STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185154	A. Building B. Wing	09/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Home of the Innocents	1100 East Market Street Louisville, KY 40206

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	483.12 freedom from abuse, neglect and exploitation F603 DBased on observation, interview, record review, and review of facility policy, the facility failed to ensure residents were free from involuntary seclusion for 1 of 3 residents sampled for abuse out of the total sample of 20 residents, (Resident (R)14). The findings include:Review of the facility policy titled, Protecting Residents from Abuse and Neglect, revised July 2024, revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Continued review revealed abuse also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain physical, mental, and psychosocial well-being. Review of the facility policy titled, Protecting Residents From Abuse and Neglect 02.05.01, defined involuntary seclusion as separation of a resident, from other residents or from her/his room or confinement to his/her room (with or without roommates) against the resident's will or the will of the resident's representative. Review of the facility policy titled, Resident Monitoring and Supervision 02.01.14.02, revealed involuntary seclusion included but was not limited to in attempt to isolate a resident to prevent him/her from leaving an area, the resident is involuntarily confined to an area by staff placing furniture, carts, chairs in front of doorways or areas of egress. Further review revealed involuntary seclusion also included a resident physically placed in an area without access to call lights, and/or other methods of communication creating an environment of seclusion and isolation.Record review revealed the facility admitted the resident on 09/09/2002, with diagnoses of Hypoxic Ischemic Encephalopathy; severe intellectual disabilities; spastic quadriplegic Cerebral Palsy; Bronchopulmonary Dysplasia; Tracheostomy Status; and Gastrostomy Status.Review of R14's Comprehensive Care Plan 01/15/2024, revealed the facility care planned the resident as at risk for injury related to lack of self-mobility with lack of safety awareness, behaviors including history of self-injurious behaviors, and presence of enteral feeding tube and tracheostomy tube. Per review of the care plan, staff direct supervision was required for residents who ambulated or had active mobility in wheelchair. Continued review of the care plan revealed active intervention was required to prevent them from wandering in unsupervised areas or exiting the facility. Further review revealed the care plan noted R14 must not be left unattended when up in his wheelchair, including in his room.Review of the Progress Notes dated 03/21/2024, revealed on that date, R14 had been in isolation due to having Rhinovirus (the virus causing the common cold which was highly contagious and spread through respiratory droplets). Review of the Progress Notes dated 03/21/2024, revealed Licensed Practical Nurse (LPN) 13 noted on at 2:47 PM on that date, that R14 reported no new changes and remained in droplet precautions.Review of the facility's investigation initiated on 03/21/2024, revealed it was noted at approximately 3:00 PM that day, Nurse Manager (NM) 3 observed R14 in his room on Maple Way, with his bed positioned in a way preventing him from reaching his doorway. Per review, the Physician, family, and Department for Community Based Services (DCBS) were notified. Witness statements were attached to the report. R14 care plan, safety assessment, face sheet and history and physical were attached to the report. Continued review of the investigation revealed the facility confirmed its team members had positioned R14's bed in a way that did not allow the resident to exit his room freely. Review of the investigation revealed the team members voiced concerns, they had attempted to allow R14 to have movement in his wheelchair while following the facility's requirements for infection prevention related to the resident being on droplet precautions. Further review revealed all team members received re-education immediately, and the team members assigned to R14 received a documented disciplinary coaching regarding the facility's policy/procedures, 02.05.01.01-Protecting Residents from Abuse and Neglect and 02.01.14.02. Resident Monitoring and Supervision.In interview with NM 3 on 09/12/2025 at 10:00 AM, she stated she had been the unit manager since February 2024, and her duties were to oversee the unit referred to as Maple Way. She reported on 03/21/2024, she had been making rounds with the Director of Support Services (DSS) and observed R14's in his room, through the window which had the blinds pulled up. NM 3 said she observed R14 up in his wheelchair, with the bed positioned behind him in a manner prohibiting him from exiting his room. She explained she entered R14's room and moved his bed to its original position, and made sure the resident was okay. NM 3 further stated she educated the staff on the unit, and informed them blocking R14 from leavings his room had not been safe and that action was considered seclusion.In interview with LPN 11 on 09/13/2025 at 10:40 AM, he stated he had been the nurse on the unit on 03/21/2024, and recalled the incident involving R14. He said he had been the nurse taking care of two of the four residents living in that

