STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185134	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazard Health and Rehabilitation Center	390 Park Avenue Hazard, KY 41702

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on interviews, record review, and policy review the facility failed to ensure that one resident (Resident (R) R119) out of a total sample of 36 residents, was protected from abuse, when R148 slapped R119 on the cheek of her face. Findings include: Review of the facility's policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy revised 07/2024 stated, Our facility does not condone or tolerate resident abuse, this includes .physical abuse .under any circumstances by anyone, including staff members, other residents .Physical abuse includes hitting, slapping, pinching and kicking . Review of R119's undated Admission Record located in the Electronic Medical Record (EMR) under the Resident tab revealed that she was admitted to the facility on [DATE] with a primary diagnosis of chronic lymphocytic leukemia. Review of R119's Quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 08/07/24 included a Brief Interview for Mental Status (BIMS) score of seven out of 15 indicating she had severe cognitive impairment. Review of R148's undated Admission Record located in the EMR under the Resident tab revealed that she was admitted to the facility on [DATE] with a primary diagnosis of dementia and remained in the facility during the survey observations. Review of R148's Admission MDS located in the EMR under the MDS tab with an ARD of-08/19/24 included a BIMS score of three out of 15 indicating she had severe cognitive impairment. Review of R148's Care Plan located in the EMR under the Care Plan tab and revised on 10/29/24 included altered moods and behaviors including agitation, anxiety, physical and verbal combativeness. She had been noted to hit, punch, pinch, kick, and scream at staff. Due to aggressive and impulsive behaviors, R148 had been assigned one-to-one supervision since 08/31/24. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility reported incident investigation dated 10/08/24 revealed R148 and R119 both resided on the secure unit at the facility. Licensed Practical Nurse (LPN2) interviewed R119 who reported she hadn't bothered anyone, was minding her own business when R148 slapped her. A physical assessment was performed and noted no visible injuries. Certified Nurse Assistant (CNA10) witnessed the incident reporting that she was assigned one-to-one monitoring for R148. CNA10 reported that she .was trying to put R119 back in her chair when R148 slapped her on her lower left cheek. CNA11 stated, CNA10 was making sure R119 didn't fall out of her chair and R148 slapped R119. The summary of interviews with staff responsible for oversight and supervision of the residents stated, Both residents reside in the secured unit on 400 hall .Staff that were interviewed stated that R148 requires a one on one sitter and has a lot of behaviors and has to be monitored continuously. She gets agitated easily and is combative. The conclusion of the facility's investigation stated We have concluded the investigation. At this time, we can verify that R148 did slap R119, with no injuries noted. R119 stated she is fine and had no concerns with R148 at this time. During an interview on 10/29/24 at 10:15 AM, R119 stated she did not recall being slapped by another resident. When asked if she knew R148, she stated, Oh yes, she's hateful. When R119 was asked if she was afraid of anyone at the facility, she said no. During an interview on 10/29/24 at 10:27AM, CNA10 reported she was R148's one-to-one monitor the day that she made contact with R119. CNA10 reported she was trying to help R119 back to her seat and all of a sudden R148 open handed slapped R119 on her cheek. R119 had mild redness on her cheek. R148 had been on one-to-one monitoring since one week after her admission. During an interview on 10/30/24 at 12:13PM, LPN2 stated on the day of the incident, staff were trying to assist R119 to sit and R148 reached out and slapped R119. R148 had not been reported to have made physical contact with any other residents but had tried. LPN2 stated that when she interviewed R119 after the incident, she stated she was fine but didn't see it coming and denied being fearful of any residents or staff. When LPN2 interviewed R148 she did not recall anything about the incident. During an interview on 10/31/24 at 11:18 AM, the Administrator stated that at the time of the incident, R148 had a sitter who witnessed R148 getting up and about to stumble. The sitter went to assist and stabilize R148, who then went behind the sitter and came around and smacked R119's face. Staff report to her frequently that R148 had outbursts and became agitated. R 148 gets easily agitated when staff try to assist her.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 46592 Based on record review, interview, and facility policy review, the facility failed to provide written hospital transfer notices for four of six residents (Resident (R) 9, 14, 35, and R58) reviewed for hospitalization out of a total sample of 36 and failed to inform the Ombudsman of the hospital transfers. The failure had the potential to cause residents to not fully understand the purpose of the hospital transfer and the Ombudsman to not be aware of resident transfers to the hospital from the facility. Findings include: Review of the facility's undated policy titled, Transfer and Discharge Rights provided by the Administrator revealed, ensure that the resident's right to refuse a transfer or discharge from the facility is not violated. The only written notice indicated in the policy was related to permanent discharge of the facility. There is no reference for the written notice for transfer when residents are transferred to the hospital. 1. Review of R14's Health Status note dated 07/30/24 and located under the Prog Notes tab of the electronic medical record (EMR) revealed R 14 was transferred to the hospital for a possible pulmonary event. Review of R14's Progress Notes and Misc [miscellaneous] tabs in the EMR revealed no documentation R14 or her representative were provided with written notice of R14's hospital transfer. 2. Review of R35's Health Status note dated 03/31/24 and located under the Prog Notes tab of the EMR revealed R35 had been transferred to the hospital for a having a temperature, feeling weak and nauseated throughout the night. Review of R35's Progress Notes and Misc tabs in the EMR revealed no documentation R35 or his representative were provided with written notice of R35's hospital transfer. 3. Review of R58's Health Status note dated 08/11/24 and located under the Prog Notes tab of the EMR revealed R58 had been transferred to the hospital for a having chest pain and bilateral arm pain. Review of R58's Progress Notes and Misc tabs in the EMR revealed no documentation R58 or his representative were provided with written notice of R58's hospital transfer. 4. Review of R9's undated Face Sheet located in the EMR under the Profile tab revealed R9 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of R9's Nurses Notes, dated 09/11/24, located in the resident's EMR under the Progress Note tab revealed .res [resident] lying in bed .diaphoretic, respirations labored, grunting noise, res [resident] states abd [abdominal] pain . new orders received to send to .ED [emergency department] [sic] . R9 was admitted to an acute care hospital for septic shock, acute kidney injury with tachycardia. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 10:50 AM, Accounts Receivable (AR) stated there is not a transfer notice given in writing to the residents or representatives when a hospital transfer occurs but stated the transport personnel get a transfer form. The AR stated she calls the Ombudsman when a hospital transfer takes place, but stated she was unable to provide documentation of the call. In an interview on 10/31/24 at 5:30 PM the Director of Nursing (DON) stated a transfer form is filled out per resident and given to the transport personnel. She stated the forms indicated pertinent medical information but was not a form stating why the resident was being transferred. When asked if the resident or representative received the notice, the DON stated they did not. The DON also stated she believed AR informed the Ombudsman of hospital transfers, but was unaware it was done by phone with no documented proof. During an interview on 10/31/24 at 5:30 PM, the Administrator was notified of the above documented findings regarding the notifications to the ombudsman. The Administrator stated, I know [AR's name] does that.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 46592 Based on record review, interview, and facility policy review, the facility failed to provide written information regarding the facility's bed-hold daily pricing for three of six residents (Resident (R)14, 35, and R58) reviewed for hospitalization out of a total sample of 36. The failure had the potential to cause confusion for residents planning on returning to the facility. Findings include: Review of the undated facility policy titled, Policy: Bed Hold and provided by the Administrator revealed, at the time of transfer of a resident for hospitalization or therapeutic leave, the facility will provide the resident and/or resident representative a written notice which specifies the duration of the bed hold or if no bed hold days available. The policy did not indicate a daily price for each respective resident's bed hold would be provided on written notice to the residents. 1. Review of R14's Health Status note dated 07/30/24 and located under the Prog Notes tab of the electronic medical record (EMR) revealed she had been transferred to the hospital for a possible pulmonary event. Review of R14's Progress Notes and Misc [miscellaneous] tabs in the EMR revealed no documentation R14 or her representative were provided with written notice of the facility's bed-hold policy including daily pricing when transferred to the hospital. 