the items that could not be located. However, nothing was replaced, and R21 did not receive any further communications from the SW. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Housekeeping Aide (HA) 5 on 07/24/2024 at 11:53 AM, she stated the box of clothes and the pink cane remained in R21's room after she was discharged . HA5 stated the aides were supposed to box the stuff up, but they did not, and someone else boxed it and left it in the room. HA5 stated the room was deep cleaned, and a nurse (HA5 could not recall the name) told HA5 to put the items in the SW's office. HA5 stated she placed the box of clothes in the pathway to the SW's desk and laid the pink cane on top of the box of clothes. HA5 stated she believed the Rehabilitation Service Manager (RSM) saw the box of clothing and the pink cane. In an interview with the Regional Nurse Consultant (RNC) on 07/23/2024 at 4:15 PM, she stated R21 called her own taxi and left abruptly without taking all her belongings. The RNC stated R21 took a taxi to her niece's residence in a nearby town. 2. Review of R28's EMR Face Sheet revealed the facility admitted the resident on 01/05/2022 with diagnoses which include infection in the bone, paraplegia, and dysfunction of the bladder. Review of R28's admission MDS, dated [DATE], revealed the facility assessed the resident to have a BIMS score of 6 out of 15, indicating his cognition was severly impaired. In an interview with R28's representative on 07/23/2024 at 7:53 PM, she stated she was R28's sister. She stated two blankets were stolen from her brother during his stay at the facility. She stated when she visited the facility, she looked in every room to see if the blankets were being used by other residents. She stated she reported the misplaced blankets to the SW on two separate occasions. She stated she also told the Chief Executive Officer (CEO) about the blankets and R28's fast charge block being taken and the cell phone charging card lying on the bed. She stated she never received any feedback from the facility about replacing the items. In an interview with the CEO on 07/30/2024 at 4:31 PM, she stated her expectation was to look for any misplaced or stolen items in the facility. The CEO stated the resident must show proof of purchase on the items that were reported missing. In an interview with the RNC on 07/30/2024 at 4:02 PM, she stated she expected any grievance to be taken and entered in the grievance log binder by any staff member who received a report from the resident. She stated as soon as the grievance was taken, an investigation would be initiated to find the missing item. The RNC further stated the item(s) would be replaced, without the resident providing proof of purchase of the item. The RNC stated it was very important to have all things documented such as grievances for checks and balances within the facility and to make sure everything was correct.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50990 Based on interview, record review, review of the facility's investigation, and review of the facility's policy, the facility failed to place items in a safe place to ensure the items could be returned to Resident (R) 21 after discharge for 1 out of 39 sampled residents. R21 stated she left her belongings at the facility after she was discharged on [DATE]. R21 stated the former Social Worker (SW) told her she would keep R21's belongings, which consisted of a box of clothes and a pink cane, in her office for safekeeping. R21 stated when she returned to pick up her belongings, they could not be found by staff at the facility, and the facility did not reimburse R21. The findings include: Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, revised 09/15/2023, revealed misappropriation of property was defined as the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review of the facility's Investigative Report, dated 07/10/2023 at 3:47 PM, revealed R21 stated concerns regarding missing items left at the facility when she had been discharged on [DATE] and stated she had concerns about the former Social Worker (SW). Per the report, the nurse (not identified) reported that R21 did leave a box of belongings and a cane. The nurse stated the items remained in R21's room until taken to the therapy gym. Per the report, the nurse stated she told this to the Social Services Assistant. The housekeeper for that hall recalled the belongings being in the therapy gym at the time of the deep clean on 06/26/2023. The items were no longer there. An investigation was initiated, and the former SW was suspended pending the investigation. Review of R21's electronic medical records (EMR) Face Sheet revealed the facility admitted the resident on 05/23/2023 with diagnoses that included diabetes type 2, depression, and bipolar disorder. Review of R21's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/11/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating she was cognitively intact. In an interview with the Regional Nurse Consultant (RNC) on 07/23/2024 at 4:15 PM, she stated R21 called her own taxi and left abruptly without taking all her belongings. The RNC stated R21 took a taxi to her niece's residence in a nearby town. In an interview with R21 on 07/23/2024 at 5:28 PM, she stated the former Social Worker (SW) told her she would keep her clothes in her office after she was discharged , but when R21 called the SW to retrieve her box of clothes and pink cane, they could not be located. R21 stated the SW told her the facility would replace the items which could not be found; however, nothing was replaced. In addition, R21 stated she received no further communication from the former SW. (continued on next page)

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	185069	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Housekeeping Aide (HA) 5 on 07/24/2024 at 11:53 AM, she stated the box of clothes and the pink cane were in the room of R21 after she was discharged . HA5 stated the aides were supposed to box the stuff up, but they did not, and someone else boxed it and left it in the room. HA5 stated the room was deep cleaned, and a nurse (HA5 could not recall the name) told HA5 to place the items in the SW's office. HA5 stated she placed the box of clothes in the pathway to the SW's desk and laid the pink cane on top of the box of clothes. HA5 stated she believed the Rehabilitation Service Manager (RSM) saw the box of clothing and the pink cane. In an interview with the RSM on 07/26/2024 at 1:18 PM, she stated R21 had received their services three times during her stay. The RSM stated she did remember seeing the box of clothes and the pink cane but nothing other than that. In an interview with the Chief Executive Officer (CEO) on 07/30/2024 at 4:31 PM, she stated her expectation was for staff to look for any misplaced or stolen items in the facility. The CEO stated that the resident must show proof of purchase on the items that were reported misplaced. In an interview with the RNC on 07/30/2024 at 4:02 PM, she stated she expected an investigation would be initiated to find missing items reported by a resident. The RNC stated that the item would be replaced without the resident providing proof of purchase of the item.

