STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185176	A. Building B. Wing	11/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Heights	446 Mt. Holly Avenue Louisville, KY 40206

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility's policies, it was determined the facility failed to ensure an effective pain management regimen, based on a thorough assessment and a person-centered care plan, was implemented for 1 of 11 sampled residents receiving scheduled pain medications (Resident (R) 1). The facility failed to administer pain medication as ordered to R1, who had a history of chronic pain and required multiple daily doses of a potent opioid analgesic. The failure created ongoing, severe pain, and R1 also experienced withdrawal symptoms which he described as, The only way the pain was going away was if I died.The findings include:Review of the facility's policy titled Pain Management, dated [DATE], revealed the facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The policy states that, in order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and prevent or manage pain, the facility will recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated, evaluate the resident for pain and the cause(s) upon admission and with changes in condition, and manage or prevent pain, consistent with the comprehensive assessment and plan of care. and the resident's goals and preferences.The policy, dated [DATE], further revealed that, based on professional standards of practice, an assessment or evaluation of pain by the interdisciplinary team may include obtaining the resident's history of pain and its treatment, identifying key characteristics of the pain such as duration of pain, timing, pattern, and radiation, determining the impact of pain on quality of life (e.g. sleeping, functioning, appetite and mood), and reviewing current prescribed pain medications, dosage and frequency. In the section on pain management and treatment, the policy stated that, based upon the evaluation, the facility, in collaboration with the attending prescriber and other health care professionals and the resident and/or representative, will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission, and that the interventions for pain management will be incorporated into the components of the comprehensive care plan. The policy further indicates that pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain, and that the interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain, including evaluating the resident's medical condition and current medication regimen and using the most effective and least invasive route for analgesic administration.Review of the facility's policy titled Controlled Substance Administration and Accountability, revised [DATE], revealed that non-stock controlled substances are dispensed from the pharmacy according to physician orders for a specific patient. Review of the facility's policy titled, Medication Reconciliation, revised [DATE] revealed that, prior to admission, staff are to obtain the current medication list from the referral source (e.g., hospital, home health, hospice, or primary care provider), obtain current medication and admission orders, verify resident identifiers, and forward the information to the nursing unit accepting the resident. The same policy further specifies that upon admission staff are to verify resident identifiers on the information received, compare (continued on next page)

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

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admission orders to hospital records and obtain clarification orders as needed, transcribe orders in accordance with procedures for admission orders, have a second nurse review the transcribed orders for accuracy and cosign to indicate the review, and order medications from the pharmacy in accordance with facility procedures for ordering medications.1. Review of R1's hospital History and Physical [H and P] revealed the hospital admitted R1 on [DATE]. Per the H and P, R1 had a history of a gunshot wound with residual paraplegia (paralysis of the lower limbs). The resident also had a chronic Stage IV pressure ulcer with osteomyelitis growing multiple drug-resistant organisms (MDRO.) This pressure ulcer was described as enlarging, with progressed loss of bone mineral density of the sacrum. The H and P noted that the resident had chronic pain and had orders for hydromorphone (Dilaudid - a potent opioid analgesic used to treat moderate to severe pain) both prior to admission, as well as during his hospitalization. Review of the facility's Discharge summary dated [DATE] at 1:53 PM revealed that R1 was discharged from the hospital to a nursing facility on [DATE]. R1, who was followed by a pain clinician (both prior to and during hospitalization), had medication orders at the time of discharge for Hydromorphone HCl oral table 2 milligrams (mg), two tablets every four hours for pain.Review of R1's admission Record revealed the facility admitted the resident from the hospital on [DATE], with diagnoses including paraplegia, muscle weakness, a sacral pressure ulcer, depression, and