2. Review of R35's Health Status note dated 03/31/24 and located under the Prog Notes tab of the EMR revealed he had been transferred to the hospital for a having a temperature, feeling weak and nauseated throughout the night. Review of R35's Progress Notes and Misc tabs in the EMR revealed no documentation R35 or his representative were provided with written notice of the facility's bed-hold policy including daily pricing when transferred to the hospital. 3. Review of R58's Health Status note dated 08/11/24 and located under the Prog Notes tab of the EMR revealed he had been transferred to the hospital for a having chest pain and bilateral arm pain. Review of R58's Progress Notes and Misc tabs in the EMR revealed no documentation R58 or his representative were provided with written notice of the facility's bed-hold policy including daily pricing when transferred to the hospital. Interview on 10/30/24 at 10:50 AM, Accounts Receivable (AR) stated the form the facility used explained timeframes and insurance obligations, but there is not a cost per day for the bed-hold on the given form. In an interview on 10/31/24 at 5:30 PM the Director of Nursing (DON) confirmed that the bed hold form did not contain daily pricing for the holds.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure that one out of two residents (Resident (R)147) reviewed for activities of daily living (ADLs) received services to help her maintain her ability to ambulate (walk) after the discontinuation of physical therapy (PT). This created the potential for R147 to decline in her ability to ambulate which could impact her goal of discharge to the community. Findings include: Review of the facility's undated Protocol for Restorative Nursing Program revealed the purpose, Assist residents in maintaining abilities and functions as possible with limits of disease/diagnosis, etc . When it has been determined that a resident may benefit from the Restorative Nursing Program, the nurse/clinical coordinator will implement the restorative nursing program . A Restorative Nursing Care plan will also be initiated for the specific plan to be done . Review of the undated Admission Record in the Electronic Medical Record (EMR) under the Profile tab revealed R147 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke caused by a blocked or narrowed blood vessel in the brain), hemiplegia (complete or severe loss of strength that results in paralysis on one side of the body), and difficulty in walking. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/02/24 in the EMR under the MDS tab revealed R147 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R147 was impaired in range of motion (ROM) on one side to the upper and lower extremity. R147 was dependent on staff for transfers and going from sitting to lying, from lying to sitting, and coming to a standing position from sitting. R147 did not attempt walking. Review of the PT Evaluation & Plan of Care dated 07/28/24 -08/26/24 and provided by the facility revealed a goal, Patient will safely ambulate on level surfaces 50 feet using Hemi-Walker with CGA (care giver assistance) with reduced risk for falls in order to increase independence with all functional ambulation. Review of the PT Discharge Summary dated 10/18/24 and provided by the facility revealed R147 received services from 07/28/24 - 10/18/24. R147 met the goal of ambulating 50 feet using a Hemi-Walker with moderate assistance. Discharge recommendations include, Recommend 2 staff to assist with ambulation with Hemi-Walker 30 feet. Review of the Therapy to Nursing Daily Communication dated 10/18/24 and provided by the facility revealed a recommendation from the PT to nursing for ambulating R147 with staff using a Hemi-Walker following R147's discharge from therapy. Review of R147's Care Plan dated 10/25/24 in the EMR under the Care Plan tab revealed R147 had the, Potential for self-care deficit. Resident requires extensive to total assistance with (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADLs . The goal was, The resident will continue to have needs anticipated and met by staff . Interventions included in pertinent part, Ambulate with assistance to allow as much freedom as possible. During an interview on 10/28/24 at 11:27 AM, R147 stated she was admitted to the facility after having a stroke and prior to that had lived at home independently. R147 stated it was her goal to discharge back to the community, but she had to be more independent in ADLs. R147 stated she needed to continue walking so she could go home. R147 stated she was discharged from PT on 10/18/24 and was supposed to receive restorative nursing and walk with staff as part of the program. R147 stated she had not walked since PT was discontinued and no one had spoken to her about restorative or about walking with her. During a subsequent interview on 10/31/24 at 3:51 PM, R147 stated staff had not offered to walk her since 10/18/24 and no one had come and talked to her about going onto the restorative program or about Certified Nurse Aides (CNAs) or restorative nurse aides (RNAs) walking with her. R147 stated it was very important to her to continue walking. Observations during the survey revealed R147 ambulated in a wheelchair: On 10/28/24 at 11:27 AM, R147 was sitting in a wheelchair in her room. On 10/29/24 at 3:54 PM, R147 was sitting in her wheelchair in the hallway. On 10/31/24 at 10:00 AM, R147 was sitting in her wheelchair near the dining room. On 10/31/24 at 10:34 AM, R147 was sitting in her wheelchair in the hallway. On 10/31/24 at 1:49 PM, R147 was sitting in her wheelchair in the dining room in an activity. During an interview on 10/30/24 at 1:28 PM, PT stated R147 had improved significantly in her ability to ambulate while receiving physical therapy. The PT stated she walked up to 50 feet upon being discharged from therapy on 10/18/24. The PT stated he had referred R147 to nursing staff for ambulation. The PT stated he documented his recommendation for services after discharge from PT on the Therapy to Nursing Daily Communication dated 10/18/24 and provided it to nursing staff. The PT stated the nursing staff determined who would go onto the restorative program and developed the program using the information therapy provided. The PT stated he did not know if R147 was on restorative currently. During an interview on 10/30/24 at 1:55 PM, CNA7 stated R147 was able to stand but it was hard for her to walk. CNA7 stated she did not ambulate with R147. CNA7 stated therapy staff would walk with R147, not the CNAs. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 2:06 PM, MDS Coordinator (MDSC)2 stated therapy staff gave the MDS Coordinators the Therapy to Nursing Daily Communication forms when residents were being discharged from therapy and there were recommendations for nursing services such as restorative. MDSC2 stated the MDS Coordinators met with the Unit Supervisors and talked about which residents would most benefit from restorative services. MDSC stated not all residents with recommendations could go on restorative because there were limitations to how many residents could be picked up and added to the restorative nursing program. MDSC stated there were two restorative aids working each day which allowed for five residents from each unit (four units and a total census of 151 residents) to receive restorative services at any given time. The MDSC stated CNAs could walk residents if the residents wanted to walk if they were not receiving restorative services. MDSC2 stated the MDS Coordinators and unit managers had not discussed R147 going on restorative services yet. During an interview on 10/31/24 at 10:33 AM, Licensed Practical Nurse (LPN)1, who was also the Unit Supervisor for R147's unit, stated R147 was recently discharged from therapy, and she would be in the next batch of residents who could go onto restorative when someone else was discharged (creating an opening). LPN1 stated therapy identified R147 as being a good candidate for restorative and presented nursing with recommendations. LPN1 stated the facility did not always have enough slots to put all residents on restorative who might be eligible or who might benefit, but eventually eligible residents would be added to the program as other residents came off the program. LPN1 stated R147 talked to her on 10/28/24 or on 10/29/24 that she wanted to go on restorative. LPN1 stated R147 wanted to discharge home and restorative was part of the plan to promote discharge. During an interview on 10/31/24 at 12:53 PM, RNA1 stated in August 2024 the facility started up the restorative nursing program again. She was not sure hold long the facility had not had the program. RNA1 verified there were four RNAs. RNA1 stated if the MDS Coordinators felt a resident was at risk of losing Range of Motion (ROM) then they referred them to the restorative program. RNA1 stated, when therapy discharged a resident from therapy services, they sent the recommendation to the MDS Coordinators, who then approved/denied the recommendation. If it was approved, the MDS Coordinator let the RNAs know when the resident was to start restorative and for how long. RNA1 stated tasks usually included ROM, transfers, and walking. During an interview on 10/31/24 at 5:26 PM, the Director of Nursing (DON) stated the restorative program was new, having been implemented a couple of months ago. The DON stated the facility had hired four CNAs to be Restorative Aides. The DON stated therapy provided education to nursing staff regarding their recommendations when residents were discontinued from therapy. The DON stated the RNAs could not manage more than 14 residents each per day. The DON stated that whichever resident was doing their best on restorative would be discharged after about a month and a half so other residents could be added. The DON stated they could not put everyone on restorative who might benefit because they did not want to overload the RNAs. The DON stated residents received restorative services three times a week for a minimum of 15 minutes. The DON stated R147 was determined to get back to the community and verified implementing a restorative program could benefit her.