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	11/26/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46710 Based on observation, interview, record review, and review of the facility's policy, the facility failed to honor the resident's right to make choices about aspects of his or her life in the facility that were significant to the resident for one of eight residents investigated for choices, Resident (R) 63. The facility failed to honor the resident's choice of days for a bath. The findings include: Review of the facility's policy titled, Resident Rights, dated 09/13/2024, revealed the facility would respect the resident's individuality and value their input by providing them a dignified existence through self-determination. Review of R63's Face Sheet revealed the facility admitted the resident on 09/17/2024 with diagnoses including surgical aftercare, muscle weakness, and difficulty walking. Review of R63's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/24/2024, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This score indicated moderate cognitive impairment. Further review revealed R63 indicated it was very important for her to choose a bath or a shower as part of her daily routine. Review of R63's Care Plan, dated 09/19/2024, revealed the facility identified R63's need for assistance with personal care, including the intervention of receiving showers for schedule. Review of the facility's document Point of Care History, dated 10/16/2024 - 11/15/2024, revealed the facility documented providing a shower for R63 on 10/22/2024, 10/29/2024, 11/05/2024, and 11/12/2024, which were all Tuesdays. Per the shower documentation, the showers on 10/29/2024 and 11/05/2024 were given after 6:00 PM. Further review revealed the facility documented giving R63 a partial bed bath on 10/18/2024, 10/25/2024, 11/01/2024, and 11/08/2024, which were all Fridays. Observation on 11/11/2024 at 10:49 AM revealed R63 sitting in bed, wearing a beige sweatshirt. Further observation revealed the resident's hair was dirty and unbrushed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mayfair Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 Tates Creek Road Lexington, KY 40502	

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F 0561

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In an interview on 11/11/2024 at 10:49 AM, R63 stated she did not get to choose when she received her shower. She further stated she preferred to get her shower in the morning, but staff often told her they did not have time. R63 stated staff would give a bed bath every few days; however, staff told her they did not have time to give a full shower except for once per week. Per interview, R63 preferred a shower because she felt cleaner after a shower than a bed bath. R63 stated she felt frustrated because she could not choose when to have her shower. Additionally, R63 stated the facility scheduled showers based on what was convenient for them, not on what the residents wanted.

Observation on 11/12/2024 at 10:56 AM revealed R63 was still in the same beige sweatshirt she was wearing on 11/11/2024 at 10:49 AM. Per further observation, R63 asked Certified Nurse Aide (CNA) 4 for a shower and stated she had not had one in two weeks. Per observation, CNA4 told R63 she had given her a shower last week. CNA4 continued to state she would check to see if the resident's shower was due today.

Observation at 11/12/2024 at 4:58 PM revealed R63's hair was still dirty and unkempt. During interview, at that time, R63 stated her daughter had helped her change her shirt because CNA4 had been running and running all day, and no one had come back to give her a shower.

In an interview on 11/12/2024 at 5:02 PM, CNA4 stated she had not given R63's shower because she had not had time due to being staffed with only two CNAs on the South Hall. She stated the resident was supposed to get a shower on Tuesdays and Fridays.

In an additional interview on 11/25/2024 at 11:17 AM, CNA4 stated when there were only two aides on the South Hall, it was nearly impossible to give showers. She further stated sometimes other staff members, such as the medical records keeper would give some showers, but not all of them, and there was not a good system for communicating which residents had been given showers and which still needed them. In continued interview, CNA4 stated residents who were due a shower typically did not want a bed bath instead because they told her bed baths did not make them feel clean in the same way as a shower.

In an interview on 11/13/2024 at 8:30 AM, R63 stated staff gave her a shower last night after dinner. R63 further stated she would have preferred to wait until this morning to have a shower, but she was afraid she would have to wait another week if she did not take a shower when offered.

In an interview on 11/15/2024 at 3:12 PM, the Unit Manager/Assistant Director of Nursing (ADON) stated he was aware residents made complaints about not getting a shower on the South Hall but did not recall specific residents at that time. He further stated that when he was aware a resident had not received a shower, he would personally ensure they received a shower that day so they could feel better. The ADON stated the shower schedule was set when he started in this role, and residents generally adapted to the twice weekly schedule on admission. Per interview, if the resident stated to the admitting nurse they would prefer a shower on a different day or time, the facility would try to accommodate that preference. Additionally, the ADON stated the facility would go above and beyond to give a resident a third shower in a week if the resident wanted it, and if staff was available to give one. He stated, to make sure showers were done, reports were run to check the Point of Care documentation. He stated this was what the direct care staff used to document baths, meals, and other direct care services. He stated if the showers were not done or documented, it was followed up by the management. He stated it would be discussed in the Interdisciplinary Team (IDT) meeting. He stated, if no shower was given, it would be addressed by the Unit Manager and the staff responsible.

(continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/15/2024 at 3:37 PM, the Director of Nursing (DON) stated the facility's shower schedules were already developed when she started as DON in 10/2024. She further stated the process was for residents to be scheduled for a shower twice per week on the days and shifts assigned for each room. The DON stated she recalled the IDT discussing a missed shower but did not recall further details. Per interview, the DON's expectation was for residents to get to choose when their shower was given because that was their right and should be something the facility could find a way to accommodate. In an interview on 11/15/2024 at 4:29 PM, the Administrator stated the facility's process for developing a shower schedule was for the Unit Manager to develop and adjust a schedule based on the resident's needs, while also working to distribute the workload for staffing so there were not too many showers due on the same day and shift. He further stated it would be his expectation that the admitting nurse would ask the resident about shower preferences on admission, but he did not know if the facility did that consistently. Additionally, the Administrator stated resident centered care was important to meet the resident's expectations for care. 50192