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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** 51155 Based on interview, record review, review of the facility's policies, and review of the facility's investigation, the facility failed to have an effective system to ensure residents' baseline care plans were developed and implemented to include instructions needed to provide person-centered care related to residents assessed to be at possible risk of elopement for 1 of 39 sampled residents, Resident (R) 6, who exited the facility on 07/10/2023 without staff knowledge. On 07/18/2024 at 7:27 PM, the Chief Executive Office (CEO) and Regional Nurse Consultant (RNC) were provided a copy of the CMS Immediate Jeopardy (IJ) Template and notified that the failure to ensure elopement risk interventions were added to R6's baseline care plan to prevent elopement is likely to cause serious injury, impairment, or death and constituted IJ at 42 CFR 483.21 (F655). The IJ was determined to exist on 07/10/2023 when the facility discovered R6 had eloped from the building. The facility provided an acceptable plan for the removal of the IJ on 07/24/2024 at 11:27 AM. This plan alleged the IJ was removed, and the deficient practice was corrected on 07/14/2023, prior to the initiation of this investigation. The plan provided by the facility alleged the following: 1. On 07/10/2023 R6 was dressed in pants, pull over shirt, and tennis shoes. The temperature was 84 degrees Fahrenheit (F). R6 was placed on one-on-one supervision upon coming back into the facility on [DATE]. R6 was helped to her room and a head-to-toe assessment by the Director of Nursing (DON) was completed on 07/10/2023 with no injuries or concerns noted. R6 had a pain assessment completed by a licensed nurse on 07/10/2023 with no concerns identified. R6 had a new elopement risk assessment and a care plan update completed on 07/10/2023 by the RNC. R6 had a Brief Interview for Mental Status (BIMS) completed on 07/10/2023 with a score of 12 (moderate cognitive impairment). R6's physician and family were notified of the elopement on 07/10/2023. Certified Nurse Aide (CNA) 3 who was on her 15-minute break sitting in her car in front of the facility, saw R6 come outside. This CNA notified staff inside the facility by calling them on the phone while continually watching the resident until staff came out, and the resident went back inside the facility with staff. 2. A head count of all residents was completed by the Social Services Director (SSD) and the DON on 07/10/2023, and all residents were accounted for. The Director of Maintenance (DOM) rechecked all door locks and alarms, and all were in working order on 07/10/2023. The Regional [NAME] President (RVP) and Chief Executive Officer (CEO) also checked all door locks and alarms on 07/10/2023, and all were in working order. (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	A review of all door checks for the previous 30 days before the elopement, 06/10/2023 to 07/10/2023, was performed by the RVP on 07/10/2023, and all checks had been completed. On 07/10/2023 the RVP reviewed elopement drills for the last 90 days, 04/10/2023 to 07/10/2023, and all had been completed. On 07/10/2023 the DON reviewed the last 30 days, 06/10/2023 to 07/10/2023, of events for current residents for any noted attempts of elopements. No concerns were identified. The RNC and the [NAME] President of Clinical Operations (VPCO) reviewed the last 30 days, 06/10/2023 to 07/10/2023, of progress notes looking for signs of elopement or exit seeking, and none were noted on 07/10/2023. All residents received a new elopement risk assessment on 07/10/2023 by the DON, Assistant Director of Nursing (ADON), Unit Manager (UM), or RNC. Any resident who was at risk based on the assessment had their care plan reviewed and revised as needed, and the elopement binders were reviewed to ensure residents were in the binder. 3. Initiated and completed on 07/10/2023, the RNC educated the CEO and the DON on the Comprehensive and Baseline care plan policies. Education was started on 07/10/2023 and was completed for all staff including clinical staff, housekeeping, dietary, administrative, business office, therapy, and activities by 07/11/2023 on the Comprehensive and Baseline care plan policies by the CEO, DON, UM, ADON, Minimum Data Set (MDS) Nurse Coordinator, or the RNC. A post-test was administered to all staff until a test score of 100% was achieved. Test questions were as follows: 1. What is a code green? 2. How do you know who is an elopement risk? 3. If you see a resident walking up to doors, pushing on doors, or talking of leaving, what should you do? 4. If a regular visiting family member asks for the door code, is it ok to give it to them? 5. If you hear a door alarm ringing, you go to the door, and you see no resident around, what should you do? 6. What is the difference in exit seeking and wandering? 7. How or where are interventions updated for exit seeking residents? 8. Where are the elopement books located? 9. What is tailgating? 10. What do you do when a code green is paged? 11. Do you let anyone out of exit doors if you are unsure if they are a resident? 12. How does anyone alert a nurse to a change in condition or behaviors of a resident? Any staff not educated by 07/11/2023, new staff, or new agency staff would be educated by the CEO, DON, ADON, UM, SSD, MDS Nurse Coordinator, or RNC prior to them working. Starting on 07/10/2023, the post-test on the education of policies would be given to 15 random staff weekly for 30 days, then 10 random staff for the next 30 days, and then five random staff for the next 30 days to make sure staff members were retaining knowledge. A grade of 100% was required or re-education was to be completed. The post-test was to be administrated by the CEO, DON, ADON, UMs, or SSD. Starting on 07/11/2023, elopement drills would be conducted daily for 10 days by the Director of Maintenance (DOM) or Weekend Manager and then monthly thereafter. Starting on 07/13/2023, all residents' progress notes would be read seven days a week for any exit seeking behavior or elopement concerns by the CEO, DON, UM, SSD, ADON, or RNC for 30 days and then Monday through Friday in the daily clinical morning meeting for 60 days. Any resident identified would have an elopement assessment completed, and if determined to be at risk, would have interventions put in place, such as the care plans reviewed/revised as needed and the elopement binder reviewed/revised as needed. Starting on 07/13/2023 the CEO, DON, ADON, UM, SSD, MDS Nurse Coordinator, or RNC would review all new admissions Monday through Friday with Saturday and Sundays being reviewed on Mondays. This would occur for 90 days to ensure any resident who was assessed on admission as being an elopement risk would have this on the baseline care plan or a comprehensive care plan and would be implemented addressing the elopement risk. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. A Quality Assurance Performance Improvement (QAPI) meeting was held on 07/11/2023 to review this plan of correction. The QAPI committee members, the Medical Director, CEO, DON, Activities Director, UM, ADON, SSD, DOM, Therapy Director, and MDS Nurse Coordinator attended and would attend as able to do so. The Medical Director had no other recommendations. Starting on 07/11/2023 QAPI would be held weekly for four weeks. On 07/11/2023 the DOM, Rehabilitation Services Manager, MDS Nurse Coordinator, Activities Director, SSD, Medical Director, ADON, and the DON were present for the QAPI meeting. An Extended Survey was initiated on 07/15/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 07/30/2024. Based on the findings of this survey, it was determined the IJ was removed and the deficient practice was corrected as alleged on 07/14/2023, prior to initiation of the investigation. Therefore, the IJ was determined to constitute Past Jeopardy. The findings include: Review of the facility's policy titled, Baseline Care Plan, revised 09/15/2023, revealed it was developed and implemented to increase resident safety and safeguard against adverse events that were most likely to occur right after admission. Per the policy, baseline care plans would be developed and implemented within 48 hours of a resident's admission. Review of the facility's policy titled, Elopement, revised 09/15/2023, revealed a care plan would be developed and implemented with interventions in place for each resident identified as an elopement risk. Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/07/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating she was moderately cognitively impaired. Review of R6's electronic medical record (EMR) Face Sheet, revealed the facility admitted the resident on 06/30/2023 with diagnoses to include urinary tract infection, adult failure to thrive, and anxiety disorder. Review of R6's admission Observation Detail List Report, dated 06/30/2023, revealed R6 was assessed to be at risk for elopement. Review of R6's Baseline Care Plan, dated 06/30/2023 revealed no documented evidence the facility developed a care plan to address R6's risk for elopement. Review of the Facility Reported Incident, dated 07/10/2023, revealed R6 was observed by Certified Nurse Aide (CNA) 3 walking in the front parking lot at 10:37 AM unsupervised. (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) 3 on 07/18/2024 at 4:20 PM, she stated the initial or baseline 48-hour care plans were completed by the nurses on the floor. She stated care plans could be created or revised by the Licensed Practical Nurse (LPN) or RN. She stated observation assessment documentation did not trigger for anything to be added to care plans. She stated nurses on the floor were expected to revise the care plan for any change in the resident's condition. She stated the facility had 21 days to complete the comprehensive care plan (after the comprehensive admission assessment was completed). She stated she assumes care plan changes get discussed at morning meetings with the clinical team after progress notes were reviewed. In an interview with the Director of Nursing (DON) on 07/18/2024 at 2:15 PM, she stated according to the baseline care plan policy, when the resident was assessed as being at risk for elopement, the nurse should have developed and implemented a care plan with interventions in place for the resident identified as an elopement risk. In an interview with the CEO on 07/30/2024 at 4:30 PM, she stated care plans were essential to providing resident-centered care for the resident, and it was her expectation that staff followed the care plan and revised them as necessary.