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07342 Based on observation, record review and interview, the facility failed to ensure that it provided an ongoing program to support residents in their choice of activities, both facility sponsored and group activities for one resident (Resident (R)49) of 36 sampled residents. Findings include: Review of R49's electronic medical record (EMR)with an admitted [DATE] from the profile tab listed a diagnosis of Pick's Disease, Parkinson's Disease with dyskinesia, unspecified joint contractures, aphasia, generalized anxiety disorder, major depression, neurocognitive disorder with Lewy Bodies, Alzheimer's Disease, unspecified quadriplegia, contracture of the right hand. R49's Care Plan from EMR under the Care Plan tab dated 08/29/24 revealed a goal for activities indicating the resident will be involved with activities as possible with stable moods and behaviors. The care plan listed preferred activities such as television, music, and sensory stimulation. Observation of R49 on the following dates and time reveal the resident in her bed or wheelchair in front of a television that was turned off in her bedroom and not involved in any activities: 10/28/24 at 10:50 AM, R49 was in bed with no television and no activity 10/29/24 at 9:31 AM, R49 was in bed, no activities, no television 10/29/24 at 10:45 AM, R49 was in bed, no activities, and no television 10/29/24 at 2:05 PM, R49 was in bed, no activities, no television 10/30/24 at 9:30 AM, R49 in her wheelchair in bedroom, no television, no activities 10/30/24 at 10:50 AM, R49 in wheelchair in bedroom, no television, and no activities 10/31/24 at 10:10 AM, R49 in wheelchair in bedroom, no television, and no activities Review of the EMR significant change Minimum Data Set (MDS) with an assessment reference date (ARD) a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated the resident's cognition was severely impaired. Review of the Activity Assessment in the EMR under MDS tab dated 07/11/24 revealed that R49 had no response for all activity preferences. Review revealed written activity logs of May 2024 through October of 2024 revealed 170 days logged of television watching, 11 days/time frames of sensory stimulation and two days of special singings all of which are initialed by the Activity Director (AD). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nurse Aide (CNA) 3 and CNA4 on 10/30/24 at 10:50 AM revealed they could not find R49's television remote to turn the television on so she could watch. CNA3 stated she was not sure how long the television had not worked. Interview with the AD on 10/30/24 at 10:55 AM, the AD stated that I put her in her room to watch television. We have tried sensory stimulation and music and reading, but do not get much of a response. Interview with the Administrator on 10/30/24 at 11:40 AM, the Administrator stated that she was not aware R49's television was not working.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure that one out of three residents (Resident (R)147) reviewed for range of motion (ROM) received services to prevent further declines in ROM after the discontinuation of therapy. Physical therapy (PT) and occupational therapy (OT) recommended R147 to wear right foot and hand splints, and that staff provide ROM exercises. The failure to implement these interventions created the potential for R147 to decline in ROM which could impact her goal of discharge to the community. Findings include: Review of the facility's undated policy titled, Protocol for Restorative Nursing Program revealed, Assist residents in maintaining abilities and functions as possible with limits of disease/diagnosis, etc . When it has been determined that a resident may benefit from the Restorative Nursing Program, the nurse/clinical coordinator will implement the restorative nursing program . A Restorative Nursing Care plan will also be initiated for the specific plan to be done . Review of the undated Admission Record in the Electronic Medical Record (EMR) under the Profile tab revealed R147 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke caused by a blocked or narrowed blood vessel in the brain), hemiplegia (complete or severe loss of strength that results in paralysis on one side of the body), and difficulty in walking. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/02/24 in the EMR under the MDS tab revealed R147 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R147 was impaired in ROM on one side to the upper and lower extremity. Review of the PT Evaluation & Plan of Care dated 07/28/24 -08/26/24 and provided by the facility revealed the reason for the referral was, Pt [patient] reports she was previously living at home alone and was indep [independent] with all mobility without any devices. Pt has declined to required DEP [dependent] x 2 [with two staff] assist for bed mob [mobility] and 2 person assist for transfers and is unable to amb [ambulate] at this time . Current orthotic device = foot drop splint. Thereabout (resting foot splint); Splint/Orthotic recommendations: PRN [as needed] in bed. Location of contracture R [right] ankle .Potential treatment approaches of therapeutic exercises, and orthotic management and training. Goals included, Pt [patient] to be fitted with resting foot splint target 8/10/24. Review of the PT Discharge Summary dated 10/18/24 and provided by the facility revealed R147 received services from 07/28/24 - 10/18/24. R147's response to treatment documented, functional abilities have progressed as a result of skilled interventions. Patient has improved functional transfers, improved wheelchair mobility, improved bed mobility, and improved gait distance . Review of the Therapy to Nursing Daily Communication dated 10/18/24 and provided by the facility revealed a recommendation from the PT to nursing for active and passive ROM, application of the resting foot splint PRN [as needed] in bed, and application of right knee brace when using the Hemi-Walker. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the OT Evaluation & Plan of Care dated 07/27/24 - 08/25/24 and provided by the facility revealed R147 was referred for OT due to functional decline with ADLs/self-care tasks and functional mobility with a goal of enhancing R147's quality of life by improving her ability to return to prior level of living. R147's right upper extremity ROM (including the shoulder, elbow, and wrist) was impaired. Review of the OT Discharge Summary dated 09/19/24 and provided by the facility revealed discharge recommendations included, OT recommends PROM [passive range of motion] for patient's RUE [right upper extremity] for all major joints through all planes of motion daily. OT recommends the use of R [right] resting hand splint daily. Pt tolerated wear of splint without signs of skin breakdown and/or pain/discomfort. Review of the Therapy to Nursing Daily Communication dated 09/19/24 and provided by the facility revealed OT recommended PROM for all major joints through all planes . Right resting hand splint applied daily. Review of R147's Care Plan dated 10/25/24 in the EMR under the Care Plan tab revealed R147 had the, Potential for self-care deficit. Resident requires extensive to total assistance with ADLs . The goal was, The resident will continue to have needs anticipated and met by staff . Interventions included in pertinent part, Therapy/restorative nursing as ordered . Review of R147's Care Plan dated 10/25/24 in the EMR under the Care Plan tab revealed, . Potential for altered skin integrity . Resident requires assist with her ADLs and continues to work with PT . require a resting right foot and a resting right hand splint . Interventions included, Resting hand splint to Right hand QS [every shift] . Resting splint to right foot daily as tolerated. R147's limitations in ROM were not documented on the care plan. The provision of ROM exercises was not documented on the Care Plan. The Care Plan did not identify a problem with R147 refusing application of her splints. Review of the Tasks for September 2024 and October 2024 (through 10/30/24), provided by the facility revealed Certified Nurse Aides (CNAs) documented daily every shift, Monitor - Right multipodus boot to right foot as tolerated q shift .Right resting hand splint to right had as tolerated q [every] shift. There was no task regarding the provision of ROM exercises. During an interview on 10/28/24 at 11:27 AM, R147 stated she was admitted to the facility after having a stroke and prior to that had lived at home independently. R147 stated it was her goal to discharge back to the community, but she had to be more independent in ADLs. R147 stated she needed to continue with exercises on her impaired right side so she could go home. R147 showed the surveyor her right hand that was curled into a fist and stated she could not open her hand. R147 stated she was discharged from OT first and then from PT on 10/18/24 and was supposed to receive restorative nursing after that. R147 stated she had a right knee brace, a right ankle brace, and a right-hand brace. R147 verified staff did not perform ROM exercises with her. During a subsequent interview on 10/31/24 at 3:51 PM, R147 stated staff had not applied her splints at all this week. She stated staff used to help her put them on but lately she had not been wearing them. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations during the survey (10/28/24 at 11:27 AM; on 10/29/24 at 3:54 PM, on 10/31/24 at 10:00 AM, 10:34 AM, 1:49 PM, and 3:51 PM) when the resident was in her wheelchair revealed R147 was not wearing splints. During an interview on 10/30/24 at 1:28 PM, PT stated he documented his recommendation for services after discharge from PT on the Therapy to Nursing Daily Communication dated 10/18/24 and provided it to nursing staff. The PT stated the nursing staff determine who would go onto the restorative program and develop the program using the information therapy provided. The PT stated he did not know if R147 was on restorative currently. He stated his recommendations included R147 wearing a right foot splint as needed to prevent foot drop that was to be worn when she was in bed and the knee brace was to be worn when staff walked R147. During an interview on 10/30/24 at 1:35 PM, OT stated the OT recommendations for R147 after coming off therapy was for her to wear her resting hand splint daily as tolerated. The OT verified the nursing staff was responsible to help her do this. The OT verified the recommendations also included ROM exercises be done with the resident. During an interview on 10/30/24 at 1:55 PM, CNA7 stated staff assisted R147 to wear splints on her right hand and foot as she could tolerate. CNA7 stated R147 had worn the splints previously but was not wearing the splints very often now. CNA7 denied providing ROM exercises to the resident. During an interview on 10/30/24 at 2:06 PM, MDS Coordinator (MDSC)2 stated therapy staff gave the MDS Coordinators the Therapy to Nursing Daily Communication forms when residents were being discharged from therapy and there were recommendations for nursing services such as restorative. MDSC2 stated the MDS Coordinators met with the Unit Supervisors and talked about which residents would most benefit from restorative services. MDSC stated not all residents with recommendations could go on restorative because there were limitations to how many residents could be picked up and added to the restorative nursing program. MDSC2 stated there were two restorative aids working each day which allowed for five residents from each unit (four units and a total census of 151 residents) to receive restorative services at any given time. The MDSC2 stated CNAs could walk residents if the residents wanted to walk if they were not receiving restorative services. MDSC2 stated the MDS Coordinators and unit managers had not discussed R147 going on restorative services yet. During an interview on 10/31/24 at 10:33 AM, Licensed Practical Nurse (LPN)1, who was also the Unit Supervisor for R147's unit, stated R147 was recently discharged from therapy, and she would be in the next batch of residents who could go onto restorative when someone else was discharged (creating an opening). LPN1 stated therapy identified R147 as being a good candidate for restorative and presented nursing with recommendations. LPN1 stated the facility did not always have enough slots to put all residents on restorative who might be eligible or who might benefit, but eventually eligible residents would be added to the program as other residents came off the program. LPN1 stated R147 talked to her on 10/28/24 or on 10/29/24 and notified her she wanted to go on restorative. LPN1 stated R147 wanted to discharge home and restorative was part of the plan to promote discharge. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 12:53 PM, Restorative Nurse Aide (RNA)1 stated in August 2024 the facility started up the restorative nursing program again. RNA1 verified there were four RNAs. RNA1 stated if the MDS nurses felt a resident was at risk of losing ROM then they referred them to the restorative program. RNA1 stated, when therapy discharged a resident from therapy services, they sent the recommendation to the MDS nurse, then the MDS nurse approved/denied the recommendation. If it was approved, the MDS nurse let the RNAs know when the resident was to start restorative and for how long. RNA1 stated tasks usually included ROM, transfers, and walking. During an interview on 10/31/24 at 5:26 PM, the Director of Nursing (DON) stated the restorative program was new, having been implemented a couple of months ago. The DON stated the facility had hired four CNAs to be RNA. The DON stated therapy provided education to nursing staff regarding their recommendations when residents were discontinued from therapy. The DON stated the RNA could not manage more than 14 residents each per day. The DON stated that whichever resident was doing their best on restorative, the resident would be discharged after about a month and a half so other residents could be added. The DON stated they could not put everyone on restorative who might benefit because they did not want to overload the RNAs. The DON stated residents received restorative services three times a week for a minimum of 15 minutes. The DON verified R147 was not currently receiving restorative services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, interview, and record review, the facility failed to maintain the cleanliness of the nebulizer mouthpiece when not in use for one of 36 residents in the survey sample (Resident (R)133). This deficient practice increases the risk of infection for a resident requiring nebulizer therapy. Findings include: Review of R133's Electronic Medical Record (EMR) undated Face Sheet located under the Profile tab, indicated R133 was admitted to the facility on [DATE] with diagnosis of acute and chronic respiratory failure with hypoxia. Review of R133's quarterly Minimum Data Set (MDS) located in R133's EMR under the MDS tab with an Assessment Reference Date (ARD) of 08/01/24, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated R133 was moderately cognitively impaired. Review of R133's Physician Orders located in R133's EMR under the Orders tab, revealed orders dated 08/04/24 Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg (milligram) one inhalation by mouth twice a day. During an observation on 10/28/24 at 12:37 PM, R133's nebulizer mouthpiece was propped up on the nebulizer machine and was not covered in a plastic bag. During an interview on 10/28/24 at 12:49 PM, Registered Nurse (RN) 5 was asked how the nebulizer mouthpieces were to be stored when not in use by the resident. RN5 stated, They are placed in a plastic bag. During an observation and interview on 10/30/24 at 11:22 AM, R133's nebulizer mouthpiece was propped up on the nebulizer machine and not covered with a plastic bag. Licensed Practical Nurse (LPN) 1 went into the resident's room and was asked how the nebulizer mouthpiece was to be stored when not in use. LPN1 replied, The mouthpiece is supposed to be stored in the nebulizer compartment and the cover to the machine is to be closed. Then it is to have a bag over the entire machine. During an interview on 10/31/24 at 4:30 PM, the Director of Nursing (DON) was notified of R133's nebulizer mouthpiece was left exposed and not covered when it was not in use. The DON stated, They are supposed to be in a plastic bag when not in use. During an interview on 10/31/24 at 5:00 PM, the Infection Preventionist (IP) nurse was notified of the observations of R133's nebulizer mouthpiece being uncovered when not in use. The IP nurse stated, It is to be stored in a plastic bag. The IP nurse was asked for the policy concerning the storage of the nebulizer mouthpiece. The IP nurse replied, We don't have a policy. On 10/31/24 at 5:30 PM, the Administrator was notified of R133's nebulizer mouthpiece observed to be propped up by the nebulizer machine and it was not covered by a plastic bag.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, policy review, and review of the admission packet, the facility failed to ensure two out of five residents (Resident (R)78 and R131) reviewed for unnecessary medications with dementia diagnoses had medication regimens free of unnecessary psychotropic medications. Failures included lack of adequate indication and identification of behaviors warranting the use of antipsychotic medications; duplicate therapy, lack of explaining risks versus benefits prior to the initiation of the medications, and a lack of qualitative and quantitative monitoring of behaviors and side effects. This created the potential for overmedication. Findings include: Review of the facility's Admission Agreement provided by the facility revealed, Too many residents, however, particularly those living with dementia, are being given off-label antipsychotic drugs to control their behavior . These drugs can have serious, life-threatening side effects for older people. Antipsychotic drugs are NOT a treatment for dementia or Alzheimer's disease, they are only appropriate for patients with specific mental disorder diagnoses such as schizophrenia . Antipsychotic drugs, when given to older adults with dementia, can be unsafe . they often come with a black box warning about their dangerous, life-threatening risks. A black box warning is the most serious warning by the US Food and Drug Administration. Review of the facility's policy titled, Medication Monitoring and Management dated June 2024 provided by the facility revealed, The facility employs a system to assure that medication usage is evaluated on an ongoing basis . the medication order is evaluated for the following: 1) The dose, route of administration, duration, and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacture's specification for use .The prescriber documents the clinical rationale in the resident's record for using a medication outside these stated guidelines . Facility staff monitor the resident for possible medication-related adverse drug reactions/consequences, including mental status and level of consciousness . When a resident receives medication from the same class or with similar therapeutic effects (duplicate therapy), the clinical rationale and benefit are documented in the resident's record. Review of the facility's undated policy titled, Protocol for Review & Reduction of Psychoactive Medications provided by the facility revealed, Residents that are prescribed psychotropic medications will be evaluated quarterly during the RAI [Resident Assessment Instrument] process and as indicated to ensure that residents are being observed for adverse effects of the medications . 