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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 - Immediate jeopardy to resident health or safety 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** 45990 Based on interview, record review, and review of the facility's policies, the facility failed to have an effective system in place to ensure residents were free from exploitation. As the representative payee for Resident (R) 17, the facility failed to properly manage and account for the R17's personal funds for one of four sampled residents (Resident (R)17). Review of R17's financial record titled Resident Statement Landscape which provided documentation of Resident Fund Management Service (RFMS), revealed large amounts of withdrawals, without a check and balancing system, beginning 12/22/2021 through 12/19/2023. Immediate Jeopardy (IJ) was identified on 11/15/2024 at 5:16 PM and was determined to exist on 12/22/2021 and Substandard Quality of Care (SQC) was identified at 42 CFR 483.12, Freedom from Abuse and Neglect, F602, related to KY00044055. The facility was notified of IJ and SQC on 11/15/2024 at 5:16 PM. On 11/15/2024 at 5:16 PM, the facility Administrator, Director of Nursing (DON), and Care Consultant were provided a copy of the IJ Template and notified that the facility failed to ensure it safeguarded, handled, and tracked monetary funds as the representative payee for Resident (R)17. This failure allowed resident(s) to potentially be exploited by family, staff, and friends. The facility provided an acceptable plan for removal of the IJ on 11/20/2024 alleging the deficient practice constituted Past IJ. The survey team validated the IJ was removed on 08/23/2024, following the facility's implementation of the plan for removal of the IJ. The deficient practice remained at a D scope and severity (S/S) following the removal of the IJ. The findings include: Review of the facility's policy titled, Resident Trust Fund (RTF), effective date 11/10/2014 and last reviewed and revised 12/01/2018, revealed the facility was entrusted with safeguarding, holding, handling, and tracking certain monetary funds belonging to its residents per their written request. Continued review revealed no more than the monthly state allowable amount would be issued in the form of cash to any one resident. Further review of the policy revealed larger amounts of the residents money would be issued as a check and required a minimum of a 24 hour notice. The policy revealed the authorized signer must evaluate the check for reasonableness and support. Continued review of the policy revealed the BOM should report immediately any unusual activity, to include the resident requesting large sums of cash, to the Administrator and the Business Services Consultant. In December of 2023, the facility reported to the State Survey Agency (SSA) that the Social Security Administration investigated concerns related to possible exploitation of a resident's money, in which the facility was the Representative Payee (Resident (R)17). According to the report, during an annual routine audit, the Social Security Administration discovered the resident's money was not spent according to the Social Security guidelines. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Abuse, Neglect, and Misappropriation of Property, dated 05/27/2016 with revision date of 09/15/2023, revealed the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property. The policy defined exploitation as taking advantage of a resident for personal gain through use of manipulations, initiation, threats, or coercion. Review of R17's Face Sheet revealed the facility admitted the resident on 12/17/2019 with diagnoses to include anxiety disorder, altered mental status, and transient cerebral ischemic attack (TIA). Review of R17's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Review of the Social Security Administration Correspondence to R17, dated 06/04/2020, revealed the Social Security Administration had chosen the facility to become her representative payee, and the facility would use the resident's money for her needs. Review of the Social Security Administration Correspondence to the facility, dated 10/11/2023, revealed the Protection and Advocacy conducted a review of the facility's residents. Further review revealed the Protection and Advocacy evaluated the facility's service provided as the residents representative payee, on behalf of the Social Security Administration. Review of the former Social Service Progress Note, dated 11/16/2023 at 2:45 PM, revealed the resident had verbal outbursts regarding her money. Per the progress note, R17's child had recently gotten out of jail and was calling her and asking for funds. Continued review revealed R17 was educated to spend money on self, but she still became angry. Review of R17's Progress Note, dated 11/22/2023 at 2:57 PM, revealed R17 had requested $2000 for her child and grandchildren for Christmas, monies (cash), and gift cards. The note stated the request was denied, and R17 became irate and demanded money. Additional review revealed R17's BIMS score was 12 on this date, indicating a moderate cognitive deficit. Review of the Protection and Advocacy Correspondence to the facility, dated 03/19/2024, revealed the Protection and Advocacy met with the facility on 11/02/2023 and reported its findings to the facility. Further review of the correspondence revealed the facility had inadequate controls for safeguarding beneficiary funds, receipts for large and unusual purchases, missing records not retained for two (2) years, and accounting reports were not returned on time. Review of the Social Security Administration Correspondence to the facility, dated 05/20/2024, revealed the facility had met with the Protection and Advocacy representative on 11/02/2023 to conduct a review of the facility's Corrective Action Plan. Further review revealed the Protection and Advocacy Analyst determined the facility had implemented its Corrective Action Plan and it was determined the facility had fulfilled its duties as the representative payee. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R17's document titled Resident Statement Landscape [Facility's Name] Resident Trust Acct, revealed debits titled as personal needs deductions, with no distinction between cash or gift cards, of $100 or greater per day as follows: 12/22/2021 - $2000; 02/23/2022 (1) - $100 (2) $22.00; 02/28/2022 - $100; 04/06/2022 - $200; 04/12/2022 - $2000; 05/09/2022 - (1) $60 and (2) $60; 06/17/2022 - (1) $150 and (2) $45; 06/22/2022 - (1) $2000, (2) $25, and (3) $45; 06/28/2022 - $180; 07/05/2022 - (1) $130 and (2) $500; 07/11/2022 - $200; 07/13/2022 - (1) $120 and (2) $30; 07/27/2022 - (1) $55 and (2) $65; 08/01/2022 - $290; 08/09/2022 - $3000; 08/22/2022 - (1) $50 and (2) $80; 08/25/2022 - (1) $1200 and (2) $20; 09/01/2022 - (1) $60 and (2) $40; 09/30/2022 - (1) $60, (2) $2760.96, and (3) $100; 11/22/2022 - (1) $1700 and (2) $60; 12/28/2022 - $1900; 01/12/2023 - $1773.19; 01/25/2023 - $150; 02/24/2023 - $1900; 03/23/2023 - $150; 03/30/2023 - (1) $75, (2) $18, and (3) $150; 04/12/2023 - $250; 05/08/2023 - $1000; 05/30/2023 - $850; 07/05/2023 - $2150; 08/08/2023 - $400; and 12/19/2023 - $300. Review of R 17's document titled Resident Statement Landscape [Facility's Name] Resident Trust Acct, dated 12/28/2023, revealed the facility reimbursed the resident 18,594. During interviews with R 55 on 11/11/2024 at 9:15 AM, R 44 on 11/11/2024 at 10:00 AM, and R 15 on 11/11/2024 at 9:00 AM, they stated they had no concerns with their funds at the facility, and the facility took good care of them. R 15's daughter was present during the resident's interview and reported no concerns. During an interview on 11/12/2024 with R 17, she stated she had no concerns with money other than she did not get enough of it. Further, she stated she just wanted to go home and did not want to discuss her funds. In an interview with Family Member (FM)17, on 11/15/2024 at 11:38 AM, he stated he, his wife, and children no longer received gift cards or cash from his mother, R17. FM 17 stated in the past his cousin or his father would pick up gift cards and large amounts of cash from the facility that the former Social Services Director (SSD) would leave in an envelope at the front desk to be picked up. FM 17 stated, if his cousin or his father were not able to stop by the facility to pick up the gift cards and cash, the former SSD would mail them to him, his wife, and kids, which was out-of-state where they resided. He stated he would call and text the former SSD on her personal cellular phone to make the request for gift cards and cash from R17. The FM 17 stated he was not sure if the former SSD informed R17 of the amounts requested for gift cards and cash. During an interview with the former BOM on 11/13/2024 at 1:15 PM, she stated she was now employed as the Social Services Assistant but had been the BOM during the time R17s funds were distributed to her family. The former BOM stated she could not recall the policy or process for the distribution of the resident's funds during that time. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the current BOM on 11/13/2024 at 10:25 AM, he stated he was not employed at the facility during 2023 and could not speak to R17's distribution of funds. He stated his tasks as BOM included keying in all deposits and keeping track of most all of the transactions. He stated the Administrator was in charge as the representative payee, but he did not know who was responsible in 2023 since he did not work at the facility then. He stated the process now was that residents made a request to the Assistant BOM. He stated then the BOM would check to see if the funds were available to cover the request. Further, he stated the facility would make out the check, and each check must have two signatures and proof of what the funds were for, with the Administrator signing the check last. He stated if the funds were not being spent for the resident's needs, the transaction would not go through. He stated if the request was for a large amount of money, usually above the resident's $60 monthly allowance, then that would be broken up in increments over a few days. During an interview with the Protection Agency Analyst Representative on 11/14/2024 at 8:57 AM, she stated her job title was representative payee analyst. She stated her department looked at the representative payee for social security payees. Per the interview, she stated she was familiar with R17's financial statements for November and December of 2023. However, she stated she was prohibited by the Social Security Administration to report her findings to anyone. She advised the State Survey Agency (SSA) Surveyor to ask the facility for reports of the Corrective Action Plan and the Verification of Correction, which were given to the facility. In an interview with the former Social Service Director (SSD), on 11/15/2024 at 11:46 AM, she stated she was unaware the facility was R17's representative payee. The former SSD stated R17 came to her office and made requests to send FM 17, his wife, and her grandchildren gift cards and cash. The former SSD stated once R17 made the request, the former Administrator would write her a check. The former SSD stated once she received the check, she would cash the check to make the requested purchases for R17. The former SSD stated if she was busy and was not able to attend to R17's request right away, R17 would come to her office angry, irate, yelling, and harassing her to get her request filled immediately. She further stated she gave R17's son, wife, and grandchildren gift cards and cash. Per the interview, she stated she did not feel as though she was doing anything wrong at the time, as she thought she was meeting the needs of the resident. Further interview with the former SSD, on 11/15/2024 at 11:46 AM, she stated she was never paid for goods and services. The former SSD stated in November 2023 the former BOM handed her a reconciliation form and told the former SSD she needed to complete the form. The former SSD stated the former BOM explained to her that a form should have been completed as the facility was the resident's representative payee. Further, the former SSD stated she was informed at that time that the previous BOM had applied on the facility's behalf to become the resident's representative payee so that the resident's monthly expenses could be covered. In continued interview, on 11/15/2024 at 11:46 AM, the former SSD stated an investigation was initiated by the Regional Business Office Consultant and Adult Protective Services. The former SSD stated in 12/2023 the investigation was completed, and she came to the facility and handed the former Administrator her resignation letter, which was effective immediately. The former SSD stated she was devastated to learn the facility was the resident's representative payee and would have never given the resident large sums of money to give away to her family and friends. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the former Social Worker (SW), on 11/14/2024 at 10:40 AM, she stated she remembered R17. She stated she remembered there had been a huge investigation about R17's funds, and when it was discovered no one at the facility knew the facility was the resident's representative payee (RP). She stated when R17 was first admitted , there were issues with her son taking funds. She stated that in order for the facility to receive payment, the BOM had to request to become the resident's RP, on behalf of the facility. The SW stated the previous BOM should have informed staff of the facility's responsibility as R17's RP, prior to leaving the facility. However, she did not tell anyone. During an interview with the Regional Business Office Consultant (RBOC) on 11/14/2024 at 3:00 PM, she stated she had been doing this for about [AGE] years. She stated her job duties included making sure facilities were following guidelines set forth by the Social Security Administration and assuring facility documents were filled out correctly. She stated she was still performing monthly random audits as guided by the Corrective Action Plan. She stated she discovered R17's discrepancies when she looked at the RP audits. She stated she found all the receipts for gifts and monies. She stated she felt the facility did not follow the RP procedures at that time, but the old policy was very vague. She stated the policy was revised after R17's incident to reflect segregation of duty and to include more specifics. In continued interview with the Regional Business Office Consultant (RBOC), on 11/14/2024 at 3:00 PM, she stated currently R17 was the only resident the facility had listed as its Representative Payee (RP), adding this facility had very few people that used the RP services. She stated the purchase of the gift cards was very excessive and staff was allowing R17 to have more money than she should have received. During an interview with the former Administrator on 11/14/2024 at 9:19 AM, she stated she was the Administrator from April 2023 to August 2024. She stated she reported the allegation of exploitation to the SSA back in December of 2023. She stated the report was based on an audit the Social Security Administration performed. She stated she really could not remember the findings, but until that time the facility was unaware they were R17's RP and that was why the distribution of monies happened. She stated the prior BOM had left employment at the facility, and no one knew the facility was R17's RP. She stated the former SW would purchase items for the resident, but was unsure of what really happened with R17's funds. In an interview with the former [NAME] President of the facility on 11/15/2024 at 4:33 PM, she stated the complaint reported was self-reported by the facility. The former [NAME] President stated she found out the Social Security Administration had visited the facility to complete the RP audits. The former [NAME] President stated the SSD bought everything R17 had asked for and that included purchasing gift cards and large amounts of cash available for family to pick up at the facility. The [NAME] President stated the facility reimbursed R17 in a check due to the facility taking responsibility and recognizing the facility failed to protect the resident from exploitation. She stated the former SSD was suspended while this incident was investigated. During an interview with the facility's current Interim Administrator on 11/14/2024 at 9:43 AM, he stated the facility acted as a gatekeeper for all transactions when assigned as the RP for a resident. He stated if the facility saw a resident was giving away monies to family, there would be a concern since those monies were there for resident needs and supplies. Further, he stated if there was any suspicious activity in a resident's account, the facility would look into it as soon as possible. (continued on next page)