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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** 51155 Based on interview, record review, review of the facility's policies, review of the facility's investigation, and review of the website Weatherchannel.com, the facility failed to have an effective system in place to ensure residents' safety for 1 of 39 sampled residents (Resident (R) 6). On [DATE], R6 eloped from the facility unescorted, unsupervised, and without staff knowledge. On [DATE] at 7:27 PM, the Chief Executive Officer (CEO) and Regional Nurse Consultant (RNC) were provided a copy of the CMS Immediate Jeopardy (IJ) Template and notified that the failure to ensure residents were provided supervision and protected from further elopement is likely to cause serious injury, impairment, or death and constituted IJ at 42 CFR 483.25 F689. The IJ at F689 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.25. The IJ was determined to exist on [DATE] when the facility discovered R6 had eloped from the building. The facility provided an acceptable plan for the removal of the IJ on [DATE] at 11:27 AM. This plan alleged the IJ was removed, and the deficient practice was corrected on [DATE], prior to the initiation of the investigation. The plan provided by the facility alleged the following: 1. On [DATE] R6 was dressed in pants, pull over shirt, and tennis shoes. The temperature was 84 degrees Fahrenheit (F). R6 was placed on one-on-one supervision upon coming back into the facility on [DATE]. R6 was helped to her room and a head-to-toe assessment by the Director of Nursing (DON) was completed on [DATE] with no injuries or concerns noted. R6 had a pain assessment completed by a licensed nurse on [DATE] with no concerns identified. R6 had a new elopement risk assessment and a care plan update completed on [DATE] by the RNC. R6 had a Brief Interview for Mental Status (BIMS) completed on [DATE] with a score of 12 (moderate cognitive impairment). R6's physician and family were notified of the elopement on [DATE]. Certified Nurse Aide (CNA) 3 who was on her 15-minute break sitting in her car in front of the facility, saw R6 come outside. This CNA notified staff inside the facility by calling them on the phone while continually watching the resident until staff came out, and the resident went back inside the facility with staff. 2. A head count of all residents was completed by the Social Services Director (SSD) and the DON on [DATE], and all residents were accounted for. The Director of Maintenance (DOM) rechecked all door locks and alarms, and all were in working order on [DATE]. The Regional [NAME] President (RVP) and Chief Executive Officer (CEO) also checked all door locks and alarms on [DATE], and all were in working order. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of all door checks for the previous 30 days before the elopement, [DATE] to [DATE], was performed by the RVP on [DATE], and all checks had been completed. On [DATE] the RVP reviewed elopement drills for the last 90 days, [DATE] to [DATE], and all had been completed. On [DATE] the DON reviewed the last 30 days, [DATE] to [DATE], of events for current residents for any noted attempts of elopements. No concerns were identified. The RNC and the [NAME] President of Clinical Operations (VPCO) reviewed the last 30 days, [DATE] to [DATE], of progress notes looking for signs of elopement or exit seeking, and none were noted on [DATE]. All residents received a new elopement risk assessment on [DATE] by the DON, Assistant Director of Nursing (ADON), Unit Manager (UM), or RNC. Any resident who was at risk based on the assessment had their care plan reviewed and revised as needed, and the elopement binders were reviewed to ensure residents were in the binder. 3. Initiated and completed on [DATE], the RNC educated the CEO and the DON on the Comprehensive and Baseline care plan policies. Education was started on [DATE] and was completed for all staff including clinical staff, housekeeping, dietary, administrative, business office, therapy, and activities by [DATE] on the Comprehensive and Baseline care plan policies by the CEO, DON, UM, ADON, Minimum Data Set (MDS) Nurse Coordinator, or the RNC. A post-test was administered to all staff until a test score of 100% was achieved. Test questions were as follows: 1. What is a code green? 2. How do you know who is an elopement risk? 3. If you see a resident walking up to doors, pushing on doors, or talking of leaving, what should you do? 4. If a regular visiting family member asks for the door code, is it ok to give it to them? 5. If you hear a door alarm ringing, you go to the door, and you see no resident around, what should you do? 6. What is the difference in exit seeking and wandering? 7. How or where are interventions updated for exit seeking residents? 8. Where are the elopement books located? 9. What is tailgating? 10. What do you do when a code green is paged? 11. Do you let anyone out of exit doors if you are unsure if they are a resident? 12. How does anyone alert a nurse to a change in condition or behaviors of a resident? Any staff not educated by [DATE], new staff, or new agency staff would be educated by the CEO, DON, ADON, UM, SSD, MDS Nurse Coordinator, or RNC prior to them working. Starting on [DATE], the post-test on the education of policies would be given to 15 random staff weekly for 30 days, then 10 random staff for the next 30 days, and then five random staff for the next 30 days to make sure staff members were retaining knowledge. A grade of 100% was required or re-education was to be completed. The post-test was to be administrated by the CEO, DON, ADON, UMs, or SSD. Starting on [DATE], elopement drills would be conducted daily for 10 days by the Director of Maintenance (DOM) or Weekend Manager and then monthly thereafter. Starting on [DATE], all residents' progress notes would be read seven days a week for any exit seeking behavior or elopement concerns by the CEO, DON, UM, SSD, ADON, or RNC for 30 days and then Monday through Friday in the daily clinical morning meeting for 60 days. Any resident identified would have an elopement assessment completed, and if determined to be at risk, would have interventions put in place, such as the care plans reviewed/revised as needed and the elopement binder reviewed/revised as needed. Starting on [DATE] the CEO, DON, ADON, UM, SSD, MDS Nurse Coordinator, or RNC would review all new admissions Monday through Friday with Saturday and Sundays being reviewed on Mondays. This would occur for 90 days to ensure any resident who was assessed on admission as being an elopement risk would have this on the baseline care plan or a comprehensive care plan and would be implemented addressing the elopement risk. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. A Quality Assurance Performance Improvement (QAPI) meeting was held on [DATE] to review this plan of correction. The QAPI committee members, the Medical Director, CEO, DON, Activities Director, UM, ADON, SSD, DOM, Therapy Director, and MDS Nurse Coordinator attended and would attend as able to do so. The Medical Director had no other recommendations. Starting on [DATE] QAPI would be held weekly for four weeks. On [DATE] the DOM, Rehabilitation Services Manager, MDS Nurse Coordinator, Activities Director, SSD, Medical Director, ADON, and the DON were present for the QAPI meeting. On [DATE] the Medical Director, CEO, UM, ADON, and the DON were present for the QAPI meeting. On [DATE] the Medical Director, CEO, UM, ADON, and the DON were present for the QAPI meeting. On [DATE] the Medical Director, CEO, UM, ADON, and the DON were present for the QAPI meeting. Weekly QAPI meetings were held to discuss reportables, elopement education, to review audits, to verify this plan was working, and to achieve compliance. QAPI meetings would then go to monthly thereafter. The QAPI committee would make any recommendations or changes to this plan if compliance was not being achieved. There were no concerns with compliance through the QAPI process. An Extended Survey was initiated on [DATE], and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on [DATE]. Based on the findings of the survey, it was determined the IJ was removed and the deficient practice was corrected as alleged on [DATE], prior to initiation of the investigation. Therefore, the IJ was determined to constitute Past Jeopardy. The findings include: Review of the facility's policy titled, Elopement, revised [DATE], revealed each resident should be evaluated for elopement risk upon admission and re-evaluated as needed. Additionally, a care plan would be developed and implemented