1. Review of the undated Admission Record in the Electronic Medical Record (EMR) under the Profile tab revealed R78 was admitted to the facility on [DATE] with diagnoses including dementia, panic disorder, depression, and anxiety disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/31/24 in the EMR under the MDS tab revealed R78 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. The MDS indicated R78 felt down, depressed, or hopeless seven to 11 days of the assessment period. R78 exhibited no behaviors during the assessment period. R78 received antipsychotic, antianxiety, and antidepressant medications. Review of the quarterly MDS with an ARD of 08/30/24 in the EMR under the MDS tab revealed R78 continued to be moderately impaired in cognition with a BIMS score of 10 out of 15. The MDS indicated that R78 felt down, depressed, or hopeless seven to 11 days of the assess period. R78 exhibited no behavior during the assessment period. R78 received antipsychotic, antianxiety, and antidepressant medications. Review of the History & Physical dated 05/06/24 in the EMR under the Documents tab revealed that R78 had been living at home prior to being hospitalized with nausea, vomiting, diarrhea, and hyponatremia (low sodium). R78 was taking the following medications at home: quetiapine (Seroquel) an antipsychotic 100 milligrams (mg) twice daily (bid) for mood, lorazepam (Ativan) an antianxiety medication, 1 mg at bedtime (q hs) as needed (prn) for anxiety, lorazepam .5 mg bid PRN for anxiety, and Trazadone an antidepressant 100 mg q hs. Review of Orders tab dated 10/29/24 in the EMR under the Clinical tab revealed current physician orders for medications including: -Ativan (lorazepam) tablet 1 milligram (mg), three times a day (tid) for anxiety disorder. Started on 09/05/24. Prior to this date, R78 had been prescribed Ativan 1 mg Q HS PRN and Ativan .5 mg bid prn. -Seroquel tablet 100 mg), one tablet by mouth bid for anxiety disorder, dementia with mood disturbance. This was the same dose R78 was admitted on . Review of the Care Plan dated 09/03/24 in the EMR under the Care Plan tab revealed a focus area of Psych Meds, the resident receives psychotropic medication as ordered. The goal was The resident will be free of adverse reactions r/t [related to] psychotropic medication use through the review date. The specific medications being administered (antianxiety, antipsychotic and antidepressant) were not identified. The interventions included in pertinent part: -Evaluate quarterly and prn for possible dose reductions or discontinuation of psychotropic medication and consult with the MD [Medical Doctor] prn . -Observe for any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS Extrapyramidal Symptoms)(shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cramps, nausea, vomiting, behavior symptoms not usual to the person, etc. -Observe moods and behaviors q shift -Pharmacist to review medications monthly and prn making suggestions to the MD as indicated. The Care Plan did not identify which side effects were associated with which medications. Review of the Behavior Monitoring and Interventions Report from 05/01/24 to 10/29/24, completed by the certified nurse aides (CNAs) revealed there were 47 possible behaviors listed from which the CNAs could document the behavior (or a lack of any behaviors) that occurred and 13 interventions with outcome that could be documented. Documentation indicated R78 exhibited no behaviors over the course of this five-month period. There were no specific behaviors identified for use of Seroquel. Review of the Psychiatric Nurse Practitioner's Progress Note dated 06/25/24 and the one dated 09/04/24 in the EMR under the Documents tab revealed the NP completed a behavior health evaluation and follow up on these dates. R78's affect/mood was, appropriate, anxious. R78's attitude was cooperative. R78 experienced no delusions or hallucinations and had mildly impaired cognitive function. Diagnoses included anxiety disorder, panic disorder, and dementia with mood disorder. Treatment for anxiety disorder was to continue administration of Quetiapine at 100 mg daily. The Progress Note dated 09/04/24 addressing panic disorder documented an increase of lorazepam to 1 mg, tid due to symptoms being inadequately controlled. The EMR (Medication and Treatment Administration Records, progress notes etc.) were reviewed to determine if monitoring for side effects/adverse reactions was documented. There was no documentation of ongoing monitoring for adverse reactions. There was no evaluation for tardive dyskinesia (movement disorder that can be caused by antipsychotic medication use) considering R78's antipsychotic medication use. Review of the quarterly Psychotropic Drug Monitoring Form dated 08/30/24 in the EMR under the Assessment tab revealed R78 received psychotropic medication for behaviors of agitation and irritability. The form did not indicate which specific psychotropic medications or type (antipsychotic, antianxiety, or antidepressant) of medications or the respective doses or changes in doses R78 was administered. There was no qualitative assessment of behaviors related to the psychotropic medication use. Under the heading of Adverse Reactions, a box for None apparent was checked. Under the heading of Evaluation a box for Appears controlled was checked. There was no information related to assessment for a gradual dose reductions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pharmacist's Note to Attending Physician/Prescriber dated 07/18/24 and provided by the facility revealed, The resident receives Seroquel 100 mg po (by mouth) BID (05/25/24) for anxiety w [with]/panic disorder and dementia. The FDA [Food and Drug Administration] issued a black box warning for antipsychotics which states: elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of death, found that these medications were of limited value for elders with dementia, and as a result many feel that these medications are overprescribed . Would you consider using the lowest dose for the shortest time possible and gradually reducing dose in order to discontinue once symptoms subside (please taper prior to discontinuing)? The provider's response dated 07/29/24 was checking the box that read, Disagree: An attempted dose reduction would likely impair the resident function or cause psychiatric instability. Review of the Pharmacist's Note to Attending Physician/Prescriber dated 10/16/24 and provided by the facility revealed, The resident receives Seroquel 100 mg po BID (05/24/24) for anxiety w/panic disorder and dementia. Would you consider the resident a candidate for a gradual dose reduction for the medication above? The provider's response dated 10/30/24 was checking the following boxes that read, Disagree: An attempted dose reduction would likely impair the resident function or cause psychiatric instability and Disagree: Benefits of medication sue at present dosage outweigh risk for current regimen. During an observation on 10/28/24 at 11:16 AM, R78 was lying in bed with her pajamas on with the TV on. When interviewing her, R78 stated she did not feel well, but had no specific complaints. Additional observations revealed R78 stayed in bed as follows: On 10/28/24 at 4:11 PM, R78 was lying in bed under the covers with the door open with her eyes closed. On 10/29/24 at 4:51 PM, R78 was lying in bed with blanket over her with the TV on. On 10/30/24 at 05:49 PM, R78 was lying in bed under the covers and was awake; her meal was on the overbed table. On 10/31/24 at 9:37 AM, 10/31 AM and 1:48 PM, R78 was lying in bed under the covers with the lights off and door open with her eyes closed. During an interview on 10/30/24 at 2:02 PM, CNA7 stated R78 liked to stay in bed. CNA7 stated R78 was anxious or nervous but did not exhibit any behaviors. During an interview on 10/30/24 at 2:27 PM, MDSC2 stated the MDSC Coordinator completed the quarterly Psychotropic Drug Monitoring Forms. MDSC2 stated she looked at diagnoses for antipsychotic medication use and R78's diagnosis for Seroquel was, not appropriate. MDSC2 verified the specific psychotropic medications, doses, changes in doses, and changes in behaviors, were not documented on the quarterly review form. MDSC2 stated the facility tried not to use antipsychotic medications unless a resident hallucinated or delusions or something similar; however, the physician might order them (antipsychotic medications). MDSC2 stated residents were monitored for adverse reactions to medications when a new medication was started or with a dose increase. MDSC2 stated the staff used a paper form that got uploaded into the EMR. MDSC2 reviewed the EMR looking for the paper form associated with the increase in lorazepam on 09/05/24; however, she verified there was no paper form. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 03:16 PM, the Social Service Director (SSD) stated R78 was very anxious and was nervous at baseline. The SSD stated R78 did not want to be a bother to anyone. The SSD stated R78 did not exhibit any other behaviors (besides anxiety). During an interview on 10/31/24 at 10:43 AM, Licensed Practical Nurse (LPN) 1 stated she did not know what specific behavior R78 was being administered Seroquel. LPN1 stated she did not know where documentation for monitoring for potential adverse reactions was located. LPN1 stated R78 did not have an approved diagnosis for use of the Seroquel and that there was a Black Box warning for use of Seroquel showing the medication was contraindicated with dementia. During an interview on 10/31/24 at 3:37 PM, the Director of Nursing (DON) stated behavior monitoring was completed each shift by the CNAs under tasks. The DON stated nurses charted physical behaviors in the progress notes. The DON stated there was no specific monitoring or assessment completed for antipsychotic medications for potential symptoms of tardive dyskinesia. The DON verified potential side effects were to be monitored on a paper form for new psychotropic medications and when medications were increased for a period of seven days. The DON stated the quarterly Psychotropic Drug Monitoring Form did not identify which medications or the doses the resident was prescribed. The DON stated R78 did not have an appropriate diagnosis to support administration of Seroquel. The DON stated R78 stayed in her room often but came out occasionally. The DON stated R78 had a history of anxiety and had calmed down since she was admitted to the facility. During an interview on 10/31/24 at 4:32 PM, the Pharmacist stated he made a recommendation related to Seroquel for R78 in July 2024. The Pharmacist stated R78 was prescribed Seroquel 100 mg a day for anxiety disorder and dementia. The Pharmacist stated he made a recommendation to decrease and eventually discontinue the medication due to there being a Black Box warning of increased risk of death and the medication showing limited value for a diagnosis of dementia. The Pharmacist stated he made a second recommendation to do a gradual dose reduction of Seroquel in October 2024. He stated the Physician had declined both recommendations. 2. Review of R131's undated Admission Record in the EMR under the Profile tab revealed R131 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety, unspecified mood, and depression. Review of the History & Physical dated 08/23/24 in the EMR under the Documents tab revealed R131 was assessed in a medical center after exhibiting altered mental status at home and was diagnosed with metabolic encephalopathy (brain dysfunction caused by an underlying condition). The only psychotropic medication R131 had been administered at home was Trazadone (antidepressant) 50 mg daily. Under the heading of Metabolic encephalopathy, R131 was documented as, Altered mental status may be secondary to dementia changes. Start the patient on Aricept (dementia medication) and Seroquel (antipsychotic). Continue Trazadone. IV [intravenous] Ativan (antianxiety medication) for agitation. Review of the admission MDS with an ARD of 08/30/24 in the EMR under the MDS tab revealed R131 was severely impaired in cognition with a BIMS: score of four out of 15. He had no mood indicators and under behaviors, R131 exhibited verbal behaviors towards others and other behavioral symptoms not directed at others occurring one to three days during the assessment period and wandering behaviors one to three days during the assessment period. R131 received antipsychotic, antianxiety, and antidepressant medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Orders tab dated 10/29/24 in the EMR under the Clinical tab revealed current physician orders for psychotropic medications including: Buspirone HCl (antianxiety medication) oral tablet 10 mg, one tablet by mouth three times a day for generalized anxiety disorder started on 09/08/24. Vistaril (hydroxyzine), an antihistamine, oral capsule 25 mg, one capsule by mouth once a day for anxiety started on 9/23/24. Klonopin (antianxiety/benzodiazepine medication) tablet .5 mg, one tablet twice a day for anxiety started on 10/08/24. Risperdal (antipsychotic medication) 0.5 mg tablet twice a day for unspecified dementia, unspecified severity with other behavioral disturbance ordered on 09/25/24. Prior to this date, R131 was prescribed Seroquel from his admission on 08/25/24; it was discontinued on 09/25/24, the same date that Risperdal was initiated. Review of the Care Plan dated 09/04/24 in the EMR under the Care Plan tab revealed a focus area of, The resident receives psychotropic medication as ordered. The specific medications being administered (antianxiety, antipsychotic and antidepressant) were not identified. The goal was, The resident will be free of adverse reactions r/t [related to] psychotropic medication use through the review date. Interventions included in pertinent part: Administer medication as ordered . Evaluate quarterly and prn for possible dose reductions or discontinuation of psychotropic medication and consult with the MD prn . Observe for any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person, etc. The Care Plan did not identify which side effects were associated with which medications. Review of the quarterly Psychotropic Drug Monitoring Form dated 09/03/24 in the EMR under the Assessment tab revealed R131 received psychotropic medication for a behavior of agitation. The form did not indicate which specific psychotropic medications or type (antipsychotic, antianxiety, or antidepressant) of medications or the respective doses or changes in doses R131 was administered. There was no qualitative assessment of behaviors related to the psychotropic medication use. Under the heading of Adverse Reactions, a box for None apparent was checked. Under the heading of Evaluation a box for No change noted was checked. There was no information related to assessment for a gradual dose reductions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Psychiatric Nurse Practitioner's Progress Note dated 09/04/24 in the EMR under the Documents tab revealed, He is currently being treated with Aricept (donepezil) for dementia, Seroquel (quetiapine) for mood stabilization and sleep, Buspar (buspirone) for anxiety, Trazodone for insomnia, and Vistaril (hydroxyzine) for anxiety. The patient reports that he is doing great since moving into the facility .He has been adjusting well to his new surrounding and expresses no significant issues with anxiety or emotional distress . The staff corroborate that the patient has been adapting well to his new environment and have observed no behavioral concerns or cognitive issues during his stay. Review of the Psychiatric Nurse Practitioner's Progress Note dated 09/25/24 in the EMR under the Documents tab revealed the R131's affect/mood was appropriate, his attitude was cooperative, his insight and judgement were impaired. R131 exhibited no delusions or hallucinations. Treatment for generalized anxiety order included stopping Quetiapine, continuing buspirone, and starting Klonopin .5 mg, one tablet bid as needed. For treatment of dementia, Risperidone .5 mg, one tablet bid was started. The progress note indicated, Over the past few weeks, the patient has been experiencing behavioral disturbance that include increased agitation, irritability, and episodes of screaming and yelling. He has become so distressed that he has started to hit himself during moments of extreme frustration . The patient has become religiously preoccupied, often obsessing about religious themes, and expressing strong beliefs that Halloween decorations are evil . There was no documentation on the form of the Resident's Representative (RR) being contacted about the addition of Risperidone, the new antipsychotic medication, on this date. During an interview on 10/31/24 at 10:13 AM, Registered Nurse (RN)4 reviewed R131's EMR and stated there were no nursing or provider notes showing R13's RR was contacted about the initiation of Risperidone on 09/25/24. RN4 stated when a medication was changed or added the nurses completed paper drug monitoring forms for seven days that were scanned into the EMR. RN4 reviewed R131's EMR and stated she did not see any monitoring forms for the psych medication changes for R131. During an interview on 10/29/24 at 9:01 AM, Family Member (F)131 stated the facility had notified her of some of the psychotropic medications the resident was taking; however, denied the facility had discussed the risks versus benefits of the medications with her. F131 stated she was aware R131 was taking Klonopin; however, was unsure when some of the other psychotropic medications were mentioned. F131 stated R131 was much more active at home and walked around a lot. F131 stated R131 was not walking much anymore. F131 stated, He has more trouble walking, getting up, and feeding himself. Observations revealed R131 was sleeping or staring off at various times of the day during the survey: On 10/29/24 at 4:22 PM, R131 was sitting on the couch in the day room with his eyes open, fixed, and staring off in front of him. On 10/30/24 at 11:03 AM and at 3:25 PM, R131 was lying on the couch in the day room with his eyes closed. On 10/31/24 at 9:39 AM R131 was sitting at the counter in the day room where he ate meals with his head down and eyes closed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/20/24 at 4:07 PM, CNA8 stated R131 could be agitated in the afternoons. CNA8 stated R131 sat out in the day room during the day and napped or talked with residents. CNA8 stated R131 seemed to be adjusting to being in the facility. CNA8 stated she did not have problems providing care to R131. During an interview on 10/30/24 at 3:00 PM, the SSD stated R131 got agitated at times and started hollering. The SSD stated she did not know much about him, and no one had come to her and reported specific concerns. During an interview on 10/30/24 at 2:32 PM, MDSC2 stated R131 screamed, cried, played in his feces, and stated he wanted to go home, and exhibited sundowning. MDSC2 stated R131 was a preacher, and they tried activities such as gospel music, turning religious channels on TV, and had given him sermon books, but the interventions lasted a short while or did not work. MDSC2 reviewed R131's EMR and stated both the regular NP and psych NP had ordered psychotropic medications for R131 and there had been a lot of medication changes. MDSC2 stated the facility did not have a formal system/tool used for monitoring potential adverse reactions to the psych medications. During an interview on 10/31/24 at 3:52 PM the DON stated she was aware the facility was high in psychotropic medication use. The DON stated the facility had done some gradual dose reductions but most of them were unsuccessful and the residents had to go back onto the medications. The DON verified there was no system/form used for monitoring potential side effects. The DON stated the MDS reviewed psychotropic