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F 0602

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The facility provided an acceptable IJ Removal Plan on 11/20/2024 that read verbatim:

1. Resident #17 account was audited by the Signature Compliance Department on 11/22/23 and credited by the facility for $18,594.15 on 12/13/23. The facility is the representative payee for Resident 17. The ResidentTrust Fund policy was reviewed and revised on 3/26/24 by the Signature Compliance Department and Signature Business Services Department to include requirements for disbursement logs for petty cash box, remaining funds deposited back into a resident trust account after shopping, direct debit, and representative payee. Resident 17 was interviewed on 8/19/24 by the Administrator. Resident stated she had no issues, complaints, or concerns on how her money was being handled at that time. Resident 17 was concerned about the personal needs allowance being $40 and was reminded by the Facility Administrator that the amount was increased to $60 in July 2024, and she expressed understanding. Business Services Consultant audited Resident 17's trust account on 8/19/24 to ensure there are no concerns related to the withdrawals, deposits, closed accounts, representative payee accounts, authorization agreements, trust fund petty cash box, and recordkeeping practices. No concerns were noted. Resident followed by psychiatric services and social services and remains at her baseline. Resident also continues to participate actively in group and individual activities with no concerns noted. Required updates are being provided to the Social Security Administration regarding representative payee account for Resident #17 by the Business Office Manager as indicated. Business Office Manager reviews Resident#17'strust account monthly to ensure all monies dispersed are for resident care needs and receipts/invoices are present to account for the monies dispersed.

