STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 50990 Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide residents and/or guardians with resident personal funds account quarterly statements for 5 of 5 residents sampled for personal funds accounts, (Residents (R) 1, R6, R8, R22, and R49). The findings include: Review of the facility's policy, Resident Rights, dated 02/15/2024, revealed the facility must furnish to each resident a written description of (their) legal rights which included a description of a manner in protecting personal funds. Review of the facility's policy, Resident Personal Funds, dated 01/09/2024, revealed the facility was to ensure individual financial records were available to the resident through quarterly statements and upon request. 1. Review of R1's, Resident Statement dated 02/10/2025, revealed the resident had a credit of $1,344.00 at the end of the business day on 02/01/2025. Review of the facility's Surety Bond Certification dated 08/30/2024, revealed the facility was licensed and certified for $145,000.00. In interview with Representative 1 on 02/10/2025 at 10:19 AM, he stated he did not receive quarterly statements from the facility concerning R1's personal funds. Representative 1 stated he used an old quarterly statement, changed the date and mailed his payment in with the old quarterly statement. He stated he did receive a statement with what he owed the facility; however, the amounts never were the same each month. Representative 1 stated he just sent in $1,344.00 per month and he had no idea if he had any credits or owed money at that date and time. 2. In interview with R6 on 02/13/2025 at 10:45 AM, she stated she did not receive her quarterly statement unless she asked the Business Office Manager (BOM) for the statement. R6 stated when she withdrew money from her Resident Fund Account, she signed to confirm she received her money; however, the receipt did not give the balance of her account. (continued on next page)

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. In interview on 02/09/2025 at 3:25 PM, R8 stated he had not received a quarterly statement. He stated he had to call the BOM to inquire about his balance. 4. In interview on 02/03/2025 at 1:52 PM, R22 stated he did not receive a quarterly statement from the Business Office. 5. In interview with R49's Representative on 02/10/2025 at 10:17 AM, she stated for some months she had not received a quarterly statement from the facility. Representative 49 stated she went to the facility to pick up the quarterly statement due to not receiving them by mail, as she requested. In interview with the BOM on 02/10/2025 at 1:37 PM, she stated she transferred to the current facility from a sister facility in June 2023. The BOM stated October 2024 was when the facility should have had quarterly statements. She stated however, the facility was bought by another company in August 2024 and did not transfer resident funds accounts until November 2024. The BOM stated the quarterly statements were mailed from the corporate office to residents and/or their guardian at the address on file with the facility. In interview with the Director of Nursing (DON) on 02/13/2025 at 10:23 AM, she stated residents could request to receive their quarterly statements at any time. She stated she was unaware residents were not receiving their quarterly statements. The DON stated not providing quarterly statements to the residents violated their rights. She stated the business office was responsible for sending out quarterly statements to the residents and guardians. The DON stated the facility had been bought by another company in August 2024. In interview with the Administrator on 02/13/2025 at 9:38 AM, she stated residents had issues with receiving quarterly statements. However, residents had been receiving their statements since her hire date, 12/18/2024.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51281 Based on observation, interview, and review of facility policy, the facility failed to ensure the residents' environment was safe, clean, comfortable, and homelike. The facility failed to provide a functional and comfortable environment for residents related to cold water temperatures for 14 out of 19 resident rooms. (Rooms 101, 102, 103, 105, 106, 107, 108, 109, 110, 121, 122, 124, 125, and 126). The findings include: Review of the facility's policy titled, Resident Rights, revised 02/15/2024, revealed the residents had a right to a safe, clean, comfortable, homelike environment, including but not limited to receiving treatment and support for daily living. Review of the facility's policy titled, Safe and Homelike Environment, revised 03/09/2024, revealed housekeeping and maintenance services were provided as necessary to maintain a sanitary, orderly, and comfortable environment. Further review of the policy revealed under General Considerations to report any unresolved environmental concerns to the Administrator. Observation on 02/03/2025 at 2:43 PM of the temperature of the sink's water in room [ROOM NUMBER] revealed when only the hot water was turned on it was cold to the touch. Further observation revealed that despite running the water for approximately five (5) minutes, there was no change in the temperature. Observation on 02/03/2025 at 3:16 PM of the temperature of the sink's water in room [ROOM NUMBER] revealed it was cold when only the hot water was turned on and ran for greater than five (5) minutes without any change in temperature. Observation on 02/03/2025 at 9:10 AM of the temperature of the sink's water in room [ROOM NUMBER] revealed it was cold if only the hot water tap was on and ran consistently for five (5) minutes. Observation of room water temperature in room [ROOM NUMBER], on 02/07/2025 at 2:44 PM revealed despite Licensed Practical Nurse (LPN) 6 allowing the water to run for eight (8) minutes during R20's wound care, the water never got warm. On 02/07/2025 at 9:43 AM an observation of the Hall A Shower room revealed the shower did not turn on and the water in the sink was cold and did not get hot despite letting it run for over five (5) minutes. Observation of room water temperatures on 02/09/2025 at 4:01 PM revealed the following: room [ROOM NUMBER]'s hot water temperature was 55 degrees Fahrenheit (F); room [ROOM NUMBER]'s hot water temperature was 50.4 degrees F; and, room [ROOM NUMBER]'s hot water temperature was 52 degrees F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the water temperature in Hall A Shower Room on the East Unit on 02/10/2025 at 10:00 AM revealed the hot water temperature for the sink was 48.7 degrees F and for the shower was 44 degrees F. Observation of the water temperatures for Hall B on the East Unit on 02/10/2025 at 10:03 AM revealed for rooms 121 through 126, no water temperatures were over 50 degrees F. Respectively in room number order they were: 48.4 F, 47.2 F, 44 F, 44.5 F, 44.1 F, and 46.1 F. On 02/09/2025 at 3:53 PM the water temperatures of the hot water in multiple rooms were checked. room [ROOM NUMBER]'s hot water temperature after running for 5 minutes was 55 degrees F. The hot water in room [ROOM NUMBER] after running for 5 minutes was 52 degrees F. The hot water in room [ROOM NUMBER] after running for 5 minutes was 50.4 degrees F. The hot water for the shower room on the 100 Hall sink, after running for 5 minutes was 56.8 degrees F, and the hot water from the shower after running for 5 minutes was 57.4 degrees F. In an interview with Resident (R) 20 on 02/03/2025 at 2:43 PM she stated she had no hot water in her sink for over a month. R20 stated this was why she had not been able to get her hair washed. In an interview with R6 on 02/03/2025 at 3:55 PM she stated she had met the new owner of the facility, and she made him aware of the lack of hot water in their rooms. R6 stated she had met with the Ombudsman over some issues as well, including the lack of hot water in the room. In an interview with R50 on 02/04/2025 at 9:01 AM he stated it took a long time for his water to get hot, if it ever did get hot. In an interview with R43 on 02/04/2025 at 9:10 AM he stated his water in his sink was always cold. In an interview with R83 on 02/04/2025 at 11:15 AM she stated they have had no hot water in their room for a month. In an interview with R72 on 02/04/2025 at 12:10 PM she stated was no hot water in their room for months. In an interview with R73 on 02/04/2025 at 12:30 PM she stated they have no hot water in their room, have not had any hot water for months. In an interview with R14 on 02/04/2025 at 4:00 PM she stated they have not had any hot water in their room for at least a month. In an interview with R51 on 02/04/2025 at 4:05 PM she stated they had no hot water in their room and haven't had any for a month. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/07/2025 at 9:47 AM in an interview with the Maintenance Director (MD) and the Assistant Maintenance Director (AMD) it was revealed they did not know that Hall A Shower Room shower was not working; nor did they know there was no hot water in rooms on Hall B. The MD said he did the water temperature checks last Friday, and they were fine. When asked how he does the water temperatures he stated that he picks a room on each hallway and takes the temperature of that room only. Each week he picks a different room for that hallway. He stated that he then records that number for the hallway in the facility's electronic maintenance record. The MD and AMD stated they had pipes burst and ceiling caved in due to extreme cold temperatures in January. He stated no residents lost heat or hot water during the incident. On 02/07/2025 at 10:07 AM the night shift unit manager for the East Unit, Registered Nurse (RN)1 stated she was not sure how long Hall A Shower Room had not worked or had hot water. On 02/07/2025 at 1:25 PM in an interview with the day shift Unit Manager (UM)10 for the East Unit, she stated Hall A Shower Room did not have hot water and that was why the staff used Hall D Shower Room. She stated Hall C Shower Room was currently being remodeled and was unsure how long it had been closed. She thought that both had been down since November or December. On 02/12/2025 at 9:38 AM in an interview with the Director of Nursing (DON), she stated they have had no hot water off and on for the last few weeks. The DON stated she understood why Hall A Shower Room could not be used due to the cold water. She stated she did think it was an issue that 72 residents were using the one shower room on the East Unit that worked. On 02/12/2025 at 10:31 AM in an interview with Social Services (SS), when the pipes burst some residents ran out of hot water due to the high demand for the one shower room and he would have to tell them to wait a half an hour until the water heated back up and try getting a shower again. He stated that for the female residents who were able to walk, the Certified Nursing Assistants (CNA) took them to the locked women's unit for a shower instead. On 02/13/2025 at 8:18 AM in an interview with the Administrator she stated renovations were ongoing and they were currently working on three of the six shower rooms: [NAME] Unit Shower, East Unit Hall A Shower, and East Unit Hall C Shower. The reason there was no hot water was due to these renovations, but this issue had been fixed. She stated she was unaware of the cold water in residents' rooms and in Hall A Shower Room until this past Sunday when they were made aware and since then a plumber had come and fixed the issue. When asked if she felt one shower was sufficient for 72 residents, she stated the facility had three other showers residents could utilize.