with interventions in place for each resident identified as an elopement risk. Review of R6's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses to include urinary tract infection, adult failure to thrive, and anxiety disorder. Further review revealed R6 was discharged from the facility on [DATE] at 6:03 PM and sent to an acute care facility for an evaluation. Review of R6's admission Observation Detail List Report, dated [DATE], revealed R6 was assessed to be at risk for elopement. Review of R6's Baseline Care Plan, dated [DATE], revealed no documented evidence the facility developed a care plan to address R6's risk for elopement. Review of R6's quarterly MDS, with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident to have a BIMS score of 12 out of 15, indicating she was moderately cognitively impaired. The MDS also revealed R6 required partial/moderate assistance with ambulation. Review of R6's Progress Note, dated [DATE], revealed R6 was seen by Licensed Practical Nurse (LPN) 1, walking up the hall with her belongings packed stating she was going to be picked up by the sheriff. Review of R6's Progress Note, dated [DATE], by Registered Nurse (RN) 1 revealed R6 exhibited more confusion than she did on [DATE]. (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 Reported Incident, dated [DATE], revealed R6 was observed by CNA3 walking in the front parking lot on [DATE] at 10:37 AM unsupervised, and the facility was unable to determine the cause of the elopement. According to the internal investigation documentation, the Weather Channel revealed the outside temperature for [DATE] was 86 degrees F, sunny skies with a breeze. This was verified by the State Survey Agency (SSA) Surveyor at Weatherchannel.com. In an interview with R6's daughter and emergency contact on [DATE] at 9:22 AM, the daughter stated R6 was confused and recently diagnosed with dementia by two separate hospitals. The daughter stated R6 was admitted to the facility on [DATE] to be with her spouse, who had suffered a heart attack a couple of days after R6's arrival to the facility and was transferred to a local hospital. The daughter stated R6's spouse expired the day she eloped from the facility. The daughter stated the facility's staff reported to her that R6 walked out the front door. She stated the facility's staff told her R6 was dressed in normal clothing, and staff failed to recognize R6 was not a visitor. She stated the facility's staff told her R6 had told staff she was going to visit her spouse. In an interview with CNA3 on [DATE] at 12:00 PM, she stated she was the aide who witnessed R6 in the facility's parking lot. She stated the facility had conducted an elopement drill earlier that morning. She stated after the elopement drill, CNA3 went out of the building at 10:30 AM to take a 15-minute break in her car. She stated she saw R6 walking outside in the parking lot approximately 20 feet from the building's entrance, and she recognized R6. She stated she then called CNA1, who was working inside the building, to ask about R6 being outside. She stated staff immediately came out and helped assist R6 back inside. According to CNA3, R6 stated she was going to the hospital to see her husband. When CNA3 was asked how R6 exited the building, CNA3 stated, I'm guessing she followed someone out. CNA3 stated she was parked in the fourth spot on the north side of the facility, and R6 was seen walking away from the building toward the road and was approximately 20 feet from the front door at the round landscaping circle area. In an interview with LPN1 on [DATE] at 8:02 PM, she stated R6 was mostly confused. LPN1 stated she felt R6 was an elopement risk the day she was assigned to her on [DATE]. LPN1 stated she did not remember if the provider was notified regarding R6's increased confusion and wandering behaviors. A telephone interview with RN5, who was present at the time of the elopement and one of R6's nurses, was attempted on [DATE] at 3:00 PM and again at 7:45 PM. Voice messages were left by the SSA Surveyor for a return call; however, no return call was received. In an interview with the Business Office Manager (BOM) on [DATE] at 9:15 AM, she stated she was working the front desk the day of the incident. She stated her job during the elopement drill was to watch/check the front desk, front door, front porch, and front conference room. She stated she was not familiar with the resident and did not know what R6 looked like. The BOM stated she did not remember if she opened the door or if she was at the front desk at the time of the elopement. In an interview with the former Social Worker (SW) on [DATE] at 9:20 PM, she stated R6 was alert and oriented with intermittent confusion, and sundowning (when residents with dementia experience increased confusion and wandering from late afternoon into the night) was a concern. In an interview with the DOM on [DATE] at 3:45 PM, he stated he was working the day of the elopement; however, he did not know how R6 got out. He stated the surveillance cameras were updated after [DATE], and therefore no surveillance tapes were available for review. (continued on next page)

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	185069	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the ADON on [DATE] at 1:13 PM, she stated R6 arrived at the facility to be with her spouse, who was a resident at the facility. She stated CNA3, who was taking a break and sitting in her car in the front parking lot, called into the building to ask if R6 was allowed to be outside unsupervised, and CNA3 was told no. She stated staff then went out to bring R6 back inside the building. She stated she attempted to call and notify R6's spouse, since he was listed as next of kin and was in the hospital, and then called R6's daughter and made her aware of the elopement. The ADON stated, I assumed the resident got out by tailgating behind someone else leaving. In an interview with the DON on [DATE] at 2:15 PM, she stated it was her expectation that the staff member responsible for managing the front door would ensure that no resident walked out behind any visitor, and they should verify the door was fully closed to prevent an elopement. In an interview with the CEO on [DATE] at 1:40 PM, she stated she was scheduled to be off work the day of the incident. She stated she was not in the building at the time of the elopement and was called into the facility after the elopement occurred. The CEO stated R6 made it to the front of the building and was brought back in by CNAs. She further stated elopement education was provided to all staff. The CEO stated she was unsure how R6 exited the building.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44001 Based on interview, record review, and review of the facility's policies, the facility failed to maintain correct recordkeeping of all controlled drugs on four of four medication carts, which ensured an accurate inventory of medications by accounting for controlled medicines the facility received, dispensed, and administered affecting 77 out of 77 residents. The facility failed to ensure individual residents' narcotic records were documented as signed when a controlled substance was administered for 2 of 39 sampled residents (Resident (R) 8 and R18). Additionally, the facility failed to provide pharmaceutical services, including dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 1 out of 39 sampled residents (R30). Review of narcotic count sheets for four of four medication carts revealed staff failed to sign inventory sheets for controlled narcotics, sign narcotic count sheets at the change of shift, and sign narcotic sheets prior to shift's end. Additionally, licensed staff failed to sign out narcotic medications as given to R8 and R18. Review of R30's medication administration record (MAR) revealed that Licensed Practical Nurse (LPN) 12 signed out three narcotic pills as being given, but LPN12 did not administer the medication to R30. Additionally, LPN12 signed out one dose of a narcotic analgesic administered by LPN4. The findings include: Review of the facility's policy titled, Controlled Medication, dated 05/30/2024, revealed the facility would ensure controlled medications were handled, stored, and disposed of, and record keeping was in place in accordance with federal, state and other applicable laws and regulations. Further review of the policy revealed that at shift change or when the keys were rendered a physical inventory of all controlled medications was conducted by two licensed nurses/medication aide and was documented on the controlled medication accountability record. Per the policy, the off going