2. The facility is the representative payee for no other residents. Out of an abundance of caution, starting on 8/19/24 and completed on 8/21/24, the Business Services Consultant audited all resident trust accounts to ensure there are no concerns related to the withdrawals, deposits, closed accounts, representative payee accounts, authorization agreements, trust fund petty cash box, and recordkeeping practices. Starting 8/19/24 and completed on 8/21/24, all current residents with a Brief Interview for Mental Status (BIMS) score of 8 or above were interviewed by the Social Services Director to inquire if they had any concerns about their trust account. Starting 8/19/24 and completed on 8/21/24, resident representativesfor residents with BIMSbelow8 were interviewed by Social Service Director to inquire if they had any concerns about the resident trust account. No concerns were noted.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mayfair Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The Resident Trust Fund policy was reviewed and revised on 3/26/24 by the Signature Compliance Department and Signature Business Services Department to include requirements for disbursement logs for petty cash box, remainingfunds deposited back into a resident trust account after shopping, direct debit, and representative payee. The Regional Business Services Consultant educated the Signature Care Consultant (SCC) on the ResidentTrust Fund Policy on 8/19/24. A posttestwasgiven and 100% was obtained.The sec educated the Interim Administrator on the Resident Trust Policy on 8/19/24. A posttest was given and 100% was obtained.The Interim Administrator educated the Director of Nursing, Social Service Director, Business Office Manager, and Assistant Business Office Manager on the Resident Trust Policy on 8/19/2024 and completed by 8/21/24. A posttest was given to these staff members after the education was provided. A score of 100% was required and anyone not receiving a 100% score was re-educated and provided another posttest. This process continued until a 100% score was obtained by all staff. All new Administrators, Business Office Managers, Social Service Directors, and Assistant Business Office Managers will be required to have all education and posttest during orientation by the Administrator or Regional Business Services Consultant prior to their working. A score of 100% is required and anyone not receiving a 100% score will be re educated and provided another posttest. This process will continue until a 100% score is obtained by all staff. The Signature Care Consultant educated the Interim Administrator, Social Service Director, Unit Managers, Staff Development Coordinator, Activities Director, Minimum Data Set Coordinator, Business Office Manager and Interim Director of Nursing on the Abuse, Neglect and Misappropriation of property policy starting on 8/16/2024 and completed by 8/20/24. A Post test was given to these staff members starting on 8/16/24 and completed by 8/20/24 after the education was provided. A score of 100% was required and anyone not receiving a 100% score was re-educated and provided another posttest. This process continued until a 100% score was obtained by all staff. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Interim Administrator, Social Service Director, Unit Managers, Staff Development Coordinator, Activities Director, Minimum Data Set Coordinator, Business Office Manager and Interim Director of Nursing educated all facility staff which included certified nurse aides, Kentucky Medication Aides, Licensed Nurses, Therapy staff, Environmental Staff, activities staff, maintenance staff and business office staff on the Abuse, Neglect and Misappropriation of property policy starting on 8/17/24 and completed by 8/22/24. Post test given to these staff members starting on 8/17/24 and completed by 8/22/24 after the education was provided. A score of 100% was required and anyone not receiving a 100% score was re-educated and provided another posttest. This process continued until a 100% score was obtained by all staff. Any Staff not receiving this education and posttest by 8/22/24 will receive this education and post test prior to being able to work their next shift. A score of 100% will be required and anyone not receiving a 100% score will be re-educated and provided another posttest. This process continued until a 100% score was obtained by all staff. The facility does not utilize agency staff. All new hires to the facility will receive education on Abuse, Neglect and Misappropriation of funds and posttest during orientation by the Administrator, Director of Nursing, or Staff Development Coordinator prior to their working. A score of 100% is required and anyone not receiving a100% score will be re-educated and provided another posttest. This process will continue until a 100% score is obtained by all staff. Starting 8/24/24 ongoing, the Business Office Manager conducts a monthly audit of all residents for whom the facility is the representative payee to ensure that all monies dispersed are for resident care needs and receipts/invoices are present to account for the monies dispersed. The Social Services Director, Business Office Manager, or Assistant Business Office Manager will conduct interviews of 5 random residents or resident representatives to determine if they have any concerns related to the resident trust account. This will occur weekly x 4 weeks, then reduce to monthly x 2 months. Results of the audits will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exists the audits will be conducted on a random basis. The Regional Business Services Consultant will audit 2 resident trust accounts weekly x 4 weeks and then reduce to 2 resident trust accounts monthly x 2 months to ensure there are no concerns related to the withdrawals, deposits, closed accounts, representative payee accounts, authorization agreements, trust fund petty cash box, and recordkeeping practices. 4. An Ad Hoc Quality Assurance meeting was held on 8/19/24 with the Medical Director, the Facility Administrator, the Director of Nursing, and the Signature Care Consultant (SCC) regarding plan of correction that was formulated and implemented at that time on 8/19/24. The facility administrator presented the plan and information at the QAPI meeting on 8/19/24. The Medical director attended on 8/19/24 and was notified of implementation of plan of correction. The Medical Director reviewed the entirety of the plan and made no further suggestions. The Medical Director stated the plan was appropriate. Starting on 8/19/24 the Facility Administrator held a Quality Assurance meeting weekly for 4 weeks to review audits and discuss any concerns related to those audits regarding resident #17 exploitation. No concerns for exploitation or misappropri ati on were noted in the audits dating back to 8/19/24. QAPI meetings were then decreased to monthly for recommendations and further follow up regarding the above stated plan. No concerns for misappropriation or exploitation have been identified and 100% compliance has been maintained. Moving forward the facility administrator will continue to be the person who presents the information and audits at the QAPI Meetings, and the following members are expected to be present unless unable to attend: Facility Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Staff development Coordinator, Plant Ops Director, Social Services Director, Activity Director, Therapy Director, and MDS Coordinator. The QAPI Committee willdetermine at what frequency any ongoing audits will need to continue. The Administrator is responsible for implementing this plan.