STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185076	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradford Heights Nursing & Rehabilitation	950 Highpoint Drive Hopkinsville, KY 42240

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. 47798 Based on observation, interview, record review, and facility policy review, the facility failed to ensure each resident had the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care and the resident had a right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 30 sampled residents (Resident #6 (R6)). The findings include: Review of the facility's policy titled, Resident Self Determination and Participation, dated 02/22/2024, revealed the facility was to promote and facilitate a resident's right to self-determination through support of the resident's choice. Further review revealed a resident had the right to make choices about aspects of his or her life that were significant to the resident. Review of R6's Face Sheet for revealed the facility admitted the resident on 05/06/2016, with diagnoses that included chronic obstructive pulmonary disease (COPD), anxiety disorder, and morbid obesity (severe), due to excess calories. Review of R6's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 08/02/2024, revealed the facility assessed R6 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This score indicated the resident was cognitively intact. Review of R6's comprehensive care plan revealed the facility care planned the resident for Activities of Daily Living (ADL), dated 11/21/2022. Continued review of the ADL care plan revealed the interventions included when bathing or showering R6 was to have a maximum assist of two staff twice weekly and as necessary. Review of the facility's bath/shower schedule documentation revealed from 05/26/2024 through 09/16/2024, R6 received partial to full bedbaths. The shower record noted R6 was to receive showers on day shift; however, over the past four months the resident only received a bed bath/partial bed bath five times on night shift. Further review revealed no documented evidence R6 received a shower during that timeframe. (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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with R6 on 09/17/2024 at 6:00 AM, he stated he would like to take a shower, but he did not think he could fit on the shower bed any longer due to his size. R6 stated he would like to be taken into the shower, have his hair washed, and just let the water run over him. He stated he had voiced his concern about bathing to the new girl (Administrator). R6 stated he had been told he could not have showers because he could no longer fit on the shower bed/table. He further stated it had been a long time since he had been able to take a shower and that made him feel sad. During an interview with Certified Nursing Assistant (CNA) 8 on 09/19/2024 at 10:30 AM, she stated she thought R6 received his baths on the night shift. She stated she had provided care of R6 and he refused his bedbaths often, and told her he had already washed up. CNA8 stated she did not think R6 would fit on the shower bed. She stated she did not think there was any other option for R6 in order for him to be able to take a shower. During an interview with the Assistant Director of Nursing (ADON) on 09/20/2024 at 3:00 PM, she stated residents were given a choice if they wanted a shower or a bed bath. She stated she did not know who was responsible for assessing residents to know their bathing/showering preferences. The ADON stated R6 preferred to have a bed bath. She further stated the facility had bariatric shower equipment that could be utilized for morbidly obese residents. During an interview with the Director of Nursing (DON) on 09/19/2024 at 3:29 PM, she stated R6 was scheduled for baths or showers twice a week. The DON stated R6 had received showers previously using the shower bed; however, he had gained weight and no longer fit on the bed. She stated she thought R6 preferred bed baths and was unaware R6 wanted to take a shower. The DON stated residents should be given a choice and staff should give the resident their preference, a bath or shower. During an interview with the Administrator on 09/20/2024 at 3:00 PM, she stated the facility did not have a set way to assess a resident's preferences, to include their bathing preference. The Administrator stated she thought R6 wanted a bed bath. She stated the facility had a bariatric shower chair that was available to give R6 a shower if he chose to have one. The Administrator stated staff should just ask the resident whether they wanted a bath or shower and just do what they preferred.