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	483.12 freedom from abuse, neglect, and exploitation F607 EBased on interview, record review, and review of the facility policy, the facility failed to ensure all allegations of abuse and injuries of unknown origin were reported within 2 hours to the State Survey Agency (SSA) for 1 of 3 residents sampled for abuse out of the total sample of 20 residents, (Resident (R)77). The findings include:Review of the facility policy titled, KCC DTI Protecting Residents from Abuse and Neglect, effective 11/2018 and revised 07/2024, revealed the facility was obligated to report a suspicion of a crime to law enforcement and report any allegations of abuse, neglect, exploitation, or misappropriation of resident property to the appropriate authorities, which included Child or Adult Protective Services (CPS/APS) and the Office of Inspector General (OIG). The policy also stated leadership team members were to report incidents/allegations to the state agencies immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury.Review of the admission Record for R77 revealed the facility admitted the resident on 04/12/2021, with diagnoses including Lesch Nyhan Syndrome (a rare congenital disorder occurring at birth that affects a child's brain and behaviors causing symptoms of uncontrollable self-injury, including lip and finger biting or head banging); spastic quadriplegic cerebral palsy; and moderate intellectual abilities. Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/21/2025, revealed the facility assessed R77 to have a Brief Interview for Mental Status (BIMS) score of 06 out of 15, indicating severe cognitive impairment. Review of the facility document titled, Initial Report, submitted to the OIG on 07/07/2025, revealed R77 reported to staff on 07/05/2025, that Certified Nursing Assistant (CNA) 8 had been hitting him at night.In interview on 09/13/2025 at 10:25 AM, the Quality Assurance and Performance Improvement (QAPI) Manager stated staff were trained to report all allegations of abuse to leadership immediately and leadership was expected to report the allegation within 2 hours to OIG. When asked about the delay in submitting the Initial Report until 07/07/2025, after being aware of the allegation on 07/05/2025, she stated she had been made aware of R77's allegation of abuse on 07/05/2025 and initiated an internal investigation. The QAPI Manager reported however, she had not initially planned to report the resident's allegation to the OIG. She explained because of R77's Lesch Nyhan Syndrome (LNS) diagnosis, he frequently made false accusations and made outlandish statements such as his bus being involved in a crash on the way home from school or a family member hitting him though they were not even in the building. The QAPI Manager said CNA 8 had not worked in the days leading up to R77's accusation, so staff thought the allegation was odd. She said after consulting with the facility's Chief Quality and Compliance Officer (CQCO) on 07/07/2025; however, it was decided the facility should go ahead and report the incident to OIG to ensure they were not missing things. The QAPI Manager reported since the discussion with the CQCO on 07/07/2025, if R77 made an allegation of physical abuse we do the whole process. She further said residents could have an injury or emotional distress and we could miss something, or it could happen again if all allegations were not reported as required.During interview with CNA 8 on 09/13/2025 at 11:47 AM, he stated R77 said I hit him. He loved to say things like that. He stated (when asked how staff were trained to respond to a resident's allegation of abuse) he responded, tell the supervisor so leadership can investigate it. CNA 8 further stated, I was suspended while they investigated this, and then after the investigation I got to come back.In interview with Neighborhood Nurse Manager (NM) 2 on 09/13/2025 at 12:11 PM, he said R77 tended to fabricate things; however, stated it doesn't change anything related to the facility's abuse policy and procedures. He reported staff were trained to immediately notify a member of leadership if a resident reported an allegation of abuse, adding, there is no confusion about that as far as I know.During interview with the Director of Nursing (DON) on 09/13/2025 at 2:38 PM, she stated her expectation was for staff to immediately notify leadership of any resident allegation of abuse so it can be assessed appropriately. She explained leadership should relay the resident allegation information to her, and then she would notify either the QAPI Manager or the Administrator. The DON said, The QAPI Manager then notifies OIG if it is reportable. She further stated (when asked about the required timeframes for reporting allegations of abuse to OIG), I am not exactly sure. The QAPI Manager handles that, I rely on her to make the determination and to do the reporting.During interview with the Administrator on 09/13/2025 at 4:00 PM, she stated abuse allegations were to be immediately reported to a leader and then we determine our next steps. She said allegations come to me or the QAPI Manager. We get together to discuss it and determine when to report. The Administrator stated, If it is a report of abuse, we need to report it within 2 hours. She