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 50192 Based on observation, interview, record review, review of the facility's job description, and review of the facility's policies, the facility failed to provide R46 with devices necessary to maintain hearing for 1 of 3 residents investigated for hearing device use, Resident (R) 46. The facility failed to provide alternate communication devices to R46 when his hearing aid was not functioning appropriately, starting in 07/2024. This adversely affected R46's ability to receive private information and participate in life-enrichment activities from 07/20/2024 until 11/13/2024 because he did not have a supplemental communication device. As a result of not providing a more private method of communication, and the staff resorting to yelling in the resident's ear, his care needs and any personal information was exposed to everyone in the area. The findings include: Review of the facility's policy titled, Resident Rights, effective 06/01/2015 and last revised 09/15/2023, revealed federal and state laws guaranteed certain basic rights to all residents of the facility. These rights included the resident's right to privacy and confidentiality. Review of the facility's policy titled, Activity Program, effective and revised date 08/22/2023, revealed one-to-one activities would engage residents to their capacity level within each activity session to promote and provide social, cognitive, physical, and emotional well being and would stimulate or provide solace to promote self-respect, self expression, personal responsibility, and choice. Per the policy, the Activity Director, should provide appropriate adaptations for a resident who required them as needed. Review of the Job Description for Social Services Director, dated 05/2022, revealed this position would identify and provide for each resident's social, emotional, and psychological needs. It also stated the Social Services Director (SSD) would provide for the continuing development of the resident's full potential during his/her stay at the facility. Review of R46's Face Sheet revealed the facility admitted the resident on 07/17/2024 with diagnoses of hemiplegia and hemiparesis following a cerebral infarction (stroke), cognitive communication deficit (extreme hearing deficit), need for assistance with personal care, and depression. Review of R46's Grievance Report, filed in 7/2024, revealed R46's daughter stated her father's hearing aid had been washed with his bed linens on 07/20/2024. Per the report, R46's daughter/Power-of-Attorney (POA) took the hearing aid to an outside audiologist who claimed it was repaired and confirmed it was working by a computer. However, per the report, R46's daughter stated it still was not working for the resident to hear human voices without static. Review of R46's Activity Note, from 10/2024, revealed the resident enjoyed music, television, and bingo. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R46's Point of Care (POC) Certified Nurse Aide (CNA) documentation on 11/13/2024 revealed a new entry that R46 had impaired communication, and the intervention was a communication board and an amplifier. Observation on 11/12/2024 at 9:28 AM revealed R46 was in his pajamas with his face unshaven. He did not respond to the knock at the door or conversation with his roommate. When the State Survey Agency (SSA) Surveyor tried to communicate with him, he did not respond. His roommate stated he was deaf, and you would need to yell in his right ear. Further observation revealed R46 was able to read lips but not well. During an interview on 11/11/2024 at 7:21 PM with R46's daughter/POA, she stated she had concerns as she reported in her complaint to the facility about the 07/20/2024 incident. She stated R46 had not been able to hear correctly since his hearing aid was broken, and she was concerned that the audiology service provided by anyone else besides the company that sold them to her, might interfere with the warranty of the hearing aids. During an interview on 11/12/2024 at 9:38 AM with the Activity Director (AD), she described R46 as more of an observer. She stated R46 used to come out of his room and hang out, but since the facility had COVID he had spent more time in his room. She stated staff provided R46 with one-to-one activities in his room. The AD stated the resident was hard of hearing and required staff to elevate their voices to his right ear, but he responded within expected accuracy. The SSA Surveyor told the AD that R46 was asked if he had used a communication board, and he stated he had not, but he had an interest in one. The AD stated that was a good idea, and she would supply this for him. During an interview on 11/12/2024 at 1:18 PM, the SSD stated R46 had his right hearing aid washed with his sheets. She stated his daughter took it to an outside provider, and it tested to be in working order. She stated the daughter had declined the audiology service the facility used at that time due to warranty or insurance concerns. She stated the damage occurred on 07/20/2024 per the grievance log, and they were deemed in good repair on 08/29/2024 by the outside audiologist to whom the daughter took the hearing aid. During an interview on 11/13/2024 at 9:40 AM with the Staff Development Coordinator (SDC), she stated she did not recall any occasion when R46's communication needs were addressed with staff education. During an interview on 11/13/2024 at 9:57 AM with the Director of Nursing (DON), she stated she felt R46 currently communicated well with the staff when he chose to. She stated staff had to speak loudly for him to understand. During an interview on 11/14/2024 at 11:05 AM with the Minimum Data Set (MDS) Director, she stated she had access to communication boards and Super Ear headphones but did not know where they were kept. She stated she did not recall ever using either with R46. During an interview on 11/13/2024 at 10:33 AM with R46, he expressed he was very happy with the amplified headset provided to him by the SSD today. He exhibited no confusion during the conversation. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 3:37 PM with the Director of Nursing (DON), she stated, as a result of R46 having the headphone-style amplifier, he would likely enjoy life better now that he was able to hear. During an interview on 11/13/2024 at 1:20 PM, the Administrator stated he spoke with the Social Worker about the facility's audiology company, and R46's family preference of using their audiology company. He stated a Super Ear (headphone amplifier) was purchased, and R46 would be allowed to borrow them. He further stated that if it [headphone amplifier] gave him peace of mind, he would work with R46's family.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49050 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure there was sufficient qualified staff available at all times to provide nursing and related services to meet the residents' needs in a manner that promoted each resident's rights, physical, mental and psychosocial wellbeing. On 11/12/2024 observation and interviews revealed only two nurse aides scheduled for 7:00 AM to 7:00 PM on the South Hall, with a census of 37 residents. The findings include: Review of the facility's policy titled, Facility Assessment, dated 2024, revealed the average full time employee per day for the year ending 2023 was 27 nurse aides. Review of the staffing schedule for 11/11/2024 revealed 14 nurse aides were scheduled for the 24-hour period from 7:00 AM on 11/11/2024 to 7:00 AM on 11/12/2024. Further review of the staffing schedule revealed from 7:00 AM on 11/12/2024 to 7:00 AM on 11/13/2024, 12 nurse aides were scheduled for the 24-hour period. Review of the staffing sheet on 11/11/2024 revealed three Certified Nursing Aides (CNA) were scheduled for the South Hall of the facility. Observation of facility staff on 11/12/2024 at multiple times revealed only two CNAs working the 7:00 AM to 7:00 PM shift on the South Hall. Review of the facility's Census, dated 11/12/2024 for the South Hall, was 37 residents. During an interview on 11/12/2024 at 1:57 PM with CNA2, he stated there were three CNAs on the North Hall and two CNAs on the South Hall. He stated he felt rushed because he had 17 to 18 residents to take care of during his shift. He stated the nurses would help if they had time. However, most of the time there were only two aides on the South Hall. CNA2 stated the unit had a lot of rehab residents, and they required more attention than some of the residents on the North Hall. He also stated with the current outbreak of COVID in the facility, it took so much more time when donning (putting on) and doffing (removing) Personal Protective Equipment (PPE) when providing care, passing lunch trays, and taking the bags of garbage from the residents' rooms from all the PPE. In an interview on 11/14/2024 at 10:32 AM with CNA2, he stated on 11/12/2024 because there were only two CNAs on the South Hall, a medical records person gave showers but did not take assignments. In an interview on 11/12/2024 at 5:02 PM, CNA4 stated she had not given R63's shower that day because she had not had time. She further stated R63 was supposed to get a shower on Tuesdays and Fridays. CNA4 stated the medical records aide had given showers that morning, but she did not know if she had been able to do R63's shower. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/25/2024 at 10:39 AM, CNA7 stated she had seen two aides working on the South Hall several times, although she did not remember exactly how many. She further stated when there were only two CNAs on South that would make each CNA responsible for 20 to 25 residents each. CNA7 stated when each aide was responsible for that large of a group, residents were likely to get their food late, which could make it cold, and it was hard to answer call lights timely. CNA7 further stated aides having more than 20 residents in their assignment would mean incontinent residents would have to wait more than two hours to get changed, which would be upsetting to the resident and could cause skin issues. Per interview, CNA7 stated management sometimes answered call lights, but would tell residents to wait for their aide to provide incontinence care. Additionally, CNA7 stated that CNAs tried to honor resident's preferences regarding showering, but it was not always possible due to staffing. In an interview on 11/14/2024 at 12:22 PM, CNA8 stated the facility needed more than two or three CNAs on the South Hall to meet the needs of the residents because residents needed to get up for therapy and tended to have more care needs than those residents on the North Hall. During an interview on 11/13/2024 at 11:22 AM with the Director of Therapy, she stated her staff would assist residents in moving from one area of the facility to another if staff was busy. She stated there were times when therapy staff had to help because nursing staff could not get to residents because of other duties. In an additional interview at 11/25/2024 at 11:17 AM, CNA4 stated when there were only two CNAs working the South Hall, residents had longer wait times to get their call lights answered, and she did not have as much time to talk to them to determine their needs and preferences. She further stated it was almost impossible to give showers with only two aides, and even if an additional staff member gave the showers, they often did not communicate with the CNAs effectively so they would know which showers they had given. CNA4 stated if someone who was not assigned a CNA group answered a call light, they would often only take care of the resident's issue if it could be done quickly and would not take a resident to the bathroom, change a brief, or perform other more time-consuming care tasks. During an interview on 11/12/2024 at 2:50 PM with CNA7, she stated on the North Hall if there were three CNAs, they had between 12 to 14 residents each, and if there were four aides, they had 10 to 12 residents each. She stated there were more shower aides on the weekend. She stated they would pull someone from the South Hall if the North Hall was short-staffed. In an interview on 11/25/2024 at 9:59 AM, Kentucky Medication Aide (KMA) 6 stated when she was working as a KMA, she typically spent most of her time administering medications but might help CNAs with short tasks, such as repositioning a resident or passing a tray. She further stated when she was working as a KMA, she did not have time to assist with a longer task, such as giving a shower, as well as administering medications on time. She stated she was responsible for a large group of residents' medications, so she likely would not have spare time to assist CNAs with their tasks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/2024 at 11:59 AM with Licensed Practical Nurse (LPN) 1, she stated typically on the South Hall there were two to three CNAs, two nurses, and no KMA. She stated, on the North Hall there were two nurses, a KMA, and four CNAs. She stated every day at lunch, one of the nurses from the South Hall had to go to the dining room to observe and help with lunch. She stated that left one nurse on the floor to administer medication, obtain glucose checks, take new admissions, chart, and perform resident care. She stated it made it really hard to get work done. She stated there was one day they asked her to go to the dining room, but she declined because she had just received a new admission and could not receive orders and take care of the new resident. She also stated on 11/12/2024 there were only two CNAs on the South unit. She stated on 11/12/2024, she helped change four different residents during lunch and helped with lunch trays. She stated it was extremely busy on the South Hall because the shorter stay residents had higher needs, and staff did not really know them as well as the long term residents. She stated having to do the CNAs' tasks took away from her ability to administer medication or respond if there was a resident who coded or had a medical emergency. During an interview on 11/13/2024 at 2:15 PM with Registered Nurse (RN) 1, she stated staffing was an issue at the facility. RN1 stated staffing was low due to employees calling out on their assigned shifts, and when call outs happened the facility could not run to its full potential and meet the expectations required for the residents. RN1 stated for instance, on 09/19/2024, R2 was not fed breakfast before he left for church at 9:30 AM due to low staffing in dietary and trays not being prepared at the scheduled mealtime of 7:30 AM. RN1 stated the facility would call CNAs on their scheduled days off to come in and assist with giving showers. RN1 stated that considering the current number of COVID residents and low staffing in dietary and floor staff, it was taking the aides a longer time or they were not able to complete tasks to care for residents with answering call lights, giving showers, and distributing evening snacks. During an interview on 11/13/2024 at 2:07 PM with the Director of Nursing (DON), she stated she had only been at the facility for three weeks. She stated she was always on the floor assisting staff with resident care and making sure all residents' needs were met. She stated it had been challenging because of COVID in the facility and not knowing if staff would come to work or call out sick. During an interview on 11/13/2024 at 10:54 AM with the [NAME] President of Operations (VPO), he stated the facility's assessment was created to determine the staffing needs based on resident acuity, number of residents assigned to each staff member, and patterns of resident care. He stated the facility tried to staff toward 3.20 hours per resident/day. He stated the facility's assessment did not provide those numbers. The VPO stated the facility used a staffing formula created for the company to determine residents' needs and the number of staff to meet those needs. During an additional interview on 11/14/2024 at 10:54 AM with the [NAME] President of Operations, he stated the facility's staffing ratios were determined by the Minimum Data Set (MDS) assessment and by a system (Strive) which was created by the Centers for Medicare and Medicaid Services (CMS) to determine per patient day (PPD) hours for staff. He stated the facility was projected to be 3.03 hours/PPD. The VPO stated, during situations where the facility might be experiencing higher acuity, the Administrator had the ability to go 30 percent above projections to account for the increased workload, which would equal 3.93 hours/PPD. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/2024 at 10:17 AM with the Administrator, he stated there was a formula used to determine staffing. He stated the formula took into account the level of care required, the MDS assessment, and other variables. He stated, on the South Hall, most of the residents were short term and it required nurse aides to spend more time and answer call lights for those residents than the residents on the North Hall, who had a longer relationship with staff, so the staff could better anticipate their needs. He stated when an aide calls out (did not come to work) or was late, management would pull some other staff to take an assignment. He stated the other staff might pass trays or answer lights because they would take on the load left open by the aide who was not present. The Administrator stated management pulled salaried staff to take assignments. Further, he stated this was reflected in the schedule for Payroll Based Journal (PBJ) tracking because these employees communicated with the business office and made sure those hours were documented in the PBJ to reflect coverage of hours in the facility. In continued interview, with the Administrator on 11/14/2024 at 10:17 AM, he stated, when management staff assisted on the floor, their hours needed to be accounted for in the PBJ to help ensure it did not trigger the facility for low staffing. He stated each time a member of management covered an hourly assignment, they were required to indicate that on the staffing sheet. The Administrator stated he expected all the administrative staff to be on call or fill in when necessary. He stated he could be seen on the floor assisting staff and residents to ensure each resident was receiving the assistance they needed. Further, he stated he expected the facility to have enough staff to adequately address all residents' needs and provide them with appropriate care. 46710