anxiety. Review of R1's Physician Orders, dated [DATE], revealed a routine order for Hydromorphone HCl oral tablet 2 mg, two tablets by mouth every four hours for pain (total of six med passes per day, for a total of 24 mg.) Review of the facility's Nursing admission Evaluation and Baseline Care Plan form, dated [DATE] at 6:32 PM and completed by Unit Manager (UM) 1, revealed that R1 displayed pain to the coccyx, which was described as throbbing. The narrative Progress Note section of the admission Assessment form documented the pain as an 8 (on a scale of 0 -10, with 10 being most severe pain) r/t [related to] sacral area wound and stomach per RSD [resident]. Further review of the admission Evaluation revealed that the nurse documented that R1's pain was acute (onset of less than 30 days) and did not address that the resident had chronic (ongoing) use of Hydromorphone, even prior to his hospitalization. Under the Pain Management Interventions Implemented portion of the form, the nurse completing the admission Assessment marked repositioning and non-pharmacological interventions (none specified.) Although R1 had admission orders for Hydromorphone and the assessment documented R1 had pain medication dependence neither Pain Medication Administered nor Notified MD/NP [doctor/Nurse Practitioner] was marked as implemented. Review of the Care Planning portion of the Nursing admission Evaluation and Baseline Care Plan, the nurse marked the need to Anticipate the resident's need for pain relief and respond promptly to any complaints of pain, offer non-pharmacological approaches and notify the physician if interventions were unsuccessful. The nurse also checked the interventions to identify what aggravated the resident's pain as well as what alleviated it; however, she failed to follow the instructions to specify this information, leaving it blank. Further review of the Care Planning Section revealed that the nurse completing the baseline care plan failed to identify the need to administer analgesia (specify medication) as per orders, monitor for non-verbal signs of pain, or monitor/record/report to the nurse when resident complaints of pain or requests for pain treatment. Although R1's Physician Orders dated [DATE] called for Hydromorphone HCl oral tablet every four hours for pain, review of the Medication Administration Record (MAR) revealed R1 did not receive the first dose of Hydromorphone until [DATE] at 8:00 PM, two days after admission. Interview with the dispensing pharmacy on [DATE] at 11:54 AM revealed that they did not receive any orders for Hydromorphone until [DATE] at 11:36 AM, when the Medical Director (R1's attending physician) first contacted them.Review of facility documentation revealed that during the two days the resident failed to receive his Hydromorphone as ordered, he suffered severe pain. In addition to the entry by UM1 dated [DATE] at 6:32 PM, documenting R1's pain at an 8/10, other documentation included:[DATE] Progress Note by Certified Nursing Assistant (CNA) 2 at 4:38 AM with pain at 8/10. [DATE] Pain rating in the MAR at 9/10 at 3:13 PM [DATE] Progress Note by Licensed Practical Nurse (LPN) 2 at (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5:19 PM documented his pain at a 9/10. [DATE] at 10:05 PM Progress Note by UM1 documented the resident stated he wanted pain medication and had been told it Would be in soon. [DATE] Skilled Daily Note by UM1 at 11:45 PM stated: RSD complains of pain to nursing staff. RSD is lethargic and sleeps, then awake to alert nurse to symptoms of painXXX[DATE] Progress Note by the Nurse Practitioner (NP) at 12:59 AM stated: Patient complains of pain in back and legs, severe and waiting for pain medications. Complains of bilateral leg muscle spasms that are usually controlled with medication but has not had any. [DATE] Pain Rating in the MAR at 12:35 AM was rated 10/10XXX[DATE] note by CNA2 at 9:08 AM stated: RSD voiced c/o to staff regarding AMA (against medical advice) r/t (related to) pain and discomfort and medication unavailable.Nurse spoke with pharmacy regarding medications as well as NP. regarding a script for the hydromorphone. Dr [Medical Director] has been notified by nurse as well regarding hydromorphone.Review of R1's progress notes from [DATE] through [DATE] showed nursing staff contacted the NP, the Advanced Practice Registered Nurse (APRN), and/or Medical Director multiple times regarding R1's uncontrolled pain and the need for his Hydromorphone during the two-day period between admission and his first dose. A [DATE] progress note by UM2 at 12:13 AM documented: Medications verified with [NP]. At 2:50 AM on [DATE], CNA2 documented the order for Hydromorphone HCL oral tablet 2 mg. Give 2 tablets by mouth every 4 hours for pain, noting that the medication is unavailable at this time. RSD is new admission. RSD, provider and pharmacy [are] aware. At 12:21 PM, LPN2 documented she spoke with the APRN, regarding narcotic medication new scripts needed regarding hydromorphone, gabapentin and clonazepam orders. In response, documentation revealed that the APRN would give a one-time dose of Norco (a different, less powerful opioid). Per