medications quarterly. The DON verified the quarterly form did not address specific medications, discontinuing medications, adding new medications or changes in the doses. During an interview on 10/31/24 at 4:47 PM, the Pharmacist stated he had requested a gradual dose reduction of R131's Seroquel and this had been completed. The Pharmacist stated he was not aware that the provider discontinued one antipsychotic (Seroquel) and ordered another (Risperdal) on the same day. The Pharmacist stated he reviewed medication regimens for duplicative therapy and verified R131 received three different medications to treat anxiety. The Pharmacist stated he would make a recommendation about this within the first six months after admission, adding the resident was new to the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, staff interview, record review and facility policy review, the facility failed to secure medications in a locked medication cart when left unattended on one of four units (300 Hallway). Resident (R)80's insulin was left on top of the medication cart and was left unattended in the hallway where visitors were present. This failure had the potential for an unauthorized person to take this insulin causing harm to themselves or others. Findings included: Review of R80's Electronic Medical Record (EMR) undated Face Sheet located under the Profile tab, indicated R80 was admitted to the facility on [DATE] with diagnosis of type two diabetes mellitus. Review of R80's admission Minimum Data Set (MDS) located in R80's EMR under the MDS tab, with an Assessment Reference Date (ARD) of 07/23/24, revealed a Brief Interview for Mental Status (BIMS) score of 11 of 15 which indicated R80 was moderately cognitively impaired. Review of R80's Physician Orders located in R80's EMR under the Orders tab, revealed orders dated 08/29/24 for Basaglar KwikPen Subcutaneous Solution Pen injector 100 unit/ml (milliliter) Inject 58 units subcutaneously two times a day related to type 2 diabetes mellitus. Observation on 10/30/24 at 5:54 PM on the 300 hallway, Registered Nurse (RN)3 left the medication cart beside the door of room [ROOM NUMBER] and walked around the corner. The medication cart was observed to be left unlocked and R80's Kwikpen insulin syringe was on top of the cart. Two adult visitors and two children were observed to be approximately seven feet diagonally across the hallway at the doorway of room [ROOM NUMBER]. On 10/30/24 at 5:56PM, Licensed Practical Nurse (LPN)1 confirmed the medication cart was unlocked and that R80's KwikPen insulin syringe was on top of the cart. During an interview on 10/30/24 at 6:00 PM, LPN1 stated, The nurse should never leave the medication cart unlocked and walk away. During an interview on 10/30/24 at 6:05 PM, RN3 stated, I walked away and didn't think to lock the cart. When asked if RN3 could visualize the medication cart when she left the, RN3 confirmed that she could not visualize the medication cart. During an interview on 10/30/24 at 6:10 PM, the Director of Nursing (DON) was notified of RN3 leaving the medication cart unlocked and unattended and that R80's KwikPen insulin pen was on top of the cart. The DON confirmed the medication cart was to be locked when left unattended by the nurse. During an interview on 10/30/24 at 6:14 PM, the Administrator confirmed the medication carts are to be locked when left unattended by the nurse. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Storage in the Facility dated June 2024 stated, . Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications such as medication aides are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, record review, document review and policy review, the facility failed to ensure the kitchen was maintained in a sanitary condition to minimize the risk of food borne illness to all 151 residents residing in the facility and who received meals from the kitchen. Specifically, the water temperature in three out of four handwashing sinks in the kitchen was not hot; sanitizer solutions were too strong; microwave ovens were soiled; individual cartons of shakes were not labeled with expiration dates, and the refrigerator/freezers on the units were not monitored and/or were not functioning properly. Findings include: Review of the facility's undated policy titled, Unit Kitchenette Policy provided by the facility revealed, Foods will be stored on the units in a manner that comply with safe food handling practices .Food and nutrition services or other designated staff should maintain clean food storage areas . Refrigerated foods will be stored below 41 degrees . Freezers must keep frozen foods solid and maintain a temperature of 0 degrees or below. Refrigerator & freezer temps [temperatures] will be monitored daily by the nutrition services staff shift food and nutrition aid . No employee items are to be in the resident's refrigerator or freezers at any time. Review of the facility's undated policy titled, Sanitation of Dishes/Manual Washing provided by the facility revealed, Quaternary Ammonium Compound Solutions - Concentration as indicated by manufacturer . Review of the label of Quat-Clean sanitizer revealed, To sanitize immobile items .prepare a fresh solution . The product is an effective sanitizer when diluted in water up to 250 PPM [parts per million] . 1. During the initial kitchen inspection on [DATE] at 10:34 AM, the following concerns were observed: a. The water temperature in the hand washing sink, located across from the steam table, was operated by pressure (pressing against a lever with one's leg). There was no way to adjust the water temperature. The water was turned on and ran for 30 seconds; the temperature was cool. There were three other handwashing sinks in the kitchen that operated in the same manner. b. The microwave oven interior was observed and it was caked with accumulated food/beverage splatters. 2. During a subsequent kitchen observation with the Dietary Manager (DM) on [DATE] at 10:30 AM, the following concerns were observed: a. The water temperature in the hand washing sink, located across from the steam table was turned on and ran for 30 seconds. The water temperature was measured by the DM after 30 seconds and it was 77 degrees Fahrenheit (F), cool to touch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. The water temperature in the hand washing sink, located by the reach-in refrigerator, was turned on and ran for 30 seconds. The water temperature was measured by the DM, and it was 85 degrees F, it was cool to touch. c. The water temperature in the hand washing sink, located in the dish room area, was turned on and ran for 30 seconds. The water temperature was measured by the DM, and it was 64 degrees F, cold to touch. The DM verified none of the water temperatures in these three handwashing sinks were as hot as they should be for adequate handwashing. The DM stated on [DATE] at 10:38 AM that he had noticed previously that the water temperature in the hand washing sink across from the steam table was not always warm. d. The concentration of the wiping rag sanitizer solution in the dish room was checked by the DM using a quaternary ammonia test strip. The concentration was observed and confirmed by the DM as 500 parts per million (PPM). The DM stated on [DATE] at 10:39 AM that the solution should be mixed to a concentration between ,d+[DATE] PPM. The DM checked the concentration of another bucket of wiping rag solution located by the tilt skillet, and it read 500 PPM. The DM stated the dietary staff did not document checking the concentration of the wiping rag sanitizer solutions. The DM went to the dispenser and mixed a new bucket of solution, and it also read 500 PPM. The DM confirmed the solutions were too strong and could leave a chemical residue on the surfaces that were cleaned. e. The microwave oven interior was observed, and it was caked with accumulated food/beverage splatters, in the same condition as noted on [DATE]. The DM stated on [DATE] at 10:41 AM that it was filthy. 3. On [DATE] from 10:36 AM - 11:08 AM the kitchenettes on the resident units were inspected with the DM. None of the refrigerator/freezer logs in the five kitchenettes (100 unit, 200 unit, 300 unit, 400 unit, 440 secure unit) included documentation of the freezer temperatures. The DM verified the logs documented only refrigerator temperatures. In addition, the following concerns are noted in the kitchenettes: a. The kitchenette in the 400 Unit had a refrigerator/freezer. There were two thermometers in the refrigerator; one read 43 degrees F and the other 44 degrees F, verified by the DM, who stated the refrigerator was not cold enough and stated the goal was for temperatures to be 41 degrees F or below. There was a variety of snacks in the refrigerator such as sandwiches, yogurts, and assorted beverages. The DM stated dietary staff was responsible for cleaning and monitoring the refrigerators/freezers and microwaves in the kitchenettes. b. The kitchenette in the 200 Unit had a refrigerator/freezer. The interior of the refrigerator had a large sticky area (food/beverage residue); the DM stated the refrigerator needed to be cleaned. A thermometer in the refrigerator read 44 degrees F. There were four cartons of unlabeled, individually packaged four ounce Ready Care shakes. The label on the shakes indicated the shakes expired 14 days after being pulled out of the freezer. The DM stated it was unknown what date the shakes had been pulled out of the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. The kitchenette in the 300-unit had a refrigerator/freezer. A thermometer in the refrigerator read 52 degrees F. The DM measured the temperature of one of the Ready Care shakes and it was 54.8 degrees F. There were sandwiches yogurts, cream cheese, shakes and other beverages in the refrigerator. There were two undated cartons of Ready Care shakes in the refrigerator. The DM measured the temperature of the freezer, and it was 20 degrees F. The DM stated it should be zero degrees or below. There were popsicles and individual portions of ice cream that were soft to touch. The DM stated they should be frozen solid and indicated he would throw away the contents of the refrigerator and freezer. 