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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. 45914 Based on interview, record review, and review of the facility's policy, the facility failed to ensure its grievance policy was followed to ensure prompt resolution of all residents' grievances and completion of such grievances for 2 of 30 sampled residents (Residents (R6 and R73)). The findings include: Review of the facility's policy titled, Resident and Family Grievances, revised 03/14/2024, revealed the facility was to support each resident's and family member's right to voice grievances without fear of discrimination or reprisal. The policy stated the (facility's) grievance official was responsible for overseeing the grievance process; receiving and tracking grievances through to the conclusion. Continued review revealed the staff member receiving a grievance was to record the nature and specifics of the grievance on the designated grievance form and forward the form to the grievance official as soon as practicable. Per policy review, the written decision was to include, at a minimum: the date the grievance was received; steps taken to investigate the grievance; and a summary of pertinent findings or conclusions. Further review revealed the written decision was also to include: a statement as to whether the grievance was confirmed or not confirmed; any corrective action taken; and the date the written decision was issued. In addition, the policy revealed all grievances were to be maintained for a period of no less than three years from the issuance of the grievance decision. 1. Review of R73's Face Sheet revealed the facility admitted the resident on 08/10/2023, with diagnoses that included anemia, coronary artery disease (CAD), heart failure, and diabetes mellitus. Review of R73's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 08/14/2024, revealed the facility assessed R73 to have a Brief Interview for Mental Status (BIMS) score of a 15 out of 15. This score indicated R73 was cognitively intact. Review of the facility's document titled, Grievance Form, dated 09/19/2024, revealed the document concerned R73's report of lost clothing. Continued review revealed R73 was, missing red shorts about three weeks now; however, the grievance date was noted it occurred on 09/10/2024 or 09/11/2024. Further review revealed the Form had not been completed to include who the staff member was investigating the grievance or who was completing the form, and there was no signature documented by the grievance official. In interview, during the Resident Council Meeting, on 09/18/2024 at 2:08 PM, R73 stated he had clothing that had been missing for some time. He stated he was missing a pair of shorts and two shirts ever since those items were taken to the laundry. R73 stated those clothing items still not been returned to him. He stated the facility had told him if they could not find his missing items they would be replaced; however, the resident stated he still had not received the missing items' replacement. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Social Services Director (SSD), on 09/19/2024 at 10:50 AM, she stated she was the facility's grievance official. The SSD stated she had a folder outside her door and made residents aware they could complete a grievance form with their concerns and place it back in the folder or slide it under her door. She stated or the residents could talk with her about their concerns if they preferred. The SSD stated the process depended on the grievance, as not all grievances were documented due to real-time resolutions. She stated if they could resolve the resident's concern right away they would not document that information on a grievance form. Per the SSD in interview however, if a resident's concern required a more thorough investigation that information would generally be documented which also included any Resident Council concerns. She stated anything that was determined to be valid would be addressed immediately. The SSD stated on admission families were asked to put residents' names on their clothing when it was brought into the facility. She further stated if there were concerns with lost clothing and those items were not found, the facility replaced those missing items. 47798 2. Review R6's Face Sheet revealed the facility admitted the resident on 05/06/2016, with diagnoses that included: anxiety disorder, morbid obesity (severe) due to excess calories, and chronic obstructive pulmonary disease (COPD). Review of R6's Quarterly MDS Assessment with an Assessment Reference Date (ARD) of 08/02/2024, revealed the facility assessed R6 to have a BIMS' score of a 14 out of 15, which indicated the resident had intact cognition. Review of the facility's grievance log dated 03/01/2024 through 09/01/2024, revealed no documented evidence of grievances noted for R6. In interview with R6 and Family Member (FM) 9 on 09/17/2024 at 11:06 AM, they stated they were unsure of what a grievance form was. R6 stated he had reported several missing items of clothing (to the Administrator) that had been sent to laundry and not returned. The resident stated he called the new girl (Administrator) that was now in charge if he had any complaints. R6 and FM 9 stated they had not received any communication after the complaints about the missing clothing had been made. In interview with the Administrator on 09/18/2024 at 10:00 AM, she stated she had been in her position for seven months. R6 and FM 9 both had access to her personal cellular (cell) phone and called her with any issue they might have. She stated she just takes care of the problem right then. The Administrator stated she did not document any of the telephone calls from R6 or RM 9, nor the problems they had reported or whether they were resolved. She stated she was not familiar with the facility's grievance policy or what it said; however, she did not feel like her process was incorrect. The