the note, the Medical Director was contacted regarding scripts, and the pharmacy was called regarding the medications. At 1:51 PM, she further documented: This nurse spoke with [NP] regarding resident pain medication. New orders for Norco 10 every 6 hrs PRN for pain until Dilaudid comes in. Resident is aware and voiced understanding regarding pain medication. On [DATE] at 9:08 AM, CNA2 documented in the progress notes that nursing staff had spoken with the pharmacy, NP, and Medical Director regarding the script for Hydromorphone.Review of R1's Physician Orders revealed that although the additional order was given on [DATE] at 3:15 PM for Hydrocodone-Acetaminophen oral tablet 10-325 mg, one tablet by mouth every six hours as needed for pain for two days, per the MAR, the medication was only given three times - [DATE] at 3:13 PM and on [DATE] at 12:35 AM and 5:20 PM. In an interview with R1 on [DATE] at 11:49 AM, he stated that he was seen by a pain clinic and was on Hydromorphone when he was at home, as well as in the hospital prior to admission to the facility. R1 stated, I arrived [to the facility] around 10:00 PM on [DATE] and [the facility] had none of my meds. I received my first dose [of Hydromorphone] late the second day. My body went into shock. He continued to say, Nobody was checking on me. I was going through withdrawals. I was crying. The withdrawals make you want to die; make you want to commit suicide. The only way the pain was going away was if I died. The nurses kept telling me the meds were coming. Finally, I said I need to go to the hospital. I was crying and vomiting and no one cared. I was told the reason for the delay in the facility receiving my [Hydromorphone] was the doctor didn't put the script into the pharmacy. There was no order placed to the pharmacy. Review of R1's Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. Attempts to interview UM1 who completed the admission Assessment and Baseline Care Planning document were unsuccessful, as UM1 was no longer employed by the facility and did not have a working phone number.In an interview with RN1 on [DATE] at 1:01 PM, she stated she recalled R1's admission, his uncontrolled pain, and the Hydromorphone delay. Though she was unsure of the cause of the delay, she stated: [Hydromorphone] is not something we keep in the EDK and recalled speaking with UM1 about the issue. She detailed: I spoke with [UM1], made multiple calls to pharmacy and I may have talked to the [Medical Director] but if not, I know I spoke with [UM1] who should have talked to him. Sometimes (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	we have issues where we notify the [Medical Director], we need something, but they don't get it ready. That could have been the issue, but I am not sure. When asked why R1 only received three doses of Hydrocodone between when it was ordered in the afternoon of [DATE] and when he received his first dose of Hydromorphone the following evening on [DATE], she stated: The only thing I can think of, and I am guessing, is we may have been getting them from the EDK (Emergency Medicine Kit). Sometimes there is two to three in the EDK. It depends on what is going on. It could also be that we were running short.In an interview with RN2 on [DATE] at 2:40 PM, she stated she did not recall R1's admission to the facility. She explained the admission process, stating that, When we get a new admission, we review the paperwork [the resident] brings with them, like if it was a discharge or something. We call the NP to go over the orders. I will verify the orders and then put the orders in. That would happen day one, within the first few hours of their arrival. She added that, If they have narcotics, we have to get an [Electronic Script]. I will let the [Medical Director] know we need the script and then I will call the pharmacy within 20 minutes or so to confirm they received it. RN2 stated that this was the same process used for after-hours admissions. She further stated that the process was the same for after-hours admissions, explaining, You can still talk to someone at the pharmacy so no matter what time they're admitted , the process is still the same. When asked about the facility's pre-admission processes, she stated, Some hospitals call and give report, but not all do. Some hospitals will fax over the scripts, some send it with EMS (Emergency Medical Services), and it is brought with [the resident] that way. If the hospital does not call to give report, you can call the hospital and try to locate the nurse to get a report.In an interview with LPN2 on [DATE] at 3:05 PM, she stated the facility's process for new admission orders consisted of verifying the orders with the Medical Director and calling the pharmacy to have medications sent stat [immediately].In an interview with UM2 on [DATE] at 4:25 PM, she recalled assisting with R1's admission, stating she double checked [R1's] orders when he arrived and reached out to the NP to get med approvals for his prescriptions, but could not recall what caused his Hydromorphone to be delayed.During further interview of LPN2 on [DATE] at 3:05 PM, she stated, I spoke with [the Medical