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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. 51281 Based on interview, record review, and facility policy review, the facility failed to ensure its abuse prohibition policy was implemented by failing to verify and maintain documentation of screening and training, including criminal record checks required for pre-employment for 9 of 12 personnel files reviewed. The criminal background check, the nurse aide abuse registry check, and/or the Kentucky Adult Caregiver Misconduct Registry (KACMR) check was not completed for newly hired employees. Additionally, there was not documented evidence to support newly hired staff had received the abuse training required at the beginning of employment. The findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, revised 03/05/2024, revealed, Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident's property. 1. Background, reference, and credential checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Further review of the policy revealed the pre-employment checks were to be completed before the employee came to the facility for orientation. Further review of the policy revealed new employees would be educated on abuse, neglect, exploitation, and misappropriation of the resident's property during initial orientation. Existing staff would receive annual education through planned in-services and as needed. Review of the Kentucky Revised Statutes (KRS) 209.032, effective 07/15/2014 and amended on 07/15/2024, revealed a vulnerable adult services provider, such as a long-term care facility was to, Query as to whether prospective or current employee has validated substantiated finding of adult abuse, neglect, or exploitation - Administrative regulations - Central registry of substantiated findings made on or after July 15, 2014. Continued review of the Statute revealed an employee included a person hired directly or through contract by a vulnerable adult services provider with duties that involved or might involve one-on-one contact with a resident. Further review revealed a vulnerable adult services provider was to query the cabinet as to if a validated substantiated finding of adult abuse, neglect, or exploitation was entered against an individual who was a prospective employee of the provider. 1. Review of the personnel file for Registered Nurse (RN)4 revealed a hire date of 01/28/2025, but the nurse aide abuse registry and KACMR check was not completed until after RN4's hire date, on 01/30/2025. Also, there was no documentation to support RN4 had completed abuse training. 2. Review of the personnel file for RN9 revealed a hire date of 01/24/2025, but the nurse aide abuse registry and KACMR check were not completed until after RN9's hire date, on 02/05/2025. Also, there was no documentation to support RN9 had completed the abuse training. 3. Review of the personnel file for Certified Nursing Assistant (CNA)23 revealed a hire date of 01/24/2025, however, her nurse aide abuse registry and KACMR checks were not completed until 02/13/2025. Additionally, there was no documentation to support CNA23's abuse training was completed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the personnel file for CNA24 revealed a hire date of 01/24/2025, however, there was no evidence to support the employee's criminal background check or the nurse aide abuse registry check were completed. Further review revealed no documentation to support the KACMR was checked. Also, review of CNA24's personnel filed showed no documentation that the abuse training had been completed. 5. Review of the personnel file for CNA25 revealed a hire date of 02/04/2025. Continued review revealed no documentation to support the CNA had completed abuse training. 6. Review of the personnel file for CNA26 revealed a hire date of 02/11/2025. Further review revealed no documentation to support the CNA had completed the abuse training. 7. Review of the personnel file for CNA14 revealed a hire date of 11/13/2024. Continued review revealed no documentation to support a criminal background check, nurse aide abuse registry check, or KACMR check were completed. Also, there was no documentation to support the CNA had completed the abuse training. 8. Review of the personnel file for CNA19 revealed a hire date of 03/24/2024 with no documentation to support the facility had completed a criminal background check, nurse aide abuse registry check, or KACMR check. Further, there was no documented evidence to support the CNA had completed abuse training. 9. Review of the personnel file for the former administrator revealed no hire date was provided. Further review revealed no documented evidence to support the nurse aide abuse registry check was completed. Continued review of the personnel file revealed the facility had completed the KACMR check on 01/17/2024 with the criminal background check completed on 01/04/2024. Additionally, there was no documentation to support the administrator had received abuse training. In an interview with the Administrator, on 02/13/2025 at 11:00 AM, she stated the two staff persons in Human Resources were responsible for completing the required pre-employment checks for newly hired employees. The Administrator stated there was a background check, a CNA abuse registry check, and one other check required for all newly hired employees. She stated the reason for these checks was to ensure there was no one working in the facility who was convicted in a court of law for abuse, a felony, or certain drug charges. The Administrator stated her expectation of the staff was for these checks to be completed prior to the new employee stepping foot inside the building. She stated if these checks were not completed prior to a new employee reporting to work at the facility, it was possible for them to potentially hurt one or more of the residents. She stated the current owners of the facility took over on 09/01/2024, thus had no knowledge of the employees background checks who were hired before then Further, the Administrator stated abuse training was completed upon hire, during orientation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Regional [NAME] President of Talent and Acquisition, who was currently filling the Human Resources role until they hired a permanent Human Resources person, on 02/13/2025 at 11:05 AM, regarding the pre-employment checks required for newly hired employees, she stated she and the other Human Resource staff person were responsible for completing the required pre-employment checks. She stated they completed a criminal background check that included the Office of Inspector General (OIG) exclusions check, and she stated it was outsourced through a contracted agency. The Regional [NAME] President of Talent and Acquisition stated there was also a KBN misconduct check completed, along with a license verification. She stated these checks were required to be completed before the new employee was allowed to walk inside the building. Further, she stated if the checks were not completed before the orientation, the new employee would be sent home until all the proper checks were completed. In continued interview, she stated any employee who was hired prior to 09/01/2024 would have had their background checks completed by the previous owner of the facility and anyone hired after 09/01/2024 was processed through them.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50442 Based on interview, record review, and review of the facility's policy, the facility failed to ensure an allegation of abuse was reported immediately, but no later than two hours after the allegation was made for one of five sampled residents (Resident (R) 79). On12/09/2024, Certified Nursing Assistant (CNA) 14 alleged that while changing R79, the resident become combative and CNA13 was observed to have choked the resident at approximately 5:20 AM. CNA 14 reported the alleged abuse at 8:37 PM to administration, which was approxmiately 15 hours after the incident was observed and delayed the facility's investigation of abuse. The findings include: Review of the Facility's policy titled, Abuse, Neglect, and Exploitation, date implemented 02/01/2024 and date revised 02/01/2024, revealed it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Further review of the policy revealed the facility would have written procedures that included reporting of all alleged violation to the Administrator, state agency, adult protective services, and all other required agencies (e.g., law enforcement when applicable) within specified time frames: Immediately, but not later than two hours after the allegation was made, if the events that cause the allegation involved abuse. Review of the Facility Investigation Initial Report dated 12/09/2024, revealed the incident occurred on 12/09/2024 at 5:24 AM but was not reported to the Administrator until 12/09/2024 at 8:37 PM. Family Member (F)4 was notified on 12/2024 at 9:00 PM (no day specified on the form). In a description of the incident, the Interim Administrator (IA) reported that at 8:37 PM on 12/09/2024, she received a call from the Staffing Coordinator (SC)19 who had a brief conversation with CNA14 CNA14 stated on the morning of 12/09/2024 around 5:20 AM she witnessed CNA13 choke R79, while providing care. CNA14 stated R79 had soiled her clothing and was being changed when she grabbed onto CNA13. CNA14 stated this made CNA13 angry and she reached over and forcibly choked R79. R79 gasped for air when the choke hold was released. CNA13 was not at work and was unable to be reached by phone. CNA13 was placed on suspension once reached. CNA14 was in-serviced after the reporting about the procedures on abuse identification and immediate reporting. Police were notified at 9:20 PM and arrived at the facility around 9:30 PM to take CNA14's statement. R79 was assessed at 10:30 PM on 12/09/2024 and there was no evidence of injury (bruising, scratches, bleeding, change in voice, hoarseness, or shortness of breath). The initial report was filed on 12/09/2024 (no time indicated) by IA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's Five (5) day follow up investigation, dated 12/13/2024, revealed that R79 was examined by the Administrator, a CNA, and a Police Officer and there were no physical signs of abuse. The IA interviewed all staff on shift the night of the incident and Social Services (SS) reviewed all residents to be interviewed on the night shift assignments. The Director of Nursing (DON) with her team performed skin assessments on all vulnerable residents on the unit. No residents indicated any concerns and skin assessments were free from bruising or injury. Further review of the investigation packet only contained the interview sheets and not the skin assessments. There was only one witness to the incident (R14) who stated that CNA13 was cleaning up R79 and R79 began to fight. CNA13 stated she did not choke R79 and did not know why someone would report her as doing so. She stated that R79 had a bowel movement and that CNA14 came in to help her clean up R79. They bathed and dressed R79. The two nurses (no names given in the report) that normally supervised CNA13 and CNA14 stated that there were no known or alleged complaints against either CNA. Both nurses stated they were in and out of residents' rooms all night and never witnessed any concerns with resident care. Per a statement made by an unnamed nurse and CNA13, she was in the room while CNA13 was giving R79 a bed bath. All staff working the night of the incident were trained again on abuse and immediate reporting requirements. The Incident Investigation packet had a list of all staff that received this training on 12/09/2024. Review of R79's Electronic Medical Record (EMR) revealed R79 was admitted to the facility on [DATE] with the medical diagnoses of dementia, hypertension, and hyperparathyroidism. Review of R79's quarterly Minimum Data Set (MDS) from 10/10/2024 revealed that R79 had a Brief Interview for Mental Status (BIMS) of 03, severe cognitive impairment. The State Survey Agency (SSA) surveyor requested the Police Investigation Report from responding police department on 02/10/2025 at 11:28 AM. However, no report was provided for review. Observation of R79 on 02/04/2025 at 10:37 AM revealed the resident was sitting in the common area of the locked women's unit, dressed and clean. There were no signs of bruising or injury noted. She was not able to be interviewed. She only smiled when the SSA surveyor spoke with her. In an interview with F4 on 02/06/2025 at 9:12 AM he stated the facility called and notified him that R79 was placed in the shower by her caregiver when the resident became agitated and aggressive. He stated the facility reported the resident's caregiver choked R79. Further, he stated he was not aware of any mistreatment of the resident since. On 02/10/2025 at 10:54 AM, the State Survey Agency (SSA) surveyor attempted to call the witness, CNA14. The CNA no longer worked at the facility and the phone number provided was no longer in service. On 02/10/2025 at 10:56 AM in a phone interview with CNA13 she stated that she took care of R79 the entire thirteen (13) months she was employed at the facility. CNA13 stated that R79 was often combative with staff when they were trying to change her after incontinence or when she was getting a shower. She stated she was suspended over an incident that occurred with R79 and was not allowed to return to work until the incident was investigated. Per the interview, she stated the CNA (CNA14) reported to staff that she had been rough and hit the resident. CNA13 stated the facility had unsubstantiated the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/2025 at 2:01 PM in a phone interview with the Interim Administrator (IA), she stated she remembered making the report. She stated the original verbal report of the choking incident went to Staffing Coordinator (SC). She stated the SC called her at approximately 8:30 PM on 12/09/2024 to report the incident of abuse. The IA stated she had just arrived home and turned around and went back to the facility and took the statement from CNA14. The IA stated she then called the police, and they came and did an exam of R79 with the IA. Per the interview, she stated the police looked for marks that would signify any abuse. The officer used a flashlight to look at R79's neck. She further stated that once the police officer left the facility, she instructed her staff to complete another exam to make sure nothing was missed. The IA stated she could not found any evidence of the abuse. In continued interview, with the Interim Administrator (IA), on 02/10/2025 at 2:01 PM, she stated she talked to all the staff and no one reported they saw or heard anything (on the day of the alleged incident). The IA stated that after this incident they suspended a couple of CNAs. CNA13 was also placed on suspension. She stated that she left before the investigation was completed on CNA13. The Administrator stated the police officer contacted her on her last day at the facility and stated he did not believe the abuse occurred but thought that staff made up allegations to get back at the other. The IA stated CNA14 delayed her reporting of the incident. On 02/12/2025 at 9:38 AM in an interview with the Director of Nursing (DON), she said that CNA14 reported she was in the room with another CNA (CNA13) when R79 became combative. She stated CNA14 reported CNA13 had placed her hands on R79's neck and choked her. Per the interview, the DON stated her expectation of the staff was for staff to report allegations of abuse immediately. The DON stated staff should ensure the resident was out of harms way. Then, after ensuring the safety of the resident, the nurse , DON, or Administrator should be contacted. Further, she stated the reporting CNA (CNA14) was sent home and CNA13, the alleged perpetrator, was put on leave. She stated the allegation was not substantiated and CNA13 was brought back on day shift at the recommendation of Human Resources (HR). On 02/13/2025 at 8:18 AM in an interview with the Administrator she stated that she was not employed at the facility when the incident with CNA13 and R79 occurred. Her expectation was if there was an allegation of abuse staff should make sure the resident was safe and tell the nurse about the allegation immediately. Then the nurse would make her aware of the situation. The staff member that was the alleged perpetrator would be taken off work until the allegations were investigated.