Administrator stated she thought the way she handled R6's concerns was adequate. She stated she could only provide the time and date of the telephone calls from her telephone. During an interview with the SSD on 09/20/2024 at 9:18 AM, she stated she was responsible for all grievances and followup. The SSD stated R6 had no documented evidence of any grievances on file. She stated R6 and FM 9 called the Administrator's (personal) cell phone directly and the resident's concerns were handled in real time (right then) by the Administrator. The SSD further stated the Administrator had not communicated any of R6's problems with her. She additionally stated she felt like the Administrator handling R6's concerns/problems in real time was sufficient. (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 additional interview with the Administrator on 09/20/2024 at 3:00 PM, she stated R6 had never voiced any concerns regarding missing clothing. The Administrator stated she did not know what the facility's grievance policy stated because she had not read it word for word. She stated she was unable to say if she had been following the facility's grievance policy and would have to read the policy word for word. The Administrator stated she felt like as long as residents' concerns were addressed it did not matter what the facility's policy stated. In addition, she stated it did not matter if residents' concerns and the resolution of them was documented.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents received a Level II Preadmission Screening and Resident Review (PASRR) referral based on the positive Level 1 PASRR screening results for 1 of 2 residents sampled for Level II PASRR out of the total sample of 30 residents (Resident #23 (R23)). The facility assessed R23 to have a positive Level I PASRR screen on admission on 10/26/2022, related to her diagnoses and psychiatric (psych) stay. Based on the positive Level I PASRR, R23 required a Level II Screening related to diagnoses of schizophrenia and bipolar disorder. However, the facility failed to ensure R23 received a Level II PASRR evaluation as required. The findings include: Review of the facility's policy, Resident Assessment-Coordination with PASRR Program, revised 03/14/2023, revealed, the facility coordinated assessment with the Pre Admission Screening and Resident Review (PASRR) program under Medicaid. Per policy review, the PASRR assessment was to ensure individuals with a mental disorder, intellectual disability or a related condition received care and services in the most integrated setting appropriate to their needs. Continued review revealed all applicants to the facility were to be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the state Medicaid rules for screening. Policy review revealed a positive Level I screen necessitated an in-depth evaluation, known as PASRR Level II, of the individual by the state-designated authority. Further review revealed the PASRR Level II assessment must be conducted prior to admission to a nursing facility. Additional review of the facility's policy revealed the PASRR Level II evaluation should be placed in the resident's Electronic Health Record (EHR). Review of R23's Face Sheet revealed the facility admitted the resident on 10/26/2022, with diagnoses that included schizophrenia unspecified, bipolar disorder unspecified, anxiety, and depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R23, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This score indicated R23 was cognitively intact. Review of the Admission MDS assessment dated [DATE], Section A 1500, Pre Admission Screening and Resident Review, read as follows, Has the resident been evaluated by Level 2 PASRR and determined to have a serious mental illness, and or mental retardation or a related condition. Further MDS review revealed the Pre Admission Screening question was answered No. Review of Section I of the MDS, Active Diagnosis, revealed the facility documented R23's primary medical condition was schizophrenia. Review of R23's Level I PASRR documentation dated 10/28/2022, revealed a positive screening had been identified. However, further review revealed no documented evidence the facility had referred R23 for the required Level II PASRR assessment. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Social Services Director (SSD) on 09/08/2024 at 11:19 AM, she stated R23 had not met all three criteria for a Level II PASRR evaluation, and therefore was not referred for that screening. When the State Survey Agency (SSA) Surveyor asked her R23 could not have a change after being hospitalized in the psych hospital for eight months, the SSD had no response to the question. During an interview with the Director of Nursing (DON) on 09/20/2024 at 5:47 PM, she stated a PASRR Level 2 assessment was not completed for R23, as the resident had not met the criteria in all three categories as stated in the regulation. Per the DON, when the referral came for R23's admission to the facility, she did an onsite visit with the resident at the psychiatric (psych) hospital. She stated she did not recall seeing any recommendations from the psych hospital when R23 was discharged . She stated R23 had her initial visit with psych services in January 2023, and the resident had not exhibited any behaviors since being admitted to the facility. In interview with the Administrator on 9/20/2024 at 7:00 PM, she stated a Level 1 PASRR review was required prior to a resident's admission to the facility. She stated a Level I would trigger if a Level II (PASRR) was to be completed. Per the Administrator, the State system did not trigger a Level II (PASRR) evaluation. She stated she was not sure exactly what would trigger a Level 2 (PASRR assessment). The Administrator stated she did not think that R23 triggered for a Level II even though she had diagnoses of schizophrenia, bipolar, depression and anxiety and was admitted to the facility following an eight month inpatient stay at an acute psychiatric hospital.