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	483.12 Freedom from abuse, neglect, and exploitation F610 DBased on observation, interview, and record review, the facility failed to ensure it conducted a complete and thorough investigation for an injury of unknown origin for 1 of 3 residents sampled for abuse out of the total sample of 20 residents, (Resident (R)75). The findings include:Review of the facility's policy titled, Protecting Residents from Abuse and Neglect, effective 11/2018, revealed the Quality Assurance and Performance Improvement (QAPI) Manager or assigned designee was to initiate an investigation of any allegation of abuse, neglect, or misappropriation. Further review revealed the QAPI Manager or assigned designee was to take immediate action to ensure the safety of residents.Review of R75's medical record revealed the facility admitted the resident on 08/08/2025, with diagnoses that included cerebral palsy. Review of the Progress Notes for R75 dated 08/08/2025, revealed no documented evidence the facility noted discovering an abdominal bruise on the resident. Review of the facility's, Final Report/5 Day Follow Up, dated 08/08/2025, revealed the facility had not initiated their own full internal investigation of the injury of unknown origin (abdominal bruise) for R75. Continued review of the Final Report/5 Day Follow Up revealed it was noted, CPS is currently investigating, so interviews have been paused to prevent interfering in their investigation. No team members were named by CPS as potential perpetrators of abuse or neglect. In interview on 09/12/2025 at 3:31PM, the QAPI Manager stated Per KRS, what we have been told as a childcare agency is that interviewing during an investigation is obstructing. The QAPI Manager said my supervisor said we are told not to interview or discuss incident during an investigation. We do investigate, but we do not interview. The QAPI Manager reported Once CPS come in and officially open an investigation, we stop interviews. Based on our experience as a childcare facility, we do not interview. KRS 620-we address this in our overarching procedure, and we follow those. In interview on 09/12/2025 at 1:47 PM, the Child Protective Services (CPS) Case Manager stated, CPS never advised the facility that they could not investigate until the CPS investigation was complete. She reported CPS do not ever advise any facility not to investigate, and said, most facilities start their internal investigation immediately. The CPS Case Manager explained the hospital did not have any concerns of abuse which is why R75 was released back to the facility. She further stated she was still investigating at the time. In interview on 09/13/2025 at 2:37 PM, the Director of Nursing (DON) stated, I did not participate in this investigation. Since this occurred, we had a QAPI meeting on Monday. I do not recall discussion of this incident during the QAPI meeting. She said Anytime CPS is involved, we are not allowed to ask until resolved, as CPS performs their own investigation. The DON reported it was her understanding if CPS was involved, we do not interfere, nor ask questions. She stated there were certain things the QAPI Manager might discuss with CPS, but otherwise we stop all processes and let them investigate. The DON said if we do not know the cause, of an injury we report that. She explained the facility still conducted their investigation to see if we can determine how the bruise (or injury) occurred. The DON reported the purpose of the facility's investigation was to determine if someone had not followed the facility's policies/procedures; if retraining was needed to protect residents; and to ensure staff had the information they needed. She stated if a facility investigation was not done, we may miss interviews, which are necessary to determine how and what happened, and what needs to be done to prevent recurrence. The DON said QAPI made the determination to report the injury of unknown origin and did the reporting, and she did not personally have access to make reports. She further stated her understanding was the investigation was still pending. In interview on 09/13/2025 at 3:14 PM, the Chief Quality and Compliance Officer (CQCO) stated the purpose of investigating injuries of unknown origin was to determine why the resident had been harmed, with a goal to protect the resident. She reported if the facility's investigation was not completed the potential issues included, continued mistakes, errors, or harm. The CQCO said the purpose of reporting to the state agency was to ensure the external reviewers determine abuse/neglect, as the facility did not substantiate abuse internally. She stated, by the 5-day report, the facility had summarized interviews, did the documentation, performed physician consults, and completed medical chart information.In interview on 09/13/2025 at 3:59PM, the Administrator stated the facility investigation continues to ensure protection, root cause, and training. The Administrator further stated, CPS/APS investigations take precedence; we do not interview when they are involved.