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	185165	A. Building B. Wing	02/13/2025

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on observation, interview, review of the clinical record, and review of the facility policy the facility failed to develop the baseline care plan for 1 of 4 residents sampled for elopement and care plans out of the 33 total sampled residents, (Resident (R)401). The facility admitted R401 on 01/21/2025 and assessed the resident as at risk for elopement on that date. However, the facility failed to develop a baseline care plan with necessary interventions to address the resident's risk for elopement. R401 left the facility without staffs' knowledge on 01/24/2025. Immediate Jeopardy (IJ) was identified on 02/12/2025 and was determined to exist on 01/24/2025 in the area of 42 CFR S483.21 Baseline Care Plan, F655 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 02/12/2025 at 4:23 PM. On 02/12/2025 at 4:23 PM, the facility's Administrator, Regional [NAME] President of Clinical (RVPC), and Regional [NAME] President (RVP) were provided a copy of the IJ Template and notified that the facility's failure to ensure a baseline person-centered care plan was developed based on R401's admission assessment to ensure resident safety is likely to cause serious injury, impairment, or death. The facility provided an acceptable IJ Removal Plan, on 02/13/2025 at 2:47 PM, alleging removal of the IJ on 02/13/2025. The State Survey Agency (SSA) validated the IJ had been removed on 02/13/2025, as alleged, after an acceptable IJ Removal Plan was received and further interviews, observations, and record reviews were conducted to verify the immediate corrections. Remaining non-compliance continued at a S/S of a D at F655. Refer to F689 The findings include: (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility's policy, Elopement and Wandering Residents, reviewed/ revised 03/06/2024, revealed residents who exhibited wandering behavior and/or were at risk for elopement were to receive adequate supervision to prevent accidents. Per the policy, residents were to receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Continued review revealed an elopement occurred when a resident left the premises or a safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do so. Policy review revealed the facility was to establish and utilize a systematic approach to monitoring and managing residents at risk for elopement. Review of the policy revealed the facility's systematic approach was to include identification and assessment of risk and implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Further review revealed residents at risk were to be assessed for risk of elopement upon admission by the interdisciplinary care plan team (IDT), who were to evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Additional policy review revealed interventions to increase staff awareness of the resident's risk, modify resident behavior, or minimize risks associated with hazards were to be added to the resident's care plan and communicated to appropriate staff. Review further revealed charge nurses and unit managers were to monitor the implementation of interventions, response to interventions, and document accordingly. Review of the facility policy, Baseline Care Plan reviewed/ revised 12/23/2023, revealed the facility was to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care. Per review, the baseline care plan (CP) was to be developed within 48 hours of a resident's admission and was to include minimum healthcare information necessary to properly care for a resident. Continued review revealed the admitting nurse or supervising nurse on duty should gather information from the admission physical assessment, hospital transfer information. Further review revealed the admitting nurse or supervising nurse on duty was to establish initial goals for the resident and interventions should be initiated that addressed the resident's current needs including any safety concerns to prevent decline or injury, such as elopement. Additionally, policy review revealed a supervising nurse should verify within 48 hours a baseline CP has been developed. Review of the clinical record for R401 revealed the facility admitted the resident on 01/21/2025, with diagnoses that included: hemiplegia and hemiparesis following cerebral infarction, epilepsy, aphasia following cerebral infarction, and chronic congestive heart failure. Review of the facility's, Wandering/Elopement Risk Evaluation, dated 01/21/2025 revealed the facility assessed R401 as at risk for elopement. Review of the Speech Therapy (ST) Evaluation and Plan of Treatment dated 01/22/2025, revealed R401 was assessed through the St. Louis University Mental Status (SLUMS) examination. Per review, R401 was evaluated to have a SLUMS score of 6 out of 30 indicating severe cognitive impairment, but the resident's BIMS score was 12 out of 15, indicating moderate cognitive impairment. Continued review revealed R401 demonstrated severe cognitive deficits for short term memory, delayed recall, orientation, problem solving, and safety awareness. Per review, R401 required speech services to enhance cognitive skills, promote safety awareness/insight, facilitate immediate memory, enhance short term memory, and facilitate orientation abilities. Continued review revealed R401 was oriented to person, with thought orientation assessed as 25%; memory was severe, short -term memory was 25%, deductive reasoning 25%, and cause/effect 25%. The resident was confused but participatory. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/27/2025 revealed the facility assessed R401's Brief Interview for Mental Score (BIMS) as 14 out of 15, which indicated no cognitive impairment. Review of the facility's summary of its investigation, completed by the Director of Nursing Services (DNS), dated 01/26/2025, revealed R401 left the faciity on [DATE] at approximately 8:45 PM, to buy cigarettes, when the resident sustained a change in condition and was transported via Emergency Medical Services (EMS) to the hospital with stroke like symptoms. Review of the CP for R401 revealed the care plan initiated on 01/22/2025 included identified areas of skin breakdown, nutrition, pain, ADLs (activities of daily living), falls, diabetes, antiplatelet therapy, seizure disorder, and incontinence. Per review of the CP, the facility identified a problem for ADLS for R401 regarding his impaired decision making and impaired cognition. Continued review revealed the facility identified R401 as at risk for falls due to diminished safety awareness, cognitive impairment, and wandering. However, review of the CP revealed the facility had not developed it to provide interventions for wandering or risk for elopement. Continued review of R401's CP revealed on 02/04/2025, the facility developed a CP regarding the resident's impaired cognitive function related to impaired decision making with poor safety awareness and wandering. Further review of R401's CP revealed the facility had not addressed and provided interventions to address the resident's risk for elopement after he eloped on 01/24/2025. Observation on 02/07/2025 at 9:28 AM, of R401 revealed the resident stood and ambulated independently. Observation of R401 on 02/07/2025 at 9:42 AM revealed the resident sitting in a wheelchair (w/c) on the facility's smoking patio. In interview on 02/07/2025 at 1:47 PM, R401 stated he had not been to the hospital since he had been at the facility. He stated he slipped on the ice before he came to the facility which was the reason his left arm did not move (however, review of R401's hospital records revealed he had a stroke which affected the arm). R401 stated he could leave the facility when he liked and went out with family once and the second time he went out by himself about a week ago. He further stated he knew to sign out when he left with family or friends. In interview on 02/07/2025 at 2:34 PM, Family Member (F)10 stated R401 got out one weekend, got lost and almost froze to death a couple of weeks ago. She stated she did not know how he had gotten out and thought he fell in a ditch and someone called EMS (Emergency Medical System). F10 reported the facility called her and asked if R401 was with her and where he could be. She said R401 ended up in the emergency room (ER). She further stated the resident did not remember what happened. On 02/08/2025 at 8:17 AM, in interview Licensed Practical Nurse (LPN) 7 stated he was told in report R401 eloped from the facility. The nurse stated R401 had some cognitive impairment due to the stroke before he got there. He stated R401 could walk around without a walker. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In interview on 02/09/2025 at 1:42 PM, Certified Nurse Aide (CNA) 27 stated the aides were aware of a resident's care plan interventions from the Kardex, usually in the computer. She stated she provided care for R401 and he was unable to use his left arm due to a stroke. The CNA stated she did not think R401 could go out of the facility on his own due to both mental and physical reasons. She stated R401 could walk, but after some time the resident would need a w/c as he did not have the strength to be gone for hours by himself. CNA 27 stated she did not know about the resident's mental capacity to go out of the facility on his own. In interview on 02/09/2025 at 1:57 PM, LPN 6 stated the resident's CP was to be updated by the nurse responsible for the resident when the resident returned from the hospital. She stated the charge nurse was responsible for residents' baseline care plans when they were a new admission. The LPN stated if the nurse was busy the unit manager would complete the baseline care plan. She stated she started employment at the facility in October and had not completed a baseline care plan yet. LPN 6 stated R401 was very impaired (cognitively), and as you talked to him she noticed a change in the conversation and he said things that did not make sense. She further stated R401 looked like he was a visitor and she thought he was a visitor before. The LPN also stated on admission we have to sign if it was felt the resident was at risk of wandering. She stated she always looked at the residents' care plans to see if there were any updates for the resident to ensure continuity of care. In interview on 02/09/2025 at 2:31 PM, LPN 15 stated she only worked nights at the facility. She stated she could not recall if she completed R401's admission as there were so many admissions and she worked on multiple units. The LPN stated R401's elopement risk assessment meant he was a wanderer. She stated management never told us to keep a close eye on R401 and management took care of everything related to a resident being at risk. LPN 15 stated normally the nurses completed residents' baseline care plans; however, the night shift supervisor typically did them on that shift. She stated she only updated the care plans with an immediate intervention if there was a fall, per the DNS's direction, otherwise, she did not really mess with the care plan. LPN 15 further stated R401 was not able to go out of the facility on his own, and she had not been informed he was an elopement risk. On 02/10/2025 at 1:51 PM, in interview the East Unit Manager (UM) stated when a resident was first admitted to the facility the nurse started the admission process which included the admission care plan. She stated the next day the admission was reviewed in the clinical IDT meeting to ensure everything had been done, the new resident's CP was completed in the IDT meeting to get into more detail and focus on that particular resident. The East UM stated if a resident had a change in condition, the next day the IDT reviewed the change and MDS would update the resident's care plan if warranted. The East UM stated if it was the weekend, the DNS would do it. She further stated R401 was not able to go out of the facility by himself without supervision as his cognitive scores were low on his BIMS. The East UM additionally stated if R401 did go out he could get hit by a car or kidnapped. In interview on 02/10/2025 at 2:56 PM, the Social Worker (SW) stated the nurses did the elopement assessment when a resident first came into the facility. He stated if the resident was assessed at risk for elopement, the resident should have a wanderguard (WG) in place. The SW stated the nurses did the elopement risk assessments; however, he managed that book. He stated he helped with the care planning for behavior programming, but the nurses did the at risk for wandering or elopement care plans. The SW reported when R401 returned to the facility (after the elopement), he was placed on one to one (1:1) supervision for a while. He further stated when R401 returned he did not put any additional interventions in place, as interventions were usually discussed in the IDT meeting. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In interview on 02/11/2025 at 9:53 AM, the Night Shift Manager stated she did not know what R401's care plan information related to risk for elopement had been before he left (eloped from) the facility. She stated the comprehensive care plan was the responsibility of the MDS Nurse; however, the admission nurse was responsible for the baseline care plan when the resident was first admitted to the facility. The Night Shift Manager said the baseline care plan was how staff knew what the resident's needs were when they did not yet know the resident's care needs. She stated the baseline CP should be based off the History and Physical, resident history such as when the hospital mentioned fall risk or elopement risk. The Night Shift Manager stated the care plan was for the facility to follow to provide care and meet the resident's needs. She stated if the baseline care plan was not completed, staff would not know how to care for the resident and the resident could elope and anything could happen. In interview on 02/12/2025 at 10:37 AM, the MDS Coordinator stated any nurse could complete the baseline care plan; however, she usually did them herself the next day. She said there was an admission assessment (in the computer) and the baseline care plan could be done there. The MDS Coordinator stated she usually did the baseline care plan in the actual care plan section (in the computer) as it was the facility's version of the baseline care plan. She stated the baseline care plan was determined by the basic care plan such as ADLs and support needed, risk for pain, anything the resident was at risk for, and the nurse could update or change the care plan. The MDS Coordinator stated the care plan was updated with the comprehensive assessment and if there was a change in the resident's condition. She stated she thought the other MDS Coordinator started R401's baseline care plan. The MDS Coordinator said she and the other MDS Coordinator talked about R401 being at risk for elopement when he first came to the facility; however, his care plan for wandering was not initiated until 02/04/2025 based on the MDS Assessment. She stated she looked at different things for a resident's care plan needs including resident assessments and evaluations. The MDS Coordinator stated she had not known R401 was assessed by the admission nurse at risk for elopement and stated we would care plan that. She further stated she participated in the clinical meeting, but did not recall if R401 was discussed, as the other MDS Coordinator attended at times. On 02/12/2025 at 1:14 PM, in interview the Staff Development Coordinator (SDC) stated the nurse put in residents' baseline care plans in coordination with the MDS Coordinator and clinical team. She said she participated in the clinical meetings and reviewed R401's elopement risk assessment. The SDC reported being at risk meant to keep an eye on him through special attention, and have processes in place so he stayed in the facility for his safety. She stated the IDT meeting discussed updating R401's care plan after he returned to the facility. The SDC said the purpose of the baseline care plan was to provide care centered around the resident's needs. She stated if the baseline care plan was not developed or updated multiple things could fall through the cracks as that care plan was their guidelines for how to care for a resident and what their needs were. The SDC further stated if information was not in the care plan for staffs' knowledge, the resident could be harmed and it could be dangerous because staff would not know what the resident's needs were. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In interview on 02/12/2025 at 1:59 PM, the DNS stated when a resident was newly admitted to the facility, the floor nurse at the time of admission was responsible to complete the resident's baseline care plan and had 48 hours to complete it. She stated the facility had a checklist to go over in the next morning's clinical IDT meeting. The DNS said the comprehensive care plan was initiated and updated by the MDS Coordinator the next day after the admission came in. She reported the clinical meeting reviewed residents for risk of elopement; however, could not recall if R401 was reviewed. The DNS stated when a resident triggered as at risk for elopement, the process would depend from resident to resident based on the diagnosis. In interview on 02/12/2025 at 3:03 PM, the Administrator stated R401's admission elopement risk assessment provided an automatic score and that could have been because of diagnoses of hemiparesis and history of stroke. She stated the IDT meeting decided if the resident was a true elopement risk, and had determined R401 was not a risk. The Administrator said she would have to look in the file to see if that was documented anywhere (however no documentation was provided to the State Survey Agency [SSA] Surveyor). She reported she did not expect to see a care plan for risk of elopement if the resident was not at risk; however, the elopement risk assessment was to determine if a resident was at risk. The Administrator stated if the (elopement risk) assessment was based off a wanderer and part of the diagnosis where the assessment talked about the symptoms, the resident would score higher. She stated the purpose of the baseline care plan was to tell about the resident, what risks and behaviors were exhibited and put interventions in place. The Administrator further stated if a resident at risk for elopement did not have care plan interventions, staff would not know the resident had the potential to be an elopement risk and could be a safety concern as the resident could get out and a lot could happen.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50990 Based on observation, interview, record review, and review of the facility's policy, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 22 sampled residents, (Resident (R) 22). The facility failed to develop R22's comprehensive care plan regarding a SoftPro Ambulating ankle foot orthoses (AFO) Boot (an ankle foot orthoses used to treat mild to moderate lost range of motion of the ankle/foot and to facilitate assisted weight bearing). The finding include: Review of the facility's policy, Comprehensive Care Plan Guideline, dated 05/22/2018, revealed the facility ensured appropriateness of services and communication that met the resident's needs, severity/stability of condition, impairment, disability, or disease in accordance with state and federal guidelines. Review of the facility's policy, Resident Rights Guidelines, dated 02/15/2024, revealed the facility ensured resident rights were respected and protected and provided an environment on which they could be exercised. Review of R22's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 05/25/2020, with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, cerebral infarction and dementia. Review of R22's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 01/02/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated he was cognitively intact. Review of the comprehensive-person centered care plan for R22, dated 01/02/2025, revealed no documented evidence of a care plan to address the resident wearing a SoftPro Ambulating AFO boot on his left foot. Observation on 02/03/2025 at 1:35 PM, revealed R22 could not self-ambulate in his wheelchair due to wearing a broken SoftPro Ambulating AFO Boot on his left foot. Further observation revealed R22's wheelchair footrest was not elevated to keep the resident's foot from dragging on the floor. Observation on 02/03/2025 at 3:15 PM, revealed R22 was wearing a SoftPro Ambulating AFO boot on his left foot, asking staff to lift his foot and place it on the footrest of his wheelchair. Observation between 02/03/2025 and 02/12/2025 at various times revealed R22 was wearing the SoftPro Ambulating AFO boot around the facility. In interview with R22 on 02/06/2025 at 9:10 AM, he stated his SoftPro Ambulating AFO boot was broken, and the Director of Nursing (DON) informed him she was going to order him a new boot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the DON on 02/06/2025 at 9:23 AM, she stated she was aware R22's SoftPro Ambulating AFO Boot was broken, and she had ordered another boot. The DON stated she was unaware of Resident 22 not being care planned for the boot. The DON stated she assumed the resident was care planned for the boot as he had been wearing it for sometime. In an interview with Minimum Date Set Coordinator (MDSC) on 02/12/25 at 10:37 AM stated she has been at the facility for almost two years. The MDSC stated she completes the care plans and that all nurses in facility have access to complete a care plan. The MDS Coordinator stated if a resident was admitted she completed the care plan the next day. The MDS Coordinator stated nurses could complete the care plan under evaluations then select the admission assessment located where they could complete a baseline care plan. The MDS Coordinator stated the facility's version of baseline consist of basic activities of daily living, support need, and anything a resident may be at risk. In interview with the Administrator on 02/13/2025 at 9:38 AM, she stated comprehensive care plans should be updated within 24 hours of admission, so the correct care could be provided for the resident. The Administrator stated baseline and comprehensive care plans were very important for patient care. She stated the facility provided the best quality of care to all residents and R22's care plan not being developed (to include the AFO) could just possibly be an oversight. In additional interview with the DON on 02/13/2025 at 10:23 AM, she stated it was very critical any resident's baseline and comprehensive care plans were developed or updated in a timely manner. The DON stated comprehensive care plans should be completed seven days after the completed comprehensive (MDS) assessment. Additionally, the DON stated documentation in the progress notes for R22 should have included any occupational and physical therapy notes regarding the use of the SoftPro Ambulating AFO Boot the resident was issued and wearing.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure each resident received adequate supervision for two of 12 sampled residents, Residents (R) 400 and R401. On 01/21/2025, the facility admitted R401 and assessed the resident as at risk for elopement; however, failed to address that risk in the baseline care plan. Therefore, on 01/24/2025 at approximately 10:30 PM, R401 left the facility without facility knowledge (which could be considered an elopement) and was not located until the next morning (of 01/25/2025) at a local hospital. Additionally, the facility failed to assess R400 for smoking safety and falls in its initial assessment of the resident upon admission. Immediate Jeopardy (IJ) was identified on 02/12/2025 and was determined to exist on 01/21/2025, in the area of 42 CFR S483.25 Accidents, F689 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 02/12/2025 at 4:23 PM. On 02/12/2025 at 4:23 PM, the facility's Executive Director, Regional [NAME] President of Clinical (RVPC), and Regional [NAME] President (RVP) were provided a copy of the IJ Template and notified that the facility's failure to ensure the resident's safety is likely to cause serious injury, impairment, or death. The facility provided an acceptable IJ Removal Plan, on 02/13/2025 at 2:47 PM, alleging removal of the IJ on 02/13/2025. The State Survey Agency (SSA) validated the IJ had been removed on 02/13/2025, as alleged, after an acceptable IJ Removal Plan was received and further interviews, observations, and record reviews were conducted to verify the immediate corrections. Remaining non-compliance continued at a S/S of a D at F689. Refer to F655 The findings include: 1. Review of the facility's policy, Elopements and Wandering Residents, reviewed/revised 03/06/2024, revealed the facility ensured residents at risk for elopement received adequate supervision to prevent accidents and received care in accordance with their person-centered plan of care addressing unique factors contributing to elopement risk. Per review, elopement occurred when a resident left the premises or safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do that. Continued review revealed the facility was to establish and utilize a systematic approach for monitoring and managing residents at risk for elopement. The systematic approach was to include identification and assessment of risk .implementing interventions to reduce hazards and risks, and monitoring the effectiveness and modifying interventions when necessary. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Further review of the facility's policy, Elopements and Wandering Residents, reviewed/revised 03/06/2024, revealed residents were to be assessed for risk of elopement upon admission by the interdisciplinary team (IDT). The policy review revealed the IDT was to evaluate unique factors contributing to the risk and to develop a person-centered care plan, with adequate supervision provided to help prevent elopements. In addition, charge nurses and unit managers were to monitor implementation of interventions, response to interventions, and document accordingly. Review further revealed if a resident was not located in the building or on the grounds, the Administrator or designee were to notify the police department, along with appropriate reporting to the State Survey Agency (SSA). Per the policy, documentation in the medical record was to include physician/family notification, care plan discussion, and consultant notes as applicable. Review of the facility's policy, Baseline Care Plan, reviewed/ revised 12/23/2023, revealed the facility was to develop and implement a baseline care plan (CP) for each resident. Per review, the baseline care plan was to include interventions to address the resident's current needs, including any safety concerns to prevent injury, such as elopement, and any identified needs for supervision. Review of the clinical record for R401 revealed the facility admitted the resident on 01/21/2025 with diagnoses of aphasia following cerebral infarction, epilepsy, hemiplegia and hemiparesis following cerebral infarction, and congestive heart failure (CHF). Review of the facility's, Wandering/ Elopement Risk Evaluation dated 01/21/2025 at 11:46 PM, revealed R401 was At Risk for Elopement. Review of R401's Progress Notes dated 01/21/2025, revealed R401 was noted as alert and oriented times one (x1). Review of the Care Plan (CP) dated 01/22/2025, for R401 revealed the facility identified the resident to require assistance with Activities of Daily Living (ADLs) related to impaired decision making and impaired cognition. Continued review of the CP revealed the facility also identified on 01/22/2025, the resident as a risk for falls, related to diminished safety awareness, cognitive impairment and wandering. However, further review of R401's CP revealed no documented evidence the facility addressed the resident's assessed risk for elopement. Review of the Speech Therapy SLP Evaluation and Plan of Treatment dated 01/22/2025, revealed R401's short term goals included to increase orientation to person, place, time, purpose, and caregivers. Per review, R401's previous level of functioning (PLOF) was 100%, and the baseline (on 01/22/2025) was 25%. Review revealed R401 had a diagnosis of stroke and increased confusion and cognitive decline. Continued review revealed the reasons R401 was referred to Speech Therapy (ST) included confusion and decreased cognition. Review revealed the resident's BIMS was noted as 12 out of 15, and the St. Louis University of Mental Status (SLUMS) score was noted as 6 out of 30, indicating severe cognitive impairment. Further review revealed R401 demonstrated severe cognitive deficits for short term memory, delayed recall, orientation, problem solving, and safety awareness. Review of the Speech Therapy Treatment Encounter Note dated 01/24/2025 at 12:48 PM, revealed R401 answered orientation questions with 25% accuracy with moderate visual cues. Continued review revealed the resident recalled information from a read story with 20% accuracy with moderate cues, and answered problem solving questions with 30% accuracy with moderate cues. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the undated facility, Timeline of Events Starting 8:30 PM 01/24/2025, revealed R401 had been observed at 8:30 PM, during the scheduled smoking session. Review of the Timeline revealed at 9:00 PM, staff observed R401 wearing a shirt, sweatshirt, jacket, pants, and shoes, and telling staff he was going out for cigarettes and waving his debit card to show he was going to buy smoking supplies. (However, the facility investigation summary noted R401 left the facility at approximately 8:45 PM.) Per review, at 10:00 PM the Unit Manager, was notified upon her arrival to the facility, R401 had not returned from getting smoking materials. Per review, the facility was immediately searched and a head count completed. Continued review revealed on 01/25/2025 at 12:25 AM, the Administrator was notified R401 had not returned from shopping and the DNS notified at 12:32 AM. Review revealed at 2:00 AM, the ED, DNS, Maintenance Director, and Staff Development Coordinator (SDC) arrived at the facility to assist in locating R401. Continued review of the undated facility, Timeline of Events Starting 8:30 PM 01/24/2025, revealed at 3:00 AM, the Maintenance Director audited 100% of the facility doors, door alarms, and windows to ensure proper functioning, and the door codes were changed. In addition, review revealed at 6:30 AM, the local hospital called the facility to notify them R401 was under their care and supervision. Further review revealed the EMS record noted R401 called 911 while out shopping and had been picked up by EMS at 2:00 AM. Review of the website www.wunderground.com temperature for the city R401 was picked up in by EMS on 01/25/2025 at 1:56 AM, revealed the temperature was 26 degrees Fahrenheit. Review of the local Emergency Medical Services (EMS) [Resident] Patient Care Record for R401 dated 01/25/2025, revealed EMS received a call on 01/25/2025 at 2:03 AM, for seizures. Per review, at 2:21 AM, EMS arrived to R401's location, an intersection approximately 7.79 straight line miles from the facility. Continued review revealed EMS personnel noted R401 had altered mental status and the primary impression was stroke. Further review revealed EMS transported R401 to the local hospital, approximately two to three blocks away. Review of the EMS record additionally revealed R401 told EMS, he had been discharged from a hospital, and described an area that did not have a hospital located there. The EMS Record further revealed R401 did not know what the year was. Review of the hospital's, ED Physician Notes Final Report for R401 dated 01/25/2025 at 11:14 AM, revealed the ED Physician Note documented R401 arrived at the hospital for upper extremity weakness, and had been previously seen for a stroke. Further review of the ED Physician Note revealed it documented stroke as most likely chronic, with a discharge diagnosis of History of Ischemic Stroke. In interview on 02/07/2025 at 1:47 PM, R401 stated he had not been to the hospital since being admitted to the facility. (He did not recall the incident on 01/24/2025). R401 stated he slipped on the ice before he was admitted to the hospital and that was why his left arm did not move. (However, he was admitted to the facility on [DATE], with a diagnosis of a stroke with hemiplegia and hemaparesis). R401 reported he was able to leave the facility whenever he liked and had done so about a week ago. He stated he went out with family once and left a second time by himself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In interview on 02/07/2025 at 2:34 PM, R401's family member (F)10 stated the resident got out of the facility one weekend and got lost. She stated he almost froze to death and ended up at a local hospital. F10 said she did not know how R401 got out of the facility, and he had not had a coat on at the time. She stated R401 got disoriented and she thought he had fallen in a ditch and someone called EMS for him. F10 reported the facility had called her, but she had her phone ringer turned down, but finally answered her phone at 4:00 AM. She further stated the facility asked her if R401 was with her and asked where he could be. F10 reported R401 ended up in the emergency room ; however, he did not remember what happened. In interview on 02/08/2025 at 8:17 AM, Licensed Practical Nurse (LPN) 7 stated he was told in report from the third shift nurse, R401 left the facility between 9:00 PM and 10:00 PM (on 01/24/2025). The LPN stated he did not receive in report what R401 went to the hospital for; however was told the resident eloped from the facility. Per LPN 7 in interview, when R401 returned from the hospital, the resident told him (the nurse) he went out the double door up the ramp (toward the front lobby) and went to a gas station or store. The LPN said R401 told him someone called 911 and the ambulance took him to the hospital. He reported R401 was placed on one to one (1:1) supervision upon return to the facility, although it was stopped prior to the next shift he (LPN) was back to work. The nurse further stated R401 had some cognitive impairment due to the stroke he suffered before he was admitted to the facility. In interview on 02/09/2025 at 1:42 PM, Certified Nurse Aide (CNA) 27 revealed she knew R401 went out once and returned from the hospital. She stated she did not think R401 was able to go out on his own, both physically and mentally. CNA 27 stated she had not received in report any information saying the resident could not go out on his own. In interview on 02/09/2025 at 1:57 PM, LPN 6 stated R401 was very impaired (cognitively). The LPN stated she could talk to the resident and thought he was cognitive (intact); however, as time went by she would begin to notice a change in his conversation. She said R401 would begin saying things that made no sense. She stated R401 was not able to come and go as he pleased. Observation of facility's exit doors on 02/09/2025 at 3:30 PM, revealed the exit doors on A hall, B hall (to the facility parking lot at the end of the driveway), C hall, the double doors to go up the ramp (toward the front lobby area) all had keypads. In interview on 02/10/2025 at 1:51 PM, the East Unit Manager (UM) stated the nurse completed multiple assessments of the resident, which included the risk assessment. She stated the Interdisciplinary Team (IDT) went over the new admission the next day and ensured everything had been completed. The East UM said she would expect to see a detailed note documented in R401's chart of the completed notifications (after he eloped), if the doctor gave any orders, how the resident was acting, and any details that made the nurse come to the assumption the resident had stroke-like symptoms. She reported whether a resident could come and go as they pleased or needed supervision was determined by the resident's BIMS score. She stated R401 was not safe to go out by himself without supervision based on his low BIMS scores and cognition. She further stated he could get hit by a car or kidnapped. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In interview with LPN 12 on 02/11/2025 at 2:20 PM, she stated she did not know how R401 got out of the facility. LPN 12 said (on 01/24/2025) she had given R401 his medications at 8:30 PM, and she finished that hallway around 9:32 PM. She stated when she came back up the hallway around 10:30 PM, staff said they could not find R401. The nurse stated they looked everywhere for R401 and nobody had seen the resident. LPN 12 said we called the nurse that left late that night to see if R401 walked out behind her. The next morning, she stated she received a call from a local hospital saying R401 was in the emergency room (ER) for a stroke, and she informed the hospital the resident had walked away from the facility. LPN 12 said the facility tried to call R401's family member when they realized he was not there and tried several times with no answer. The nurse said from the time she got to work that night, R401 was asking about buying cigarettes. She reported she did not think any of the residents had gone out to smoke after 8:00 PM that night, due to the temperature being too cold. LPN 12 said she did not see the police the night R401 went missing. She stated she did not know where R401 had been located before he went to the hospital (after his elopement). In interview on 02/11/2025 at 3:08 PM, CNA 28 stated she was at the facility when R401 was admitted and he had been overly anxious and confused as it was a new place. She said he was there for a couple of days with no idea of the facility he was in. CNA 28 said R401 had been asking about leaving when she cared for him the first night and talked about his family member living in an apartment next door and about getting cigarettes. The CNA stated she had been working the night when R401 left the facility and she last saw him by the nurse's station. She reported the last time any staff saw R401 (on 01/24/2025) was around 11:30ish PM or 11:45 PM. CNA 28 said R401 went missing between that time and 1:00 AM, when he was discovered missing. Per the CNA in interview, we had no idea how long R401 had been missing. She stated when R401 returned, he said he left the facility behind someone as they exited out the door at the large parking lot end of the driveway. CNA 28 stated she was told R401 was a flight risk, but was also told by management that even though the resident scored at risk for elopement, he took care of his own affairs. She said the police were never called (when the resident went missing). In interview on 02/11/2025 at 3:49 PM, CNA 30 stated she worked the night R401 disappeared from the facility. She stated we did not know where he was. She stated before R401 went missing, she was not told he was at risk for elopement. The CNA said around 6:00 AM (the next morning) the nurse received a call from the local hospital saying the resident was there. CNA 30 reported she did not remember hearing a door alarm sound that night. In interview on 02/12/2025 at 9:53 AM, the Night Shift Manager stated her shift started at 10:00 PM the night R401 was missing, and she did not recall hearing any door alarms. She stated the CNAs reported to her when they were doing rounds around 11:30 PM, they had not seen R401. The Night Shift Manager said she checked the whole building, and then drove to apartment buildings nearby as the buildings had doors you could go into to get warm. She stated after they checked the building, she called the DNS and continued looking for R401. The Night Shift Manager said per hearsay, someone asked R401 how he left the building and he said he went out as a staff nurse left. She stated she did not know if the police were notified that night as that was the responsibility of the ED and DNS to determine. She reported R401's elopement risk assessment noted him as at risk; and he was considered