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on observation, interview, record review and review of facility polity, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment for 2 of 30 sampled residents (Resident (R)23 and R99). 1. The facility admitted R99 on 04/28/2022, and on 05/04/2024 assessed R99 as being at risk for developing pressure injuries. However the facility failed to develop a care plan for at risk for impaired skin integrity or risk for developing pressure injuries. On 05/11/2024, R99 developed a suspected deep tissue injury (SDTI) to the right heel. 2. The facility admitted R23 with diagnoses of schizophrenia, bipolar disorder, depression, and anxiety. However, the facility failed to develop and implement a care plan to address R23's psychiatric diagnoses. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, revised 02/2024, revealed it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident to meet the resident's medical, physical, mental, and psychosocial needs. Continued review revealed the care plan process was to include an assessment of the resident's strengths and needs and was to incorporate the resident's personal and cultural preferences in developing the goals of care. Additionally, all Care Area Assessments (CAAs) triggered by the Minimum Data Set (MDS) Assessment were to be considered in the development of the care plan. Further review revealed the facility's rationale for deciding whether to proceed with care planning was to be documented in the residents' clinical records. 1. Review of the facility's policy titled, Pressure Injury, Prevention, and Management, revised on 08/30/2022 revealed interventions were to be based on specific factors identified in a resident's risk assessment, skin assessment, and any pressure injury assessment. Further review revealed evidence-based interventions for prevention were to be implemented for all residents assessed as at risk or who had a pressure injury present. Additionally, policy review revealed interventions were to be documented on the resident's care plan and communicated to all relevant staff. Review of R99's electronic health record (EHR) Admission Record revealed the facility admitted the resident on 04/28/2022, with diagnoses that included: altered mental status, opioid dependence with withdrawal, and Alzheimer's Disease with late onset. Review of R99's Admission MDS assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 00 of 15, which indicated R99 was severely cognitively impaired. Review of the MDS Section M revealed the facility assessed R99 as at risk for developing pressure ulcers/injuries and not to have unhealed pressure ulcers on admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission MDS Care Area Assessment (CAA) worksheet for pressure ulcer injury dated 05/04/2022, revealed R99 was at risk for and had potential for pressure ulcer/injury. Continued review revealed the risk factors included: decreased mobility, incontinence, altered mental status, and Alzheimer's Disease. Per review, for the question, Care plan considerations would be addressed on the care plan, the facility answered Yes. However, review of R99's EHR revealed no documented evidence the facility developed and implemented a care plan for R99's assessed risk for developing pressure ulcers. Review of R99's care plan revealed a skin integrity care plan was not developed until 05/11/2024, after the resident developed an in-house pressure injury to the right heel. Review of the Comprehensive Care Plan initiated on 05/11/2022, for R99 revealed a focus problem noting the resident had an actual impairment to skin integrity related to fragile skin and weakness. Continued review revealed interventions which included: a pressure reducing mattress to R99's bed, dated 05/11/2024; encouraging good nutrition and hydration in order to promote healthy skin, dated 05/11/2022; pressure reducing mattress to bed, dated 05/11/2022; and wound care as ordered, dated 06/29/2022. Review of the facility's initial wound evaluation dated 05/13/2022, revealed R99 had a facility acquired pressure ulcer, Suspected Deep Tissue Injury (SDTI) with an onset date of 05/11/2022 to the right heel. Per review, the SDTI area measured 4.04 centimeters (cm) x 3.09 cm. Continued review revealed skin prep was ordered, and pressure reduction and offloading were recommended. In addition, recommendations were also noted for ensuring R99's compliance with the turning protocol; using a wedge or foam cushion for offloading (pressure); and elevating the resident's legs regularly. Review of the Progress Note documented by the wound care provider dated 05/13/2022, revealed, R99 had a facility acquired right heel deep tissue injury. (DTI). Continued review of the Note revealed there was a large deep tissue injury to R99's right heel. Further review revealed it appeared the resident rested her heels over the edge of her wheelchair which was likely to cause the injury. In addition, the wound care provider recommended skin prep to the DTI every shift and to continue with the protective booties. interview on 09/18/2024 at 1:18 PM, MDS Nurse 1 stated she and MDS Nurse 2 were responsible for completing the residents' comprehensive care plans. She stated the baseline care plans were initiated by the admitting nurse. MDS Nurse 1 stated she would expect the care plan to have been initiated if a resident had a problem or was at risk for having a problem. She stated the care plan should be developed/revised with interventions as needed. In interview on 09/20/2024 at 10:40 AM, the Unit Manager (UM) stated the admitting nurse was responsible for the developing residents' baseline care plans on admission. The UM stated the MDS Nurse was responsible for updating the care plan. She stated she expected all residents to have a skin integrity care plan. In interview on 09/20/2024 at 10:46 AM, MDS Nurse 2 stated she was responsible for residents' care plans. She stated if she was made aware of a new concern for a resident she updated their care plan. In interview on 09/20/2024 at 3:00 PM, the Assistant Director of Nursing (ADON) stated R99 should have had a baseline care plan developed on admission that addressed the resident's skin integrity. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 09/20/2024 at 5:47 PM, the Director of Nursing (DON) stated she recalled R99 developed a SDTI shortly after admission. She stated R99 had been followed by the wound care clinic after developing the SDTI. The DON stated she was unable to recall any interventions in place for R99 prior to developing the SDTI area. She stated a care plan had been developed for R99 after the SDTI area was discovered. The DON stated she expected care plans to be developed and implemented for all residents. She stated the admitting nurse was responsible for developing residents' baseline care plan and she expected those to be completed on admission. Per the DON heel boots were added as an intervention for R99; however, she was not sure if any other interventions had been initiated. According to the DON, heel boots should have been on the Certified Nursing Assistants (CNA) care guide and on the resident's care plan. She further stated she was not familiar with the MDS Assessment process, but R99 should have had a care plan for skin integrity. In interview on 9/20/2024 at 7:00 PM, the Administrator stated she was not familiar with R99, but the MDS Nurse was responsible for developing residents' care plans. The Administrator stated residents' baseline care plans should be completed within 48 hours of admission. The Administrator stated she would expect the care plan to be developed as required. She stated all residents had interventions in place such as turning and repositioning. 2. Review of R23's EHR Admission Record revealed the facility admitted the resident on 10/26/2022, with diagnoses of anxiety, depression, bipolar disorder unspecified, and schizophrenia unspecified. Review of R23's History and Physical, documentation from an acute psychiatric (psych) hospital stay, dated 09/24/2022, revealed the facility admitted the resident to the acute psych hospital in February 2022. Review of the Admission MDS assessment dated [DATE] for R23, of section A 1500, Preadmission Screening and Resident Review (PASRR) revealed no was the answer to the question, Has the resident been evaluated by Level 2 PASRR and determined to have a serious mental illness, and or mental retardation or a related condition? Review of Section I of the Admission MDS, for Active Diagnosis, the facility documented R23's primary medical condition was schizophrenia. Review of the Quarterly MDS assessment dated [DATE] for R23, revealed the facility assessed the resident as having a BIMS score of 15 out of 15, which indicated R23 was intact cognitively. Review of R23's Comprehensive Care Plan (CCP) dated 10/29/2022, revealed no documented evidence of care plans developed or implemented related to the resident's diagnoses of schizophrenia, bipolar disorder, depression or anxiety. Review of the CCP focus problem, Psychotropic Drug Use dated 02/02/2023, revealed R23 had depression, insomnia, and tremor. Further review revealed the interventions included, administering medications as ordered and to evaluate, record, report effectiveness, and any adverse side effects. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CCP focus problem, Psychotropic Drug Use dated 11/01/2022, revealed R23 was at risk for adverse consequences related to receiving psychotropic medications and to the resident's bipolar and schizophrenia diagnoses. Per review, the interventions dated 11/01/2022 included: reviewing for continued need at least quarterly; quantitively and objectively documenting R23's behavior. Continued review revealed the interventions also included consulting, reviewing, monitoring R23's behavior and response to medication, attempting to give the lowest dose possible, and attempting a gradual dose reduction if not contraindicated. Further review revealed an intervention added for staff to listen when R23 was upset and reassure the resident she was safe. Review of the CCP focus problem, Behaviorial Symptoms dated 12/06/2022, revealed R23 resisted care such as dressing changes, incontinent care, showers, and removal of facial hair at times. Continued review revealed the interventions dated 12/06/2022, included actively involve R23 in care, express willingness to adjust regimen, administer medications as ordered, and monitor and record effectiveness and report adverse side effects. Continued review revealed the interventions also included: allowing R23 to choose options; explaining the disease process and consequences of all of the therapy, medication and care; maintaining a common environment and approach to the resident; and obtaining a psych consult or psychosocial therapy. Further review revealed when R23 began to resist care, stop and try later, do not force the resident to do a task, an intervention dated 01/01/2023. In addition, review of the care plan revealed the interventions encompassed redirecting R23 when the resident made false allegations an intervention dated 01/24/2023, and personal care to be completed with at least two staff assist. In interview on 09/20/2024 at 10:48 AM, the Licensed Clinical Social Worker (LCSW) stated she saw R23 on a weekly basis and the resident's mood was up and down. She stated overall though R23 was doing well. The LCSW further stated she was not aware of any current episodes of behaviors that R23 was having. In interview on 9/20/2024 at 7:00 PM, the Administrator stated she was not sure if R23 should have a care plan (for her psych diagnoses) because care plans varied from person to person. She stated she was unsure if R23 should have a care plan for psychosocial concerns; however, thought R23's diagnoses should have been on the care plan.