3. During an interview on [DATE] at 11:50 AM, the Registered Dietitian (RD) stated the dietary staff should monitor the refrigerator and freezer temperatures on the units every day. The RD stated the sanitizer solution should be mixed to a concentration of 150 - 200 PPM and verified if the concentrator was higher, it was too strong. The RD stated that all individual cartons of health shakes in the unit refrigerators should be labeled so staff would know when to discard them, which was no later than three days after they arrived on the unit. The RD turned on the water at the handwashing sink near the disposal and tested the temperature with her hand. The RD stated the water was cold. During an interview on [DATE] at 5:11 PM, the Maintenance Director stated the maintenance staff checked water temperatures throughout the facility on a weekly basis, which included water temperatures in the kitchen. The Maintenance Director stated the water temperature for the handwashing sinks should be between 100 - 110 degrees F. and temperatures had not been a problem when he checked the hand washing sinks previously. The Maintenance Director stated it could take ,d+[DATE] seconds for the water to circulate and come up to temperature. The Maintenance Director stated he learned today that the refrigerator/freezer on the 300 unit was not working properly The Maintenance Director stated the dietary staff were responsible for cleaning and defrosting the refrigerator/freezers on the units and should notify him if the refrigerator/freezers were not working properly. During a follow up interview on [DATE] at 5:33 PM, the Maintenance Director brought the surveyor his water temperature logs and stated maintenance had been checking the water temperature for the dishwasher in the kitchen. The Maintenance Director stated he had been mistaken earlier in that maintenance staff had not been checking water temperatures in the hand washing sinks. Review of the logs from [DATE] - [DATE] verified the water temperatures of the handwashing sinks in the kitchen had not been monitored.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, record review, interview and facility document review, the facility was to follow Enhanced Barrier Precautions (EBP) when performing direct care to one of 36 residents (Resident (R)108) and failed to update infection control policies annually. This failure has the potential to spread infection to residents, staff are administering direct care to. Findings included: 1. Review of R108's Electronic Medical Record (EMR) undated Face Sheet located under the Profile tab, indicated R108 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, dysphagia, and adult failure to thrive. Review of R108's quarterly Minimum Data Set (MDS) located in R108's EMR under the MDS tab, with an Assessment Reference Date (ARD) of 08/19/24, revealed R108's cognition was severely impaired, and the resident had short and long term memory issues. R108 is also coded as having a gastrostomy (A surgical procedure that creates an opening in the abdominal wall into the stomach to provide nutritional support.) Review of R108's Physician Orders located in R108's EMR under the Orders tab, revealed orders dated 02/05/24 for Glucerna 1.5 @ 45 cc/hr. [cubic centimeter/hour] continuous per pump. There was also a physician's order dated 04/03/24 which stated, Enhanced Barrier Precautions every shift. Observation on 10/28/24 at 12:21 PM, Certified Nursing Assistant (CNA)5 and CNA6 were performing R108's incontinence care. CNA 5 and CNA6 wore gloves but did not wear gowns while providing this care. During an interview on 10/28/24 at 12:41 PM, when asked CNA6 if R108 was in EBP, CNA6 replied, I don't think so. When asked what Personal Protective Equipment (PPE) you would use if a resident was in EBP, CNA6 stated that she was unsure what PPE to wear. When asked which residents should be in EBP, CNA6 stated, Maybe a resident with a tube feeding. CNA6 was asked what EBP was. CNA6 replied, You gown up to protect the residents from your germs. During an interview on 10/28/24 at 12:49 PM, Registered Nurse (RN)5 was asked what EBP was and how would you know if a resident was in EBP. RN5 stated, Anyone in EBP has an orange dot besides the resident's door. Residents are in EBP, they have a wound, tube, or a history of CRE (Carbapenem-resistant Enterobacterales, a group of bacteria that are resistant to antibiotics and can cause serious infections). RN5 was asked if R108 was in EBP. RN5 stated, Yes and that staff are to wear gown and gloves with any type of direct care. During an interview on 10/28/24 at 1:06 PM, CNA5 was asked if R108 was in EBP. CNA5 stated, Yes, she is. When asked if CNA5 wore gown and gloves when performing R108's incontinence care. CNA stated, It slipped my mind. When asked how do you know when a resident is in EBP, CNA5 stated there will be an orange sticker on the outside of the door. When asked what PPE was to be worn when a resident was in EBP, and direct care is being delivered. CNA5 replied, You should wear gown and gloves when the resident is in EBP. (continued on next page)

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Hazard Health and Rehabilitation Center	390 Park Avenue Hazard, KY 41702

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/29/24 at 6:00 PM, the Infection Preventionist (IP) nurse was asked what PPE should be worn for EBP. The IP stated that gown and gloves are to be worn for direct resident care when a resident is in EBP. The IP nurse stated, When performing direct care such as bathing, changing residents, and performing dressing changes to wounds. The IP nurse confirmed R108 was in EBP due to having a feeding tube. During an interview on 10/31/24 at 5:15 PM, the Director of Nursing (DON) confirmed that any staff providing direct care to a resident in EBP are to wear gowns and gloves. During an interview on 10/31/24 at 5:30 PM, the Administrator stated, Staff are to wear gowns and gloves when performing any kind of direct care with residents that have a feeding tube, wounds, or catheters. The CNAs should have been wearing gloves and gowns when performing peri care and changing this resident's brief. Review of the facility's policy titled, Enhanced Barrier Precautions dated 03/24 stated, . EBP includes the use of a gown and gloves during high-contact resident care activities, including dressing, bathing or showering, performing transfers, changing linens, providing hygiene, changing a resident's brief or assisting them with toileting, direct care of an indwelling medical device, such as a central line, urinary catheter, feeding tube, or tracheostomy, and when performing wound care on any skin opening that requires a dressing . 2. Review of the facility's infection control policies revealed the policy titled Infection Prevention & Control Program did not have a date of the last review of this policy. Review of the facility policy titled Antibiotic Stewardship Program was dated Dev. 09/17 . During an interview on 10/31/24 at 6:15 PM, the DON stated, I honestly didn't know they had to be reviewed annually. During an interview on 10/31/24 at 6:15 PM, the IP stated, We talk about this in QA [Quality Assurance], but I don't know about how they are reviewed annually. During an interview on 10/31/24 at 6:35 PM, the Administrator stated she was looking for when the infection control policies were last updated and felt these were last updated during the facility assessment that was completed this year. On 10/31/24 at 7:20 PM, the Administrator returned to the surveyor and provided a copy of the 2024 Facility Assessment Page 20 which stated, .Part 6-Infection Control Program Evaluation (Infection Risk Assessment) 6.2 Staff are trained in basic infection control principles on hire and annually. A more thorough training is based on their position. Audits are conducted randomly such as hand hygiene, glove use, peri care, etc. This identifies areas and individuals that may need further education. Infection Risk Assessment is completed annually . The facility was unable to provide documentation other than the dates on the infection control policies that were provided earlier in the survey prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. 07342 Based on observation and interview, the facility failed to ensure that two corridors were equipped with firmly secure handrails on each side of the hallway which has the potential to affect all ambulatory residents in the facility. Failure to have handrails could affect residents' ability to safely ambulate down the hallways. Findings include: Observation on 10/29/24 at 4:20 PM revealed no handrail on the north front corridor wall in a 12 foot section. The wall was across the hall from the outpatient physical therapy room. Observation on 10/29/24 at 4:20 PM revealed no handrail on the south front corridor wall near the outpatient therapy room measuring six feet. The wall was next to the outpatient physical therapy room. Observation on 10/29/24 at 4:20 PM revealed no handrail on the south front corridor measuring 15 feet near the front door. Observation on 10/29/24 at 4:25 PM revealed no handrail on the east wall 10 feet to the fire doors. Observation on 10/29/24 at 4:25 PM revealed no handrail five feet on the west wall from a second outpatient room door to the smoke doors leading to the 100 unit. Observation on 10/29/24 at 4:25 PM revealed no handrail on the wall at the administrator office measuring 17 feet to the smoke doors leading to the 200 unit. Observation on 10/29/24 at 4:25 PM revealed no handrail on the wall at the ice cream room to the smoke doors measuring eight feet. Interview with the Administrator on 10/29/24 at 4:30 PM verified the lack of handrails on the noted corridor walls above.