at risk for elopement when he returned. The Night Shift Manager reported she was not asked to write a statement about that night. She further stated she had not heard how R401 ended up where he was when he was picked up or how he exited the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In interview on 02/12/2025 at 10:37 AM, the MDS Coordinator stated she and the other facility MDS Coordinator talked about if R401 was at risk for elopement when he first came to the facility. She stated however, she did not know R401 was assessed at risk by the admission nurse (on 01/21/2025). The MDS Coordinator stated she participated in the clinical meeting (the next morning after R401's admission) and did not recall if R401's risk for elopement was discussed. She reported she was called at 2:00 AM, (when R401 was missing) by the DNS and was told the resident had left the facility. The MDS Coordinator said when she got to the facility she called and spoke to R401's family member, who said she did not know where R401 was, and gave them some places to look. She stated she spoke to the nurse at the local hospital when the resident was located. The MDS Coordinator reported after R401 left the facility it was brought up in the clinical meeting; however, there was not a huge discussion about it. She further stated if a resident left the facility without staffs' knowledge the resident might not be safe. In interview on 02/12/2025 at 1:14 PM, the Staff Development Coordinator (SDC) stated she participated in the clinical meetings every morning. and there had been no discussion of R401's risk of leaving the facility when admitted . The SDC said however, the meeting did review R401's elopement risk assessment. She stated at risk meant the facility needed to keep an eye on him, pay special attention, and needed to have processes in place so the resident stayed in the facility for his safety. In interview on 02/12/2025 at 1:59 PM, the DNS stated when a resident triggered as at risk, the resident may or may not actually be an elopement risk, which varied from resident to resident, and was based on their diagnoses. The DNS said she could not remember what the facility policy said about that though. She stated she was first made aware R401 leaving the facility around midnight by the ED, and had been told the resident left to get cigarettes and had not returned. In continued interview on 02/12/2025 at 1:59 PM, the DNS stated she conducted the facility investigation which was a collaborative effort. She stated she asked R401 how he got out of the building and the resident told her a young fell ow let him out. The DNS said she did not know when R401 left the facility. She stated we verbally asked staff and no one saw him leave. The DNS reported however, she could not remember the names of the staff questioned and there were no written statements. She said she was not sure which door R401 went out. She stated if a resident was identified as at risk for elopement her expectation was for a care plan on elopement be implemented within 48 hours. The DNS reported she had not been able to determine who let the resident out the back door at the parking lot. She further stated R401 had last been seen by staff around 7:30 PM and 7:45 PM when he received his medicine. In interview on 02/12/2025 at 2:38 PM, the Interim Nurse Practitioner (NP) stated he supervised the former NP who reported to him no one at the facility notified her (the former NP) of R401 leaving the facility. He stated the former NP told him she had seen a sitter with R401 a couple of days later and when she asked why he had a sitter she was told he had gotten out. In interview on 02/12/2025 at 3:03 PM, the Administrator stated she had been notified by the Night Shift Manager, the night of 01/24/2025 or 01/25/2025, that R401 left the facility. She stated she called the DNS after being notified by the Night Shift Manager. The Administrator said the DNS, MDS Nurse, SDC, Maintenance Director, and herself, all came to the facility, where a thorough search for R401 was conducted. The Administrator stated facility staff called R401's family member who did not answer. She said the facility reached the family member at 4:00 AM, who said R401 was not with her, and gave staff ideas of where he could be. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In continued interview on 02/12/2025 at 3:03 PM, the Administrator stated she had been informed by the DNS on 01/25/2025, the local hospital called to ask if the facility had a resident by the name of [R401]. The Administrator stated R401 also said he went out the back (of the facility) at the double doors (at the parking lot at the end of the driveway). Review of the facility's policy titled, Protocol: Smoking, date implemented and revised 11/01/2024, revealed the policy stated Smoking Safety Screens would be completed upon admission, re-admission, quarterly, annually, with a significant change, and as needed. Review of the facility's policy titled, Fall Prevention Program, date implemented and reviewed 02/01/2024, revealed that upon admission the nurse was to complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 2. Review of R400's EMR revealed the facility admitted the resident on 01/24/2025, with diagnoses of cerebral infarction with hemiplegia and hemiparesis, seizures, and diabetes type II. Review of R400's Admission Minimum Data Set (MDS) Assessment with an ARD of 01/30/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating intact cognition. Further MDS review revealed the facility assessed the resident to require partial assistance for all transfers (bed to chair and bed to toilet). Continued review of R400's EMR revealed no documented evidence of a smoking assessment or fall risk assessment completed for R400 on her admission on 01/24/2025. Review of the CP for R400 revealed the facility developed a focus area for the resident liked to smoke, with a goal stating the resident would not suffer injury from unsafe smoking practices. Per review, the interventions included instructing R400 about smoking risks and hazards and about smoking cessation aids that were available. Continued CP review revealed the facility also developed a focus area for the resident as at risk for falls or falls related injuries related to decreased mobility and psychotropic medication use. Per review, the goal for the falls CP was for R400 to not sustain serious injury. Further review of the falls CP revealed interventions which included: making sure R400's call light was within reach and encourage the resident to use it to ask for assistance dated 01/25/2025. Additional review of the fall CP revealed other interventions included: R400 needed prompt response to all requests for assistance dated 02/04/2025; encourage use of non-skid footwear when out of bed dated 01/30/2025; encourage her to use the restroom in her own room dated 01/30/2025; and therapy to look at the need for footrests for R400's wheelchair dated 01/30/2024. Review of a Change in Condition Assessment in R400's EMR dated 01/29/2025, revealed on that date the resident sustained a fall. Per review, R400 was assessed and found to have no mental or physical changes. Continued review revealed the provider was notified, and ordered an x-ray for R400's left ankle. Further review revealed recommendations to prevent further falls were R400 needed to be supervised when transferring. Review of a Change in Condition assessment dated [DATE], revealed R400 sustained another fall. Per review, R400 was assessed and found to have no mental or physical changes. Continued review revealed the provider placed R400 on neurological (neuro) checks, with no new interventions put in place per the note. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Continued review of R400's medical record revealed no fall risks had been completed prior to her fall on 01/29/2025. Per review, on 01/29/2025, a fall risk assessment was performed and the resident had scored a 16, which indicated a low risk of falling. Review of a second fall risk assessment was performed on 02/03/2025, and R400 scored 25, which indicated a moderate risk of falling. Review of the medical record revealed a Post Fall Assessment was performed and documented in R400's EMR on 02/03/2025. Review of the Post Fall Assessment revealed R400 had fallen while trying to transfer to the toilet. Further review revealed interventions were put in place for R400 to call for assistance when transferring and a consult was placed for both Physical Therapy (PT) and Occupational Therapy (OT) evaluations. Review of R400's Physician Orders in her EMR revealed an order for PT to consult and treat from 01/25/2025 through 02/21/2025. In addition, review of the Physician Orders revealed an order for OT to consult and treat R400 from 01/29/2025 through 02/26/2025. Observation on 02/04/2025 at 9:18 AM, of R400 revealed bruising observed to her right ankle. In interview, at the time of observation, R400 stated she had fallen. Observation on 02/10/2025 at 10:06 AM, revealed R400 was taken to the front lobby by a staff member and allowed to sign herself out to go unaccompanied outside to smoke. In additional interview with R400 on 02/04/2025 at 9:18 AM, she stated she had fallen while transferring to her wheelchair. R400 stated she was able to sign herself out and go off the facility property, and often did that and went outside to smoke. She reported the facility had been changing the rules on smoking since her admission. The resident said they were letting her go out by herself, but now told her she could only go out during resident smoke breaks. In interview on 02/06/2025 at 2:50 PM, CNA 2 stated R400 signed herself out and sat by the building doors at the end of Hall B to smoke. She said staff let her and her husband go in and out when they requested to do that. CNA 2 said she was not sure if R400 was assessed to be able to smoke unsupervised or not. She stated she was not sure who did residents' smoking assessments. The CNA said R400 had fallen trying to transfer to toilet twice. She reported the facility was trying to prevent further falls for R400 by educating her to press her call button and ask for assistance when going to the bathroom or when she was transferring from bed to wheelchair. CNA 2 further stated R400 had weakness on her right side due to a stroke and that was why she kept falling. In interview on 02/06/2025 at 3:16 PM, Registered Nurse (RN) 5 stated when R400 first came to the facility less than a month ago, staff let her go outside the doors at the end of hallway B to smoke, unsupervised. She said however, now R400 had been told she could no longer do that and needed to go out in the courtyard to smoke with the other residents during smoke breaks. RN 5 said smoking assessments were done quarterly in the EMR system, they pop up on the work list in the EMR when they need to be completed. She stated a smoking assessment should have been done on R400 upon her admission; however, she was unsure if one had been completed for her or not. The RN said R400 had experienced two falls since her admission to the facility, and both falls occurred during transfers to and from her wheelchair. She stated to prevent further falls for R400 they had educated the resident to use the call bell and ask for help with transferring to and from her wheelchair, bed, toilet, etc. RN 5 further stated they had instructed her not to transfer herself without assistance, and were also, keeping the resident's bed in a low position to help prevent falls when getting out of bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In interview on 02/07/2025 at 8:58 AM, LPN 6 stated R400 was a smoker and when she first arrived at the facility, she was told she could go out into the parking lot and smoke. She said however, now R400 had to sign out and have someone with her when she went out to smoke. LPN 6 reported if R400 asked her to go outside to smoke unsupervised she would tell her she preferred she go out with the smoking group and have staff with her. She stated R400 should have had a smoking evaluation done upon admission and it could be found under the Evaluations tab in the EMR. The LPN said smoking evaluations were also done quarterly as part of the evaluations that came up to be done in the EMR. She reported R400 had weakness on the one side, and had trouble with her wheelchair fitting into the bathroom. LPN 6 stated R400's leg got tangled up in her wheelchair and she lost her balance which was the cause of one of her falls, and said however, she was not sure why the resident fell the second time. She additionally said the intervention they performed was to educate R400 to call for help before getting up. In interview with RN 1 on 02/07/2025 at 10:07 AM she stated she was the East UM for night shift. RN 1 stated R400 and her spouse did what they wanted to do, and had observed staff and learned the code to the doors in order to go in and out on their own. She said the couple had now been told they must sign in and out and get someone to go with them when they went out to smoke. RN 1 reported smoking assessments should be done on admission, quarterly, and if there was a change in a resident's condition. She said R400 had fallen over the foot pedal on her wheelchair with her first fall, and she had not heard about her falling again. The RN stated she was not sure of the interventions