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure residents received medications in accordance with professional standards of practice related a discontinued medication order not being communicated to the resident's school and pharmacy, resulting in administration of a discontinued medication for 1 of 3 residents sampled for medications out of the total sample of 20 residents, (Resident (R)40).The findings include:Review of the facility's policy titled, KCC DTI Off-site School Medication Distribution, revised 03/2025, revealed the Resident Education Nurse Coordinator (NC) or designee was required to conduct daily order reviews to identify any changes to medication orders, complete a new order form reflecting any changes, and send it to the contracted pharmacy. Further review revealed however, no documented evidence the policy addressed completing school forms or updating the school regarding residents' medication changes.Review of the admission Record for R40 revealed the facility admitted him on 06/13/2024, with diagnoses including autism, spastic quadriplegic cerebral palsy, and restlessness. Review of the admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/19/2024, revealed the facility assessed R40 as demonstrating refusals of care and behaviors of hitting and grabbing.Review of the physician's order dated 07/11/2025, revealed the provider prescribed R40 Aripiprazole (an atypical antipsychotic used to treat mental conditions which included irritability associated with autism) 3 milligram (mg) daily, increasing to 5 mg after three days. Review of the facility document titled, Permission Form for Prescribed or Over-the-Counter Drugs, dated 07/11/2025, revealed the Resident Education NC notified R40's school on 07/11/2025 of the new aripiprazole order. Review of the facility document titled, School Medication Order Form, dated 07/11/2025, revealed the contract pharmacy had been notified by the facility of the physician's order on that date. Review of the facility document titled, School Medication Order Form revealed the contract pharmacy delivered the Aripiprazole to R40's school on 08/04/2025. Review of the facility document titled, Order Listing Report, dated 08/18/2025, revealed however, the Aripiprazole order was discontinued on 07/25/2025 (10 days prior to the medication being delivered to R40's school). Review of the facility's investigative report revealed R40 experienced a change in mental status and was transported to the hospital on [DATE].Review of the hospital Discharge summary dated [DATE], revealed that during medication reconciliation at the hospital, it was discovered the school continued to administer the Aripiprazole 5 mg to R40 after the medication had been discontinued on 07/25/2025. Further review of the hospital discharge summary revealed however, the treating physicians at the hospital determined there had been no connection between the Aripiprazole medication and R40's altered mental status.Review of the facility's document titled, 5 Whys Root Cause Analysis Template, dated 08/21/2025, revealed the facility determined there had been a process failure that allowed the Aripiprazole medication error to bypass the facility's medication-order double-check process. Review further revealed there had been no communication to the school and contract pharmacy about the Aripiprazole medication having been discontinued.During interview with the contract pharmacy's Director of Pharmacy Services on 09/12/2025 at 9:07 AM, he stated the pharmacy had been notified of the Aripiprazole order for R40 on 07/11/2025. He further stated the pharmacy received no further notification of any medication change regarding the Aripiprazole medication until 08/29/2025.During interview with R40's school nurse on 09/12/2025 at 9:48 AM, she stated the school did not accept verbal orders and required written forms for all medications. She said she received the routine medication and over-the-counter medicine form for R40 that included the Aripiprazole medication on 08/06/2025. The school nurse reported she had not became aware the Aripiprazole medication had been discontinued until after R40's hospitalization on 08/15/2025. She further stated R40 received the first dose of Aripiprazole on 08/07/2025, his first day of school, and continued to receive it at school until 08/15/2025 (a total of eight days).During interview with the Resident Education NC on 09/11/2025 at 2:40 PM, she stated she called and spoke with a nurse at R40's school and verbally discontinued the resident's Aripiprazole order. When questioned regarding the process for communicating medication changes to schools, she stated there was a school form that was to be completed and faxed or emailed. The Resident Education NC acknowledged however, that form had not been completed for the discontinuation of R40's Aripiprazole medication. She further stated the facility sometimes called verbal orders to the schools.During interview with the Director of Support Services (DSS) on 09/11/2025 at 3:15 PM, she stated the process for school medications involved the use of two forms. She reported the two forms