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	185076	A. Building B. Wing	09/20/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47798 Based on interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 30 sampled residents, (Resident (R)83). R83 experienced significant weight loss; however, the facility failed to notify the Physician of the resident's significant weight loss and failed to follow recommendations from the Registered Dietician (RD). The findings include: Review of the facility's policy titled, Weight Assessment/Monitoring, dated 01/01/2021 and revised 02/20/2024, revealed the multidisciplinary team was to strive to prevent, monitor, and intervene for undesirable weight loss of facility residents. Review of R83's Face Sheet revealed the facility admitted the resident on 11/29/2023, with diagnoses that included acute kidney failure, disorientation, and weakness. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 08/06/2024, revealed the facility assessed R83 to have a Brief Interview for Mental Status (BIMS) score of seven out of 15, indicating the resident was severely cognitively impaired. Review of an email from the Registered Dietician (RD) to the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), dated 08/20/2024 at 2:54 PM, revealed she recommended R83 be weighed once a week for four weeks. Review of R83's Electronic Medical Record (EMR) revealed no documented evidence the Physician was notified and an order obtained for weekly weights as per the RD's recommendation. Review of R83's vital results documentation revealed on 07/09/2024, the resident weighed 163.8 pounds and on 08/02/2024, the resident weighed 154 pounds which was a 5.98 % weight loss in a 24 day time period. Even though the RD recommended weekly weights be obtained for R83 for four weeks on 08/20/2024, continued review revealed no documented evidence the resident was weighed again until 09/11/2024. Further review revealed on 09/11/2024, R83's weight noted an additional weight loss of 3.8 pounds, as the resident's weight was noted as 150.2 pounds. During an interview with the RD on 09/19/2024 at 9:37 AM, she stated her recommendations were communicated to the ADON and DON via an email. The RD stated on 08/20/2024, she notified the ADON and DON to add weekly weights for R83 due to the resident's significant weight loss. She further stated she expected the Physician to be notified of her recommendations. During an interview with R83's Physician on 09/19/2024 at 6:40 PM, she stated weekly weights was a standing order and she expected the standing orders to be completed. She stated even though weekly weights were a standing order, she wanted to be notified of the RD's recommendations, so she could review R83's chart. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Central Supply/Certified Nursing Assistant (CNA) on 09/20/2024 at 10:55 AM, she stated she was responsible for weighing all residents. She stated the ADON or DON provided her with a list of all residents needing to be weighed. The Central Supply/CNA stated R83 had a history of weight loss, but was currently on monthly weights as the resident had not had any weight loss recently to her knowledge. During interview with the ADON on 09/20/2024 at 3:00 PM, she stated once the RD reviewed a resident's weight, she emailed her (ADON) and the DON with her recommendations. The ADON stated she then notified the Physician and obtained orders, which she entered into the resident's EMR. She stated she verbally communicated the Physician's Orders to staff. The ADON stated they should have followed up on the RD's recommendations, and R83 should have had a progress note documenting that the Physician had been notified of the resident's weight loss with any new orders given. She further stated, there was no documentation of that information in R83's record indicating that had been done During interview with the DON on 09/19/2024 at 3:29 PM, she stated she was unable to locate any documentation that the Physician had been notified of the RD's recommendations for R83 on 08/20/2024, nor of an order entered for the weekly weights to be completed. She stated it was her's or the ADON's responsibility to ensure the Physician had been notified, orders obtained, and related documentation entered in the resident's record. The DON stated she expected staff to operate within their clinical scope of practice. She further stated she expected the residents' Physicians be notified with orders obtained and weights documented as ordered; however, was not sure why that was not done for obtaining R83's weekly weights. The DON additionally stated however, she did not see that any of that had been completed for R83. During interview with the Administrator on 09/20/2024 at 3:25 PM, she stated she expected all staff to work within their scope of practice, including the ADON and DON, who failed to do that. The Administrator stated if the RD recommended R83 have weekly weights obtained, she expected staff to notify the Physician and obtain an order for the weekly weights. She further stated staff should have done whatever the RD and/or Physician wanted done.