put in place to prevent R400 from falling again; however, would educate/ask the resident to call first, and staff would help her get to the toilet. In interview on 02/10/2025 at 8:14 AM, with the OT and PT they said R400 was currently getting PT, OT, and Speech Therapy (ST). The OT stated her assistant usually saw R400, whose goals for OT were grooming, toileting, and upper body and lower body dressing. The OT said for toileting that meant doing both transferring and performing hygiene. The OT said R400 had her OT evaluation on 01/27/2025, and her OT started after that initial assessment. The PT stated R400's PT assessment was done on 01/25/2025 and her PT started on that same day. During the interview a note from PT was reviewed which noted R400 had weight bearing issues and it was that issue that was preventing her from progressing. The PT said R400's ankle had been injured from the falls she experienced. The PT stated with the fall that occurred on 01/30/2025, R400 had received an x-ray which showed no fracture, but R400 refused to ambulate on 02/02/2025 due to pain in the ankle. The PT and OT said on 02/05/2025, they both asked for R400's weight bearing status from the provider. Per the therapists in interview, on Thursday, 02/06/2025, R400 had been deemed as non-weight bearing by the provider and was awaiting another x-ray per NP 6. Both OT and PT stated that R400 was agreeable to therapy but needed her pain controlled first. In interview on 02/12/2025 at 9:38 AM, the DON stated R400 had behaviors, and did whatever she wanted. She said R400 could and did sign h [TRUNCATED]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 45914 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a performance review was completed for every Certified Nursing Assistant (CNA) at least once every 12-months for five out of five CNAs' personnel records reviewed, CNA #2, #18, #20, #31, and #32. Additionally, the facility failed to provide evidence of regular in-service education based on the outcome of these reviews for three of five records reviewed, CNA #18, #31, and #32. The findings include: The State Survey Agency requested a staffing policy on 02/11/2025 at 3:05 PM; however, the facility did not provide a policy. During an interview, at that time, with the Executive Director he stated the facility did not have a staffing policy. He stated they based staffing off the facility's assessment. Review of the facility's policy titled, Job Description; Certified Nursing Assistant, dated 02/01/2024, revealed CNAs were to attend a minimum of 12 hours of continuing education programs provided by the center in order to maintain certification. Review of CNA2's personnel file revealed a hire date of 02/25/2022 and 13.41 annual training hours completed. However, there was no documentation of a performance evaluation in the previous 12 months. Review of CNA18's personnel file revealed a hire date of 01/18/2021 and only 5.63 annual training hours completed. Further review revealed no performance evaluation documented in the previous 12 months. Review of CNA20's personnel file revealed a hire date of 11/01/2019 and 22.75 annual training hours completed but no documentation of a performance evaluation in the previous 12 months. Review of CNA31's personnel file revealed a hire date of 08/25/2023 and no annual training hours were documented. Further review revealed no documentation of a performance evaluation within the previous 12 months. Review of CNA32's personnel file revealed a hire date of 05/09/2022 and only one annual training hour was documented. Further review revealed no performance evaluation documented within the previous 12 months. In an interview with [NAME] President of Regional Clinical Operations (VPRCO), on 02/13/2025 at 3:04 PM, she stated the facility had acquired new ownership, and trainings and education were provided through in-services, and skill fairs to ensure staff were meeting training needs. She stated the prior owners had provided the training/education documents but they had failed to provide the performance evaluations. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Administrator, on 02/13/2025 at 4:00 PM, she stated she was new in her position and was still learning her role during the change in ownership and facility processes. She stated if the performance evaluations were not completed, staff could not benefit from the provided feedback regarding the tasks they performed well or what areas that needed improvement. Additionally, she stated her expectations were that CNAs were evaluated when hired and annually to assess their competencies, skills, and knowledge and their required training would be met annually.

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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. 51417 Based on observation, interview, record review, and facility policy review, the facility failed to ensure all drugs were labeled in accordance with professional standards. Observations revealed undated, opened, unlabeled and expired medications in 1 of 5 medication carts and 1 of 2 treatment carts. Those medications included topical creams, and one oral pill. The findings include: Review of the facility's policy titled, Medication Storage, dated 02/01/2024, revealed The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. The medications are destroyed in accordance with our Destruction of Unused Drugs Policy. The policy did not address documenting on open/expiration dates, unlabeled medications, or the long-term storage of ointments/creams in the labeled, pharmacy supplied protective plastic storage bag. Review of the facility's policy titled, Medication Administration, dated 02/02/2024, revealed, Identify expiration dates. If expired, notify nurse manager. 1. During observation on 02/04/2025 at 10:57 AM of the men's memory care unit's treatment cart revealed one tube of Silvasorb gel topical medication used to treat a variety of skin wounds with an expiration date of 07/2024. This medication was not labeled and had no identifier. Additional observation revealed one tube of Diclofenac 1% topical medication used to treat arthritic pain without an open date and was not in a storage bag for Resident (R) 87. During an interview on 02/04/2025 at 10:57 AM with Registered Nurse (RN) 1, she stated that pharmacy usually go through the carts about once a month. 2. During observation of the medication cart for the B hall on 02/04/2025 at 3:50 PM, revealed a pill separated from the pack in the top drawer of the medication cart. Further observation revealed the medication was Cyclobenzaprine (a muscle relaxant) 5 milligrams (mg). The medication was unlabeled and had no resident identifier. During an interview on 02/04/2025 at 3:50 PM with Licensed Practical Nurse (LPN) 2, she stated that night shift must have left it and that she would destroy it immediately. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 2:05 PM with the Unit Manager, she stated that expired medications were not to be in the carts and were to be discarded according to the facility's policy. She stated that the nursing staff were to go through the medication carts weekly and monthly, and that included the treatment carts. She stated medications were to be labeled with the open date and initials, and kept in their bag and separated individually. She stated that random or floating pills were expected to be wasted. She stated medications should be patient (resident) identifiable and in their individual containers. The Unit Manager stated there was too much of an opportunity for a negative outcome. During an interview on 02/06/2025 at 2:40 PM with Staff Development, she stated it was difficult to discern a medication for a resident if it was left unlabeled in the medication cart, which could result in a potential medication error. She stated that education was provided annually during the skills fair on medication administration and ordering medication from the pharmacy. She stated medications come prepackaged individually with the resident's name. She stated she teaches the rights of medication administration, locking the med carts, how to properly open medications, and how to properly discard medications. During an interview on 02/06/2025 at 2:15 PM with the Director of Nursing (DON), she stated it was her expectation that expired medications were not to be in the carts. She stated the nurses were expected to look at the dates prior to use and reorder the medication and dispose the expired medications. She stated that open dates and expiration dates should be written on the medications with either the 30 day after open date or the manufacture's date, whichever comes first. The DON stated the nurses were to look at the medications in the carts daily for expiration dates and the unit managers were to check once a week. She stated random pills in the medication carts were expected to dispose the medications. The DON stated medications were to be in their separate container with a resident identifier. During an interview on 02/06/2025 at 2:33 PM with the Administrator, she stated it was her expectation that expired medications should not be in the medication or treatment carts. She stated any nurse could check at least once a week and review the carts. She stated medications have to have open dates according to policy. The Administrator stated that loose, random medications in the carts must be destroyed. She stated medications could not be in medication carts without personal containers with identifiers needed. She stated a negative outcome could be death, the right medications needed to go to the right resident.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 45914 Based on observation, interviews, and record review the facility failed to ensure it electronically submitted complete and accurate direct care staffing information, to the Centers for Medicare and Medicaid Services (CMS) for one of four quarters in 2024. The facility failed to submit direct care staffing information for the third quarter (July-September) of 2024 which triggered for no RN [registered nurse] Hours, and failure to have Licensed Nursing Coverage 24 Hours/Day Four or More Days Within the Quarter, specifically August and September 2024. The findings include: Review of the facility's provided CMS Payroll Based Journal (PBJ) report which was based on the staffing data submitted by the facility revealed excessively low weekend staffing, no RN hours, and a failure to have licensed nursing coverage 24 Hours/Day triggered for August and September 2024. A request for the facility's staffing data submitted for the third quarter (July, August, September) PBJ was requested but no verification that it had been reported successfully was provided. The facility provided an Excel spreadsheet for August and September 2024 which included payroll data for all staff; however, no verification the information was submitted or received by CMS system was provided. Further, the facility could not provide the facility's assessment completed for 2024. In an interview with the [NAME] President of Regional Clinical Operations (VPRCO), on 02/13/2025 at 3:04 PM, she stated the [NAME] President of Finance (VPF) advised her that the requested PBJ staffing data had not been submitted. She stated the VPF indicated that she (the VPF) had attempted to submit the data unsuccessfully. In an interview with the VPF, on 02/13/2025 at 3:30 PM, she stated she was responsible for submitting the payroll data to CMS for the PBJ Staffing Data Report. She stated during the third quarter there was a change of ownership and the data was entered into a new software program and could only conclude that there was an error in the software. She stated she submitted the information on 10/14/2024 but received an error message on 10/15/2024 which indicated the data was not submitted. She stated there was a lot of confusion with the third quarter because the data for July 2024 was submitted by the previous owners, but the new owners would submit the August and September 2024 data. She stated she had not contacted CMS because the error was realized after the deadline of 10/15/2024. In an interview with the Administrator, on 02/13/2025 at 4:00 PM, she stated she was new in her position and was still learning her role during the change in ownership. She stated she was made aware the staffing data had not been submitted due to a software error. She stated she understood the importance of submitting the payroll data timely to CMS because it had affected the facility's survey outcome and also decreased the facility's star rating. She stated her expectation was that the facility submitted the required data timely to ensure the facility was in compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50442 Based on observation, interview, record review, and review of the facility's documentation and policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases and infections for 2 of 3 sampled residents (Resident (R) 20 and R67). Observations of Licensed Practical Nurse (LPN)6 of R20 and R67 during wound care revealed the LPN failed to perform hand hygiene when moving from a dirty task to a clean task. Additionally, the LPN failed to ensure a barrier was in place before placing supplies on the table. In an interview with the Wound Doctor, she stated this practice could contaminate the wound and cause an infection. The findings include: Review of the facility's policy titled, Wound Treatment and Management, with a date implemented of 02/01/2024 and a date revised of 02/14/2024, revealed the purpose of the policy was to promote wound healing of various types of wounds by providing evidence-based treatments in accordance with current standards of practice and physicians orders. Review of the facility's policy titled, Hand Hygiene, revised on 02/16/2024, revealed that all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy outlined the technique for hand hygiene with alcohol based hand rub (ABHR), soap and water, and listed under what conditions each should be performed. Further review of the policy revealed the use of gloves did not replace hand hygiene. If the task required gloves, hand hygiene should be performed prior to donning gloves and immediately after removing gloves. Review of the facility's policy titled, Enhanced Barrier Precautions, revised on 02/01/2024, revealed that it was the practice of the facility to implement Enhance Barrier Precautions (EBP) for the prevention and transmission of multidrug resistant organisms. Further review of the policy stated that clear signage should be posted on the resident's door stating the type of personal protective equipment (PPE) needed for high contact resident care activities. PPE, such as gown and gloves, would be made immediately available outside the room's door and ABHR should be both inside and immediately outside the resident's door. The policy outlined who would be placed on EBP and defined what activities were considered high contact resident care activities. 