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45990 Based on observation, interview, record review, review of the facility's policies, and review of the Centers for Disease Control and Prevention (CDC) signage, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases for 3 out of 83 current residents, Resident (R) 2, R65, and R30. Observations on 11/11/2024 revealed Certified Nurse Aide 11 (CNA11) delivered a food tray to another room while still wearing her contaminated face shield that had been worn in a droplet/contact isolation room; and, CNA11 did not use the correct procedure to don (put on) and doff (remove) personal protective equipment (PPE) in a droplet/contact isolation room. The findings include: Review of the facility's policy titled, Infection Control, effective date 01/23/2024, revealed it was intended to help the facility maintain a safe, sanitary, and comfortable environment to prevent and manage transmission of diseases and infections. Additional review revealed the objectives of infection control policies and procedures were to prevent, detect, investigate, and control infections in the facility. Continued review revealed additional objectives included establishing guidelines for implementing Isolation Precautions including Standard and Transmission-Based Precautions. The policy revealed all personnel would be trained on infection control policies and practices upon hire and periodically on how to use pertinent procedures and equipment related to infection control. Review of the facility's policy titled, Transmission-Based Precautions, effective date 09/15/2023 and review date 06/12/2024, revealed Transmission-Based Precautions were initiated when a resident developed signs and symptoms of a transmissible infection or a laboratory confirmed infection and was at risk at transmitting the infection to other residents. Further review revealed Transmission-Based Precautions could include Contact Precautions, Droplet Precautions, or Airborne Precautions. Per the policy, when Transmission-Based Precautions were implemented, the Infection Preventionist, or designee clearly identified the precautions and the personal protective equipment (PPE) that must be used. The policy revealed posted signage informed staff on instructions for PPE. Review of the facility's signage (procedure to be used and posted by the resident's room) for Contact Precautions, from the CDC and undated, revealed the provider and staff must clean hands, put on gloves and gown, and discard them prior to exiting the room. Review of the facility's signage for Special Droplet/Contact Precautions, from the CDC and undated, revealed everyone must clean hands, wear PPE, which included face mask, eye protection, and gown and gloves at the resident's room door. The signage for removing PPE prior to exiting the room included removing goggles or face shield and place them in a receptacle if reusable, otherwise discard in the waste container. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Mayfair Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	1. Observation on 11/11/2024 at 9:10 AM revealed CNA11 exited R2's and R65's room with a face shield donned. Further observation revealed the residents' room was designated as a droplet/contact isolation room. Continued observation revealed CNA11 then delivered a food tray to room [ROOM NUMBER], which was not designated as a droplet/contact isolation room, wearing the same face shield. a. Review of R2's Face Sheet revealed the facility admitted the resident on 09/13/2017 with diagnoses to include chronic obstructive pulmonary disease (COPD), diabetes, and heart disease. Review of R2's Physician's Orders, placed on 11/05/2024, revealed they included COVID Isolation Droplet/Contact Precautions every shift. Review of R2's Comprehensive Care Plan (CCP), dated 11/05/2024, revealed a problem of infection control. Further review revealed the goal and approach was to maintain droplet/contact isolation precautions. b. Review of R65's Face Sheet revealed the facility admitted the resident on 04/16/2024 with diagnoses to include anemia, high blood pressure, and depression. Review of R65's Physician's Orders, placed on 11/05/2024, revealed they included COVID Isolation Droplet/Contact precautions every shift. Review of R65's CCP, dated 11/05/2024, revealed a problem listed as active infection: positive COVID-19. Further review revealed the goal and approach was to maintain droplet/contact isolation precautions. 2. Observation on 11/11/2024 at 4:45 PM revealed CNA11 donned PPE prior to entering R30's room, which was designated as a droplet/contact isolation room. Additional observation revealed CNA11 donned an N-95 mask (a more effective respirator/facepiece that filtered out 95 percent of airborne particles) over the top of the medical mask already donned and then entered the room. Continued observation revealed after CNA11 donned the PPE, she opened the door to R30's room, and while standing in the doorway she gave R30 a glass of water. Further observation revealed CNA11 then doffed the PPE in the doorway with the door open and discarded it in the waste receptacle inside the room. Review of R30's Face Sheet revealed the facility admitted the resident on 09/05/2024 with diagnoses to include cerebral infarction (stroke), congestive heart failure (condition where the heart did not pump blood as it should), and diabetes. Review of R30's Physician's Orders, placed on 11/05/2024, revealed they included COVID Isolation Droplet/Contact precautions every shift. Review of R30's CCP, dated 11/05/2024, revealed a problem listed as active infection: positive COVID-19. Further review revealed the goal and approach was to maintain droplet/contact isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA11 on 11/11/2024 at 4:45 PM, she stated she received training from the Staff Development Coordinator (SDC) on proper donning/doffing of PPE and had been trained to remove face shields after providing care to residents in isolation for COVID. The SDC stated it prevented the spread of germs. When interviewed why she had not removed her face shield after exiting a droplet/contact precautions room, she stated she got a little mixed up and should not have done it. During the interview she stated she had placed a N-95 mask over her medical mask, as it made her she feel safer, but she had not been trained to do this. During an interview with the Infection Preventionist/SDC on 11/14/2024 at 4:00 PM, she stated droplet/contact precaution signage was placed on room doors to ensure staff members knew the procedure for donning and doffing PPE. She stated training did not include to double mask prior to entering a droplet/contact precautions room because wearing a mask under an N-95 mask could interfere with the seal of the N-95 mask. When asked what staff was trained to do with face shields after using in a droplet/contact isolation room, she stated face shields should be removed and disposed with other PPE prior to exiting the room. She stated staff members were trained on this, and she expected them to follow their trainings to prevent the spread of infection. During an interview with the Director on Nursing (DON) on 11/15/2024 at 3:37 PM, she stated it was her expectation staff abided by the facility's policies. She stated it was important to follow infection control policies to prevent the spread of germs and decrease the risk of infection to staff and residents. During interview with the Medical Director on 11/14/2024 at 12:15 PM, he stated his expectations were for staff to follow trainings, policies, and procedures for infection control to prevent the spread of infections. When asked how often he was updated for COVID infections in the building, he stated he was updated weekly, and at this time, the cases were decreasing. During an interview with the Administrator on 11/14/2024 at 9:43 AM, he stated his expectation of staff was to follow infection control guidelines and COVID policies to keep residents safe. He stated he expected staff to follow all trainings performed by the SDC including for infection control. The Administrator stated there were no issues with the PPE and supplies were plentiful.