nurses/medication aide, along with the nurses/medication aide assuming the keys, would review, locate, and count the controlled medication accountability record for each resident's medication. Both nurses/medication aides would ensure the count of the remaining medications matched the medication accountability book and verify together the correct or incorrect accounting of the medication. Review of the facility's policy titled, Medication Administration, dated 09/2018, revealed medications were to be administered as prescribed and in accordance with good nursing practices. Further review of the policy revealed the individual who administered the medication dose recorded the administration on the resident's MAR immediately following the medication being given. According to the policy, staff should not report off duty without first recording the administration of any medication. The resident's MAR was initialed by the person administrating the medication in the space provided under the date and on the line for that specific medication dose administration and time. 1. a. Review of the Controlled Substance Count sheet for South Wing Front Hall on 07/24/2024 at 10:35 AM, revealed Kentucky Medication Aide (KMA) 1 did not sign the sheet when she came on shift according to the facility's policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with KMA1 on 07/24/2024 at 10:35 AM, she stated the oncoming nurse counted the narcotic cards in the locked narcotic drawer, and the offgoing nurse had the narcotic inventory sheets and read them off. She stated both nurses ensured all narcotics were accounted for. She stated if the count was incorrect, the nurses notified the DON. She stated both should sign the narcotic sheets, signifying they counted, and it was correct. Additionally, KMA1 stated the nurse/medication aide should not sign the Controlled Substance Count sheet ahead of time or sign out narcotics medication unless the nurse/medication aide administered them to the resident. She stated following facility policy regarding verifying the narcotic count was important for the safety of residents and staff. Review of the Controlled Substance Count sheet for the North Wing revealed LPN3 did not sign the inventory shift count as the oncoming nurse on 07/24/2024. Additionally, LPN3 had signed as the offgoing nurse in a blank spot without a date. During an interview with LPN3 on 07/24/2024 at 10:55 AM, she stated that she did the narcotic count with the offgoing nurse but failed to sign the Controlled Substance Count sheet. She stated she should not have documented that she signed the sheet ahead of actually doing the count. She stated following facility policy related to verifying the narcotic count was important for the safety of residents and staff. She stated accurate documentation protected the nurse's license. Further review of the Controlled Substance Count sheets for North Wing revealed there was a missing second signature on 06/30/2024 for the subtraction of one Oxycodone (an opioid pain reliever) 10 mg card; on 07/02/2024 for the addition of two Lorazepam (an anti-anxiety agent) 0.5 mg cards; on 07/17/2024 for the addition of two Oxycodone 10 mg cards; on 07/18/2024 for the subtraction of one Norco (an opioid pain reliever) 5/325 mg card and for the addition of one Norco 10/325 mg card; on 07/19/2024 for the subtraction of one Hydrocodone (an opioid pain reliever with no dose was indicated) card; on 07/22/2024 for the addition of one Norco 10/325 mg card; and on 7/23/2024 there was a missing second signature for the subtraction of one Oxycodone (no dose was indicated) card. b. Review of R8's Individual Patient's Narcotic Record for Gabapentin (pain reliever for nerve pain and an ant-convulsant) 600 milligrams (mg), revealed on 07/22/2024 at 8:11 PM, the medication was not signed out as administered, yet it was marked as subtracted from the count in the narcotic record. c. Review of R18's Individual Patient's Narcotic Record for Acetaminophen with Codeine, revealed on 07/19/2024 at 11:00 AM, the medication was not signed out as administered, yet it was marked as subtracted from the count in the narcotic record. During an interview with LPN5 on 07/24/2024 at 10:25 AM, she stated narcotics should be signed out at the time of administration, and stated, You document after you give it. 2. Review of R30's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment. Review of R30's electronic medical record (EMR) Physician Orders, dated 10/01/2023, revealed the physician ordered hydrocodone-acetaminophen 10/325 mg two tablets by mouth two times per day as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R30's EMR Physician Orders, dated 10/06/2023, revealed the physician ordered hydrocodone-acetaminophen 10/325 mg one tablet by mouth two times per day. Review of the narcotic count sheets for R30's hydrocodone-acetaminophen 10-325 mg, one tablet by mouth, two times per day, revealed on 10/17/2023 the paper count showed LPN12 signed out four hydrocodone tablets at 8:00 AM and 12:00 PM and two tablets at 6:00 PM. The State Survey Agency (SSA) Surveyor attempted to interview LPN12. However, the facility did not have a telephone number for the nurse. The SSA Surveyor attempted to interview LPN4 on 07/24/2024 at 11:00 AM. However, there was no answer on her phone. LPN4 had recently resigned from the facility. During a telephone interview with the former Director of Nursing (DON) on 07/24/2024 at 11:12 AM, she stated she was not working on 10/17/2023, and the Chief Executive Officer (CEO) prepared an investigative report. During an interview with the CEO on 07/24/2024 at 5:00 PM, she stated on 10/17/2023 there was a call-in for the shift and she was down one nurse. She stated she contacted a nurse agency service to get a replacement nurse. She stated LPN12 accepted the shift and began working at 11:00 AM. Per the CEO, the LPN4 was on the medication cart and surrendered the narcotic keys to LPN12 when she arrived at the facility. She stated the count was correct. The CEO stated that around 5:00 PM that evening she received a phone call from a colleague who informed her that LPN12 had been reported to the state Board of Nursing for diversion of narcotic pain medications. The CEO stated she went to the medication cart and told LPN12 because she was under investigation for drug diversion, she would need to leave the facility. The CEO stated she escorted LPN12 out of the facility. The CEO stated, when LPN4 took over the cart after the agency nurse was told to leave, LPN4 and the CEO performed a narcotic count and discovered three hydrocodone-acetaminophen 10/325 mg tablets were missing. During the continued interview with the CEO on 07/24/2024 at 5:00 PM, she stated R30 told her R30 received her scheduled 8:00 AM dose of hydrocodone-acetaminophen 10/325, which was administered by LPN4. However, according to the CEO, LPN4 did not sign the Controlled Drug Record sheet to document the medication was given. Per the CEO, LPN12 initialed Controlled Drug Record sheet #1, indicating she had given the 8:00 AM dose. The CEO stated she could not explain why LPN12 initialed it for LPN4. Additionally, the CEO stated LPN12 documented on Controlled Drug Record sheet #1 that she administered three additional hydrocodone-acetaminophen 10/325 mg tablets at 12:00 PM and 6:00 PM and then signed out another hydrocodone-acetaminophen 10/325 mg tablet at 6:00 PM as given on Controlled Drug Record sheet#2. The CEO stated the inventory was correct for the amount of medication that was signed out, but three pills were not administered to R30. per R30. The CEO stated R30 told her she received her 8:00 AM dose but did not receive any of the pain medication signed out as given during the day. Furthermore, the CEO stated she contacted the police and the state Board of Nursing. She stated the facility reimbursed R30 for the missing medication. During an interview with LPN11 on 07/25/2024 at 4:20 PM, she stated per policy, narcotics should be signed out at time of administration and two nurses were required to perform the controlled substance count. She stated following policy was important to prevent drug diversion. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Registered Nurse (RN) 4 on 07/25/2024 at 4:25 PM, she stated per policy, narcotics should be signed out at time of administration and two nurses were required to perform the controlled substance count. She stated following policy was important for the safety of residents and nursing staff. She stated ensuring an accurate count at the beginning of the shift helped to prevent drug diversion, which could impact a nurse's license. During an interview with the Infection Prevention/Staff Development Coordinator (IP/SDC) on 07/24/2024 at 10:50 AM, she stated narcotics should be signed out at time of administration, and all narcotic inventory sheets should be signed by two nurses when inventory was received or removed. The IP/SDC stated that following facility policy regarding verifying the narcotic count was important for the safety of residents and staff. She further stated that accurate documentation protected the nurse's license. During an interview with the Assistant Director of Nursing (ADON) on 07/25/2024 at 4:12 PM, she stated the oncoming nurse counted the controlled substances located in the locked narcotic drawer, and in contrast, the offgoing nurse had the Controlled Substance Count sheets and read them off. She stated both nurses ensured the accuracy of the narcotics count. She stated if the count was incorrect, they notified the DON. She stated both nurses should sign the narcotic sheets, signifying they had completed the count, and it was correct. The ADON stated a nurse should never sign the Controlled Substance Count sheets ahead of time or sign out a narcotic substance unless the nurse had administered the medication to the resident. The ADON stated this was important to keep an accurate narcotic count, adhere to facility policy, and protect the license of the nurses. During an interview with the Interim DON (IDON) on 07/30/2024 at 3:45 PM, she stated all licensed staff should follow facility policy regarding verifying the narcotic count because it was important for the safety of residents and staff. She further stated that accurate documentation protected the nurse's license. During an interview with the Regional Nurse Consultant (RNC) on 07/30/2024 at 4:05 PM, she stated it was her expectation that licensed nurses and KMAs followed facility policy concerning signing out controlled medication when given and verifying the narcotic count sheets with the addition and removal of narcotic cards. The RNC stated the facility's nurses and KMAs needed education. Additionally, the RNC stated her expectation moving forward was that the DON would be the leader of the nursing team and should ensure that nursing staff performed a complete and accurate narcotic drug count according to guidelines. She stated this was important for the safety of residents and staff and for maintaining accurate narcotics accounting to prevent diversion. During an additional interview with the CEO on 07/30/2024 at 4:30 PM, she stated it was her expectation that licensed nurses and KMAs follow facility policy regarding verifying the narcotic count because it was important for the safety of residents and staff and to prevent the diversion of narcotics.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44001 Based on observation, interview, record review, and review of the contracted company's policies and documents, it was determined the facility failed to maintain the kitchen in a safe and sanitary manner. This affected all 77 current residents. Observation of the kitchen revealed areas under counters, sinks, and prep areas were dirty with debris and dirty build up. Observation of the kitchen wash area revealed food stains on the walls, the floor, the area around the window, sink area, and under the sink. There was debris on the floor. Further observation revealed gnats flying near the dirty sink area. The findings include: Review of the Contract between the facility and the facility's contracted company, undated, revealed the company was responsible for routine cleaning and sanitation in the food preparation and service areas including dietary service equipment, daily kitchen floor cleaning, all kitchenware and food contact surfaces, and daily cleaning of cooking surfaces, at such intervals as to keep them in a clean and sanitary condition. Furthermore, the Contract revealed the Registered Dietitian (RD) shall inspect all areas of the dietary department including but not limited to sanitation equipment functioning and compliance with pertinent federal state and local laws. Review of the contracted company's policy titled, Environment, revised 09/2017, revealed all food preparation areas, food service areas, and dining areas would be maintained in a clean and sanitary condition. Per the policy, the Dietary Manager (DM) would ensure the kitchen was maintained in a clean and sanitary manner including floors, walls, ceilings, lighting, and ventilation. Per the policy, the DM would ensure that a routine cleaning schedule was in place for all cooking equipment food storage areas and surfaces. Review of the contracted company's policy titled, Equipment, 09/2017, revealed all food service equipment would be clean, sanitary, and in proper working order. Review of the contracted company's job description Dining Services Account Manager (DM), no date, revealed the DM managed the dining services program in a single site according to the contracted company's policies and procedures and federal and state requirements. The DM's responsibilities included touring the kitchen several times per day to assess work quality. Per the job description, the DM was a department head in the facility and must conduct themselves and their department in a professional manner. Additionally, the DM ensured established sanitation and safety standards were maintained. Review of the facility's document Kitchen Cleaning Checklist and Expectation In-service, dated 07/10/2024, revealed all employees were required to take part in the daily/weekly checklists posted in the kitchen. According to the in-service, all kitchen staff members should clean their workstations as they work and after using any equipment. Also, the in-service stated at the end of the day, staff should make sure that all equipment was wiped down following the daily or weekly checklist, and the account manager would oversee the completion of all tasks by the kitchen staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the contracted company's Facility Visit Recap Report, dated 06/26/2024, 07/12/2024, and 07/15/2024, revealed no observation or notes related to the cleanliness of the kitchen by the RD. Observation of the kitchen, during the tour on 07/17/2024 at 1:50 PM, revealed areas under shelving, counters, sinks, and prep areas were dirty with food debris, dust, and dirt. Paper wrappers, napkins, straws, and straw wrappers were also observed on the floor. There was thick, black grease and dirty build up on the stove hood and frying equipment. Continued observation of the kitchen showed areas had food stains on the walls, floor, the area around the window, sink area, and under the sink. Observation near the floor drain revealed several gnats were observed flying near the drain. During an interview with Dietary Aide (DA) 2 on 07/25/2024 at 2:00 PM, she stated staff followed the cleaning schedule in the kitchen. She further stated the kitchen staff had recently had an in-service on completing daily/weekly tasks. Additionally, DA2 stated it was important to keep the kitchen clean to prevent contamination and disease. During an interview with the Dietary [NAME] on 07/25/2024 at 2:05 PM, she stated all kitchen staff followed a cleaning schedule to include cleaning up as you go when cooking or preparing for meals. She stated equipment was cleaned on a regular basis. Additionally, she stated it was important to keep the kitchen clean and sanitary to prevent foodborne illnesses. During an interview with the DM on 07/17/2024 at 1:55 PM, she stated the kitchen was cleaned routinely according to the cleaning checklist schedule. She stated she had not noticed gnats since the kitchen drain had been cleaned. During an additional interview with the DM on 07/30/20204 at 11:25 AM, she stated there was a daily schedule for cleaning. The DM stated that all equipment was wiped down after use, the dish room was cleaned three times daily, and all other equipment was cleaned at least twice a month or as needed. She stated one specific area of the kitchen was scheduled for a weekly deep clean, for example, the refrigerator on one day and the stove on another. When asked about the unclean condition of the kitchen during observation by the State Survey Agency (SSA) Surveyor, she attributed it to being short-staffed at the time and assured the kitchen was fully staffed now. Additionally, the DM stated she had provided new training, had in-serviced staff on the cleanliness of the kitchen, and would adhere to a daily and weekly cleaning schedule. She stated it was her expectation that all staff did their daily assignments, and she would hold them accountable. She stated having a sanitary kitchen was necessary