1. Review of R20's Electronic Medical Record (EMR) revealed the facility admitted the resident on 11/15/2022 with the medical diagnoses of chronic obstructive pulmonary disease (COPD), schizoaffective disorder, chronic pain syndrome, and fibromyalgia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/2025 revealed R20 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R20's Comprehensive Care Plan (CCP), undated, revealed the resident was care planned for the focus of altered skin integrity related to an abscess of left leg (resolved) and a wound on the left hip. The goal for this focus was R20's altered skin integrity would show signs of healing. R20 was also care planned for the focus of enhanced barrier precautions (EBP) due to altered skin integrity. The goal of this focus was resident would have a reduced likelihood of transmission of resistant organisms through target date. The interventions for this focus were to educate resident and/or family on the need for enhanced barrier precautions; enhanced barrier precautions implemented during high touch care activities; and staff must wear a gown and gloves when providing high touch care. Review of R20's Physician Orders in her EMR revealed she had an order for the abscess of the left hip/leg to cleanse with normal saline, pat dry, and apply calcium alginate with silver. The wound was to be covered with border gauze. Wound care was to be done daily. She also has an order for Enhanced Barrier Precautions (EBP) related to her wound. Observation of wound care for R20 on 02/07/2025 at 2:44 PM provided by Licensed Practical Nurse (LPN) 6 revealed that she hand sanitized and put on PPE prior to entering R20's room. Once in the resident's room, the LPN raised the resident's bed and moved other items in the room on the bedside table without washing her hands or changing her gloves. The table and sink that LPN6 placed her items on were not cleaned and a barrier was not placed. LPN6 then removed the dressing from the resident's wound and did not wash her hands or change her gloves prior to opening the sterile items needed for the wound care. After opening the bandages, she washed her hands and changed gloves, then reached into her pocket to remove her bottle of normal saline used to do the wound cleansing. She did not wash her hands or change her gloves. The wound was smaller than a dime in size and had yellow drainage. She cleaned the wound and only changed her gloves, however, did not wash her hands. Her gown touched against the open dressings on the table multiple times during wound care. She placed the calcium alginate on the wound and then put on the border gauze. She touched the resident's bed controls and bedside table prior to taking off her gloves and washing her hands. She then threw away the Normal Saline(NS) and all the other items left from the wound care. On 02/03/2025 at 2:43 PM in an interview with R20, she stated that she had a boil on her left hip, adding she has had one in the past, which had healed. In an interview with LPN4 on 02/06/2025 at 3:33 PM she said R20 had a boil on her left hip and was getting wound care for it. She stated she had only seen it once, so she was unable to state if it was healing or not. Per the interview, she stated the wound had drainage but no offensive odor. LPN4 stated R20's treatments were provided on day shift. She stated the resident's wound was cleaned with calcium alginate with border dressing. 2. Review of R67's Electronic Medical Record (EMR) revealed the facility admitted her on 10/14/2022 with medical diagnoses including cerebral infarction due to embolism of the left middle cerebral artery, dementia, type II diabetes mellitus, chronic diastolic heart failure, and chronic kidney disease stage 3A. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/2024 revealed the facility did not conduct a BIMS score for the resident. The facility assessed R67 as having a pressure ulcer and at risk for developing pressure ulcers/injuries. Additionally, the record indicated R67 had one stage 2 and one stage 4 pressure ulcer. Further review revealed the facility assessed R67 as having 2 unstageable deep tissue injuries. Treatment for the PUs: pressure reducing device for bed, nutrition and hydration interventions, PU injury care, and applications of ointments/medications (other than to feet). Review of R67's current Comprehensive Care Plan (CCP) from 01/15/2025 revealed the facility care planned her for the focus of potential skin impairment related to incontinence, diabetes mellitus, current skin impairment, and limited mobility. The interventions for this focus were incontinence care every shift and as needed for incontinence episodes. Further review revealed the facility would ensure the resident received her treatments as ordered; complete observation of the resident's skin during care and report any concerns to the nurse. Review of a Wound Care Note from 02/06/2025 revealed a stage IV pressure ulcer on her sacrum that was 0. 8-centimeter (cm) x 0.3 cm x 0.1 cm. The pressure ulcer on the sacrum was assessed as having a surface area of 0.24 cm squared, with moderate serous exudate. It had 90% granulating tissue and 10% slough. The pressure ulcer was noted to have improved as evidenced by the decreased surface area. The current treatment plan for the pressure ulcer was to cleanse with normal saline, pat dry and apply alginate rope and Leptospermum honey. Further review of the note revealed staff were to use a gauze island with border to cover the pressure ulcer. Further review of the note revealed that the pressure ulcer was not likely to heal and the wound physician had recommended an assessment for ultrasound mist therapy. Observation of wound care performed on 02/07/2025 at 2:05 PM by licensed practical nurse LPN6 for R67 revealed Certified Nursing Assistant (CNA) 9 and CNA11 were in the room to help roll R67. Both CNAs performed hand hygiene and put on gown and gloves. Continued observations revealed LPN6 performed hand hygiene and donned (put on) a gown and gloves prior to entering R67's room. She did not wipe off the bedside table nor place a barrier on the bedside table prior to placing the supplies for the wound treatment onto the table. An unopened dressing fell to the floor and LPN6 retrieved the package placed it back onto the table. LPN6 indicated she forgot to bring the normal saline for cleansing R67's wound. She removed her personal protective equipment (PPE) and left the room. When she returned, she had donned a new gown and had gloves in her hands and proceeded to put the gloves on inside the room and then lowered the head of R67's bed and uncovered R67. There was no dressing over the sacral wound as LPN6 explained it was removed just prior during incontinence care. LPN6 did not change her gloves or wash her hands after lowering the head of R67's bed and removing the resident's bed covers and brief. She proceeded to open the sterile wound care supplies with the same contaminated gloves. Continued observations revealed LPN6 wiped the wound with gauze moistened with NS and patted it dry. She did not change gloves or wash her hands after cleaning the wound; and then she used her gloved fingers to wipe the Leptospermum honey onto the wound. She then took off her gloves, washed her hands, and placed new gloves on. After donning new gloves, LPN6 pressed the silence button on the tube feed pump, and did not perform hand hygiene or change her gloves. She packed the calcium alginate rope into the wound and placed a border gauze undated and unlabeled over the wound. LPN6 labeled and dated the dressing after it was adhered to R67. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing	1101 Lyndon Lane Louisville, KY 40222

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 - Some	In an interview on 02/07/2025 at 2:40 PM with LPN6 regarding the wound care treatment she provided to both R20 and R67, she stated she forgot to do some things during the wound treatment such as performing hand hygiene when she returned to the room after leaving to go and get the normal saline for the wound cleansing. LPN6 did not comment regarding her not washing her hands or changing gloves when she moved from a dirty task to a clean task (such as after cleaning the wound and then immediately putting the Leptospermum honey and calcium alginate onto the wound without washing her hands and changing her gloves). LPN6 stated she should remove her gloves, perform hand hygiene, and then put on new gloves when moving from dirty to clean in a wound care, such as after removing an old dressing. Further, LPN6 stated hand hygiene and a glove change should be done after cleansing the wound. Additionally, LPN6 stated she typically placed a barrier before placing supplies on a table and that she should have performed hand hygiene and donned fresh gloves after touching resident equipment and before opening clean wound care supplies. In an interview with the Director of Nursing (DON) on 02/12/2025 at 9:38 AM, she stated her expectation for wound care was for staff to have a clean field on which to do wound care. She stated there should be a barrier placed and staff should clean the table prior to placing the barrier. Further, she stated staff should clean their hands and put on new gloves after touching items in the room such as the bed controls, tube feed pump, or the resident. She stated staff should change gloves after cleaning the wound and wash their hands and/or use hand sanitizer each time their gloves were changed. The DON stated that she expected staff to wash their hands and sanitize after any dirty task and change gloves. In an interview with the Wound Care Nurse/Staff Development Coordinator (WCN/SDC) on 02/12/2025 at 1:17 PM, she stated it was her expectation of staff performing would care to clean the surface they were placing their barrier on with bleach wipes and allow it to dry the specified time before putting down a barrier like a chux. Then wound care supplies should be put on the clean chux. She stated staff should hand sanitize and/or hand wash before putting on PPE (gloves and gown) to enter the room for the wound treatment. Further, she stated staff should also change gloves and wash their hands when touching anything that was not clean or sterile. The SDC stated her expectation was that the Leptospermum honey would be applied to the wound with an applicator to prevent contaminating the wound and the Leptospermum honey bottle. She stated if proper hand hygiene and changing of gloves did not occur this could cause contamination of the wound and possible infection. In an interview on 02/13/2025 at 9:17 AM with the Wound Doctor, she stated she had been seeing R67 weekly for her pressure ulcer since she inherited the facility from the previous wound doctor. She stated her expectations for wound care was that nurses go into the resident's room with PPE on. She stated staff should perform hand hygiene and wear gloves for all wound care. Further, she stated gloves should be changed in between each wound. The Wound Doctor stated that if staffs' hands were soiled staff should wash their hands, otherwise, they could use hand sanitizer for hand hygiene. She stated she expected staff to change their PPE between residents. The Wound Doctor stated she expected staff to use hand sanitizer and put on new gloves after they clean the wound. Per the interview, she stated if staff touched anything in the room that was not clean or sterile, staff should complete hand hygiene and change gloves. Further, she stated barriers should be down when completing wound care, to put the supplies on. She stated if staff did not perform hand hygiene and change gloves appropriately, staff could contaminate the wound and cause an infection.