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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. 44370 Based on observation, interview, and review of the facility's policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, which had the potential to affect 90 of the facility's 94 residents who consumed food from the kitchen. Observation during the initial kitchen tour revealed numerous food items in the reach-in cooler not labeled or dated. In addition, continued observation of the kitchen revealed [NAME] 2 failed to have a beard covering in place. Further observation revealed [NAME] 2 failed to utilize utensils when serving food, using his gloved hands and not changing gloves. The findings include: Review of the facility's policy titled, Food Preparation and Service, undated, revealed, Culinary service employees shall prepare and serve food in a manner that complies with safe food handling practices. Per policy review, food preparation staff were to adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Continued review revealed bare hand contact with food was prohibited, and gloves must be worn when handling food directly. Further review revealed gloves could also become contaminated and/or soiled and must be changed between tasks, as disposable gloves were single use items and should be discarded after each use. Additionally policy review revealed dietary staff should wear hair restraints, hairnet, hat, and beard restraint, so that hair did not contact food. Review of the facility's policy titled,Leftovers, undated, revealed leftovers were to be properly handled and used or discarded as appropriate. Continued review revealed leftovers were to be covered, labeled, dated and stored appropriately and immediately after the end of the meal service. Policy review revealed leftovers were to be used within three days or discarded. Observation with the Head Cook, during the initial tour of the kitchen on 09/17/2024 at 7:10 AM, of the reach-in cooler revealed 6 bowls of fruit, not labeled or dated; a large container of leftover chili dated 07/15/2024; and 3 peanut butter and jelly sandwiches, 2 cheese sandwiches, and 2 bowls of chicken soup not labeled or dated. In addition, observation of the reach-in cooler further revealed a box of bacon opened with strips of bacon not covered. Interview with the Head [NAME] on 09/17/2024 at 7:10 AM, during observation, she stated all leftover items should have been labeled and dated when stored in the coolers. She stated staff were aware of that information. The Head [NAME] further stated the coolers and walk-in were checked on a daily basis by herself and the Dietary Manager (DM). Observation on 09/17/2024 at 1:39 PM, and on 09/18/2024 at 11:15 AM, of a male cook, revealed he had facial hair with no beard covering in place. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 09/18/2024 at 11:15 AM, during the kitchen tray line observation, [NAME] 2 was observed handling serving utensils and food items with gloved hands. Per observation, [NAME] 2 failed to use utensils when placing the following items on plates: cornbread, chicken strips, hamburger patties, mechanical soft meat, pickles and onions. Continued observation revealed [NAME] 2 failed to change his gloves between tasks, as per facility policy. Further observation revealed the Dietary Manager reminded [NAME] 2 twice to utilize serving utensils; however, the [NAME] continued to use his gloved hands. Additionally, observation revealed [NAME] 2 had facial hair with no covering in place over the hair. Telephonic (Phone) attempts were made to interview the Cook; however, they were unsuccessful. In interview with a Regional Certified Dietary Manager (CDM) on 09/20/2024 at 5:11 PM, he stated he expected foods to be labeled and dated with what the product was when it was made and the expiration date, before the food was placed in the coolers. He stated the Dietary Manager was responsible for ensuring that occurred; however, all staff were trained on that information. The Regional CDM stated facial hair depended on the length of the hair. He said a full beard required a facial covering, but a day or two of growth without shaving would depend on the length of the hair. The Regional CDM stated it was not appropriate or common practice for the [NAME] to use gloved hands to distribute foods. He stated the [NAME] should have used serving utensils to serve all foods. The Regional CDM further stated there was a potential for cross-contamination of foods when handled with gloves. In interview with the Director of Nursing (DON) on 09/20/2024 at 5:47 PM, she stated she had been the DON since 2022. The DON stated she was not sure what the dietary policy was on facial hair being covered. She stated past a certain length it should probably be covered. The DON stated she expected the [NAME] to use serving utensils when serving food. She stated there would be a potential for cross contamination of the food if gloved hands were used. The DON further stated she expected kitchen staff to follow their dietary polices and procedures related to food storage. During interview with the Administrator on 09/20/2024 at 7:00 PM, she stated the dietary department was a contract company and had their own policies. She stated she expected the dietary staff to follow their policies and ensure all items placed in the coolers were labeled and dated. The Administrator further stated she expected staff to use serving utensils when serving food and for facial hair to be covered.