for the safety of residents and to prevent the spread of infection and disease. During an interview with the Regional Dietary Manager (RDM) on 07/30/20204 at 11:25 AM, he stated he was in the facility twice monthly; however, he stated that the RD was in the facility weekly, and provided observation and plans of correction if deficiencies were found. He stated the kitchen was not clean at the time of the SSA Surveyor's observations. He stated staffing issues had contributed to routine tasks being delayed. He stated, I don't want to eat anywhere where it [kitchen] isn't clean. Seeing the kitchen this week was an eye-opener. The RDM stated it was his expectation the kitchen remained clean and sanitary. He stated a clean and sanitary kitchen was important to prevent infection control issues such as insects, pests, and foodborne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview with the RD on 07/30/20204 at 1:00 PM, she stated she provided an inspection once a month and would document any issues on an audit form. She stated the form was given to the facility's Chief Executive Officer (CEO), the DM, and the RDM. Per interview, the RD's last visit was on 07/11/2024, and she didn't notice anything major. She stated the kitchen normally was kept clean. The RD stated it was her expectation that staff was cleaning up after themselves and following the cleaning schedule. The RD stated it was important because the kitchen had the potential to put the residents at risk for foodborne illnesses. During an interview with the Director of Maintenance (DOM) on 07/17/2024 at 2:10 PM, he stated the facility had a full service contracted company to provide for the day to day running of the kitchen. He stated the facility had a contracted pest control company to provide routine and as need pest control services to the facility. The DOM stated, The gnats are bad. He stated the pest control company had been to the facility to treat for gnats, but they were not controlled. He stated the most recent routine service was on 07/08/2024, and at that time no issues of concern were noted. During an interview with the Regional Nurse Consultant (RNC) on 07/30/2024 at 4:05 PM, she stated it was her expectation that the kitchen was clean and maintained in such a manner to promote a homelike environment within the guidelines. She stated it was important because this was the residents' home, and an unsanitary kitchen was an infection control issue and had the potential to put residents at risk. During an interview with the CEO on 07/30/2024 at 4:30 PM, she stated kitchen staff should follow cleaning schedules to maintain a sanitary environment. She stated the facility had contracted out its dietary services to a third-party service group. The CEO stated her role related to dietary services was to ensure adequate food inventory and audit the kitchen for safety and cleanliness. The CEO stated the frequency of audits varied, but she did not have any documentation of auditing the kitchen for cleanliness. She stated she was not aware of the condition of the kitchen. The CEO stated the last three kitchen reports, from the contracted company and completed by the RD, did not show any concerns related to cleanliness of the kitchen. The CEO stated it was important to maintain a clean kitchen to ensure a safe and healthy environment for the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, review of the facility's policies, review of the Center for Medicare and Medicaid Services (CMS) memo, and review of the directions for use (DFU) of disinfecting products, the facility failed to identify and correct problems related to infection prevention practices for 3 out of 39 sampled residents (Resident (R) 4, R31, and R32). This failure placed the residents at increased risk for healthcare-associated infections (HAI). Observation of R4's room revealed there was a personal protective equipment (PPE) container outside of the room. There was no sign on the door indicating it was a Contact/Droplet isolation room. Interviews revealed R4 was tested and suspected to be COVID-19 positive. Observation of the Assistant Director of Nursing (ADON) revealed she did not wear gloves when administering eye and nose drops to R31 and did not perform hand hygiene after providing care to R31. Additionally, the ADON did not don (put on) PPE before entering R32's room with enhanced barrier precautions (EBP) and did not clean and disinfect a portable blood pressure cuff and pulse oximeter correctly after using them on R32. Observation of Certified Nurse Aide (CNA) 2, revealed he wore contaminated gloves in the hall and failed to perform hand hygiene after doffing (taking off) the gloves. Observation of the Business Office Manager (BOM) revealed she failed to don PPE before entering room H, a Contact precaution room. The findings include: Review of the Center for Medicare and Medicaid Services (CMS) memo titled, QSO-24-08-NH, dated 03/20/2024, revealed Enhanced Barrier Precautions (EBP) were recommended for residents with chronic wounds or indwelling medical devices and during resident care activities regardless of their multidrug-resistant organism (MDRO) status. EBPs were used in conjunction with standard precautions and expanded the use of PPE to donning of gown and gloves during high-contact resident care activities that provided opportunities for transfer of MDROs to staff hands and clothing. Review of the facility's policy titled, Infection Control, dated 01/24/2024, revealed the purpose of the policy was to maintain a safe, sanitary, and comfortable environment to help prevent and manage the transmission of diseases and infection. In addition, all personnel would receive training on infection prevention and control practices (IPCP) during their hiring process and periodically thereafter. (continued on next page)

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	185069	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review the facility's policy titled, Transmission-Based Precautions (TBP), revised 06/12/2024, revealed transmission based precautions were initiated when a resident developed signs and symptoms of transmission of a transmissible infection or had a laboratory confirmed infection; and was at risk for transmitting the infection to other residents. Per the policy, if a resident was suspected of or identified as having a communicable infectious disease a licensed nurse notified the physician for evaluation of appropriate TBPs. The Infection Preventionist (IP) had the authority to determine appropriate TBPs. Transmission-based precautions might include Contact, Droplet, or Airborne precautions. The signage on the door informed the staff of the type of TBP and instructions for use of PPE. Review of the facility's policy titled, Enhanced Barrier Precaution Policy, revised 03/25/2024, revealed EBPs were additional measures to attempt to decrease the transmission of MDROs. Per the policy, when the resident was placed on EBPs, signs were placed on the door to inform staff of instructions on PPE use. Review of the facility's policy titled, Hand Hygiene - Procedures/Guidelines, revised 09/15/2023, revealed ensuring proper hand hygiene was crucial for staff involved in direct resident contact. Per the policy, hand hygiene should be performed before handling clean or sterile supplies, before performing any aseptic task such as administration of medications, after touching a resident, and after removing gloves. Review of the cleaning and disinfecting instructions for Sani-Cloth Germicidal Disposable Wipes revealed to clean and disinfect non-porous surfaces, the user would use one or more wipes as necessary to wet surfaces sufficiently and thoroughly to clean the surface. Further review revealed the user was to unfold a clean wipe to thoroughly wet the surface and allow the treated surface to remain wet for a full two minutes to ensure complete disinfection of all pathogens, and then allow the treated surface to air dry. Review of the cleaning and disinfecting instructions for Sani-Cloth Bleach Wipes revealed the user would use one wipe to remove visible soil first and clean the surface. Further review revealed the user was to unfold another wipe and thoroughly wet the surface and allow the treated surface to remain wet for a full four minutes to ensure complete disinfection of all pathogens, and then allow the treated surface to air dry. 1. Review of R4's EMR Physician Orders revealed the resident was placed in Contact/Droplet Isolation on 07/15/2024. During an observation of the North Wing, on the initial facility tour on 07/15/2024 at 11:16 AM, a PPE container with supplies was located outside of the resident's room. There was no TBP signage on the door. During an interview with CNA4 on 07/22/2024 at 7:20 AM, she stated there was a rumor that R4 had tested positive for COVID-19. CNA4 stated she was assigned to care for R4 a couple of nights before, and she noticed R4 was not feeling well. She stated Licensed Practical Nurse (LPN) 13 told her R4 had COVID-19. She stated LPN13 put signs on the resident's door after it was confirmed only a few hours before the shift was over; however, CNA4 stated there were no signs on the door or PPE outside the room for most of the night. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LPN13 on 07/22/2024 at 6:45 AM, she stated she suspected R4 had COVID-19. She stated when the resident's daughter showed her the positive test, she placed R4 in Contact/Droplet isolation. She stated she placed PPE outside the room and TBP signage on the door. She stated the signage was on the door during the entire shift. During an interview with the Infection Prevention/Staff Development Coordinator (IP/SDC) on 07/15/2024 at 3:15 PM, she stated R4's daughter, who was a physician, tested the resident and found her to be positive for COVID-19 on 07/14/2024. She stated the daughter notified the staff on 07/14/2024 during the evening shift, but she did not know the time. According to the IP/SDC, once a resident was suspected of having COVID-19, staff should have put up TBP signage. When asked how staff was made aware of a resident in TBP, the IP/SDC stated that it was discussed during change of shift reports and in morning meetings. The IP/SDC stated signage alerted staff that the resident was under TBPs. During an interview with the former Director of Nursing (DON) on 07/16/2024 at 11:00 AM, she stated, On Sunday [07/14/2024] it was only a rumor that R4 was COVID-19 positive. She stated the facility was not convinced R4 had COVID-19. The DON stated R4's daughter told staff she believed her mother had signs and symptoms of COVID-19. She stated, the daughter, a physician, tested the resident, and according to staff, the test was positive. The DON stated the facility ordered COVID-19 testing on 07/15/2024, and test results on 07/16/2024 confirmed R4's status as COVID-19 positive. According to the DON, nursing staff placed a Contact/Droplet isolation signage on the residet's door when staff suspected R4 of having COVID-19. She did not know why the sign was not in place during the State Survey Agency (SSA) Surveyor's observation. 2. During an observation of the ADON on 07/15/2024 at 11:20 AM, revealed she was not wearing gloves when she administered nose drops to R31. The ADON then administered eye drops without using gloves or performing hand hygiene (HH) before going from the nose to the eyes. Furthermore, the ADON did not perform hand hygiene after leaving the room. During an interview with the ADON on 07/15/2024 at 11:32 AM, she stated she should have used gloves when administering eye/nose drops and performed HH after providing direct care to the resident. During an observation of the ADON on 07/15/2024 at 11:40 AM, revealed she went into an EBP room and provided direct care to R32. The ADON did not don any PPE. The ADON obtained vital signs. She exited the room without performing hand hygiene. The ADON placed the shared blood pressure cuff and pulse oximeter on the medication cart and used an alcohol wipe to clean the pulse oximeter and wrist blood pressure cuff. Review of R32's EMR Physician Orders revealed the resident was placed in EBP on 04/25/2024. During an interview with the ADON on 07/15/2024 at 11:46 AM, she stated the policy was to use bleach wipes to clean shared equipment, but she did not have any on her cart. She stated she took the equipment to the nurse's station to get bleach wipes. She stated it was her understanding that taking vitals signs was not direct care and therefore, she would not need to don PPE. She stated she was going to perform hand hygiene after she cleaned the shared equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the IP/SDC on 07/15/2024 at 3:15 PM, she stated all staff were educated to put on PPE for all direct care of residents in EBP. She stated, If you lay hands on the resident or resident belongings, you need PPE. She stated further, all shared equipment should be cleaned with Bleach or Purple Top wipes depending on need, and according to the manufacturer's instruction. She stated disinfectant wipes were kept on the medication cart. She stated alcohol wipes should not be used to clean and disinfect shared equipment. Additionally, the IP/SDC stated nursing staff did infection surveillance based on resident signs and symptoms. She stated following the facility's policies on IPCP was important for the safety and well-being of the residents and staff and to prevent the spread of infections. 3. During an observation on 07/16/2024 at 1:05 PM, CNA2 was seen in the North Wing hallway cleaning a television remote control. After disposing of the disinfectant wipe and removing his gloves, CNA2 did not perform hand hygiene. Additionally, CNA2 was observed throwing trash in a red biohazard container outside room [ROOM NUMBER], which had Contact Precaution signage on the door. Continued observation revealed CNA2 entered room [ROOM NUMBER], obtained a glove from behind the door, put on a glove, and then opened the red biohazard trash can to retrieve the trash. After wrapping the trash inside the glove, CNA2 removed the glove. However, CNA2 did not perform hand hygiene. After that, CNA2 started pushing the meal cart down the hall. During an interview with CNA2 on 07/16/2024 at 1:15 PM, he stated he should have followed proper hand hygiene procedures both before and after putting on gloves. He did not explain why he took the trash out of the red biohazard container, but he stated he should not have done so and should have washed his hands immediately after handling contaminated items. During an interview with the IP/SDC on 07/16/2024 at 1:25 PM, she stated the biohazard trash receptacle should not have been on the outside of the room. She stated staff had been educated to remove gloves and perform hand hygiene. She stated staff should not wear gloves in the hall. 4. Observation of the BOM on 07/26/2024 at 11:45 AM, revealed while passing lunch trays, she opened the door and stepped into room H, a Contact/Droplet isolation room. The BOM did not don the required PPE prior to entering the room. When the BOM saw the SSA Surveyor, she backed out of the room. During an interview with the BOM on 07/26/2024 at 12:50 PM, she stated she did not don PPE before entering room H. She stated as soon as she put her foot in, she realized her mistake and backed out. She stated she did not notice the PPE container on the outside of the room or signage on the door. She stated following infection control measures were important to prevent the spread of infection and keep residents and staff safe. During an interview with the IP/SDC on 07/24/2024 at 10:50 AM, she stated the facility followed CDC guidelines and recommendations related to infection control. She stated it was her expectation that all staff followed the facility's IPCP. The IP/SD stated it was important to always use standard precautions and wear appropriate PPE based on the type of TBP to prevent the spread of infection. During an interview with the ADON on 07/25/2024 at 4:12 PM, she stated it was her expectation that all staff followed IPCP. She stated it was important to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Interim DON (IDON) on 07/30/2024 at 3:45 PM, she stated the facility followed state and federal guidelines and recommendations related to infection control. She stated it was her expectation that all staff followed the facility's IPCPs. She stated it was her expectation the nursing staff monitored for infection control breeches. The IDON stated it was important to prevent the spread of infection. During an interview with the Medical Director on 07/25/2024 at 1:00 PM, he stated it was his expectation that the facility and staff followed IPCP to ensure a safe environment for the residents and staff. During an interview with the Regional Nurse Consultant (RNC) on 07/30/2024 at 4:05 PM, she stated it was her expectation that all staff would follow state and federal guidelines for IPCP. She stated this was important for the safety of residents and staff. During an interview with the Chief Executive Officer (CEO) on 07/30/2024 at 4:30 PM, she stated it was her expectation that all staff followed state and federal and guidelines for IPCP. She stated this was important for the safety of residents and staff and for maintaining a clean and safe environment.