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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. 45914 Based on observation, interview, record review, and review of facility policy, 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 the development and transmission of infections, for 1 of 30 sampled residents, (Resident (R)41). Observation revealed Certified Medication Aide (CMA) 2 administered R41's ophthalmic eye drops without wearing gloves. The findings include: Review of the facility's policy titled, Specific Medication Administration Procedures, dated 05/2022, revealed the purpose of the policy was for administering ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner. Continued review revealed examination gloves were to be utilized to administer the eye drops. Further review revealed the procedure required staff to perform hand hygiene, put on examination gloves, and with a gloved finger gently pull down the lower eyelid to form a pouch while instructing the resident to look up and instill the prescribed number of drops into the pouch near the outer corner of the eye. Review of R41's Face Sheet revealed the facility admitted the resident on 11/30/2020, with diagnoses to include: hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure with hypoxia. Review of R41's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/12/2024, revealed the facility assessed R41 to have a Brief Interview for Mental Status (BIMS) score of a 14 out of 15, indicating the resident was cognitively intact. Observation on 09/17/2024 at 8:45 AM, of medication (med) pass on Wing 200, revealed CMA 2 was providing medications for R41. Record review revealed R41 was prescribed Olopatadine HCl 0.2 % Solution and was to receive one drop in each eye once daily. Continued observation revealed CMA 2 had long fingernails, and did not don gloves prior to or when administering the ophthalmic eye drops to R41. Further observation revealed CMA 2 opened R41's top and bottom eyelids using her thumb and forefinger to administer the eye drops with no gloves on. In interview with CMA 2 on 09/20/2024 at 3:04 PM, she stated she was aware that when administering ophthalmic eye drops she was to clean and sanitize her hands and then shake the eye drops before using. She stated sometimes R41 held her eyes open while she had administered the resident's eye drops. CMA 2 stated during the observation she realized her error, and yes, she should have worn gloves to administer R41's eye drop solution. She further stated she was aware there was a potential for harm for residents if gloves were not utilized including cross-contamination and/or infection. Additionally, she stated she had received training when hired regarding eye drop administration which included using gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with CMA 15 on 09/20/2024 at 3:06 PM, she stated she was aware that when administering ophthalmic eye drops in a resident's eyes, staff should wash their hands, use gloves, and have a gauze pad or tissue for the excess fluid. CMA 15 stated she was also aware that not wearing gloves could potentially cause germs to be spread or cause an infection. She further stated she used a new glove for each eye when administering eye drops. In interview with Unit Manager (UM) 1 on 09/20/2024 at 3:30 PM, she stated the process for administering ophthalmic eye drops required staff to sanitize their hands and don gloves and have a tissue ready when administering eye drops into a resident's eyes. She stated she provided the tissue for residents to wipe off any excess solution. The UM stated if she had observed a CMA providing eye drops without wearing gloves she would have stopped the staff member and provided education on following the policy and procedure correctly. She further stated education and training on administering eye drops was a requirement in all schools, but staff had also received instruction when hired at the facility. In interview with the Director of Nursing (DON) on 09/20/2024 at 3:50 PM, she stated her expectations for CMA's administering ophthalmic eye drops was for them to follow facility policy and procedure, work within their scope of practice, and utilize their training regarding eye drop administration. She stated all CMA's received on the floor orientation when hired. The DON stated there was always a risk of infection if staff were not wearing gloves as required per the facility's eye drop administration policy as with any other medication administration. She further stated if staff were observed administering eye drops without gloves, that would be a teachable moment to ensure it did not happen again. In interview with the Administrator on 09/20/2024 at 4:30 PM, she stated her expectations for CMA's was for them to work within their scope of practice and follow facility policy and procedures when administering ophthalmic eye drops to residents. She stated she was not familiar with the facility's policy on eye drop administration, but had access to that policy if necessary. She further stated she did not believe residents were at risk for potential harm if CMA's were administering ophthalmic eye drops to residents eyes without wearing gloves.