Director] and the NP and called the pharmacy. I told them he needs something for pain to cover him. At first, they said to wait for the [Hydromorphone] to come. I said he is going to start having withdrawals. They didn't want to do anything until he said he wanted to go back to the hospital. I spoke to [the Medical Director] and he said he was faxing the order (to the pharmacy). I was trying really hard to get his pain medication. I made multiple progress notes. Regarding the delay in obtaining R1's Hydromorphone, LPN2 stated, The pharmacy said they didn't get the script. I was texting people, calling, and talking to administration. She added, His [the Resident's] pain was very intense.In an interview with the NP on [DATE] at 10:07 AM, she detailed the following regarding the facility's new admission order process for residents discharging to the facility from the hospital: When the resident gets here, we have an EDK we can pull meds from. We pull their meds from the discharge summary and send them to the pharmacy. The pharmacy then sends them over. She added, With Schedule 2 meds [narcotics], they have to go through our [Medical Director] because I am a NP. The nurses know it has to go directly to him. They can text or call him. He then sends it to the pharmacy. The NP recalled the delay of R1's Hydromorphone order and explained, Sometimes the hospital will send scripts straight to our pharmacy. For Schedule 2 meds it is usually a 3-day supply, but it's not consistent, it is hit or miss. In his case, it was not sent. She then reported: They (staff) told me they were just waiting for [R1's Hydromorphone] to arrive from the pharmacy. That is when I stepped in and wrote a script for Hydrocodone and had it pulled from the EDK. I had a conversation with [R1] about it and he was okay with that.During an interview with the Medical Director on [DATE] at 3:30 PM, he stated he did not recall staff reaching out to him several times regarding a need for an order for R1's Hydromorphone, and added, If they had reached out to me on the 15th (day of R1's admission) I would have done it [written the script] then. And if I missed it and they followed up with me, I would have done it. Even if I haven't seen them and the hospital prescribed it, I would prescribe it, so they (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	don't suffer. The Medical Director further stated the NP could have prescribed the Hydromorphone. He explained the Drug Enforcement Administration (DEA) permits an NP to write up to 72 hours' worth of Schedule 2 drugs and added he would have had no problem with her doing that. In a subsequent interview with the Medical Director on [DATE] at 2:57 PM, he described the facility's new admission order process for hospital discharges as like, Opening Pandora's box. He explained: The hospital is supposed to send 72 hours of pain medication for the resident, but the hospital doctor does not. He elaborated that, as a result, [I] have to write [prescriptions] for someone I haven't even seen, adding: In good faith I write the scripts. I do it all the time for the betterment of patients' lives. When asked about the response time from when nursing staff reach out to him about a needed order and when he submits it to the pharmacy, he stated: 12 to 24 hours at the most; sometimes it is like two seconds. It is not difficult.Further interview with the Medical Director revealed he could not recall any specifics regarding the delay of R1's Hydromorphone. He stated: I am unsure of the timeline. My understanding is he got hydrocodone from the EDK. No nursing home has an onsite pharmacy, they have an EDK, and it contains six meds and does not include Hydromorphone. They can call me or call the NP to keep him comfortable with whatever they have in the EDK. When asked about the process if the EDK medication is not effective in keeping the resident comfortable, he responded: We can escalate meds. Someone can reach out to me, and I can write it. When asked if Hydrocodone would be effective in the place of Hydromorphone, he stated: It is not a substitute; you may not get 100 percent relief but you're not going to go into withdrawal. That's under the assumption that they are getting that PRN every 6 hours.Interview on [DATE] at 2:33 PM with a representative of R1's pain clinic revealed that he was a long-term patient and was seen for pain relief, both when the resident was living at home, as well as, for consultation during his hospitalization. The representative stated that no one had reached out to them for assistance with the resident's pain management.An interview was conducted with Registered Pharmacist (RPH) 1, from the facility's pharmacy on [DATE] at 2:13 PM. When asked about the potential consequences of a 48-hour gap between Hydromorphone doses, he stated: Pain management would be shot. To go from receiving Hydromorphone to zero, within hours of that last dose he would begin experiencing some degree of withdrawal and it would get worse with time. He explained that the two medications (Hydromorphone and Hydrocodone) were not equivalent, noting, Hydrocodone is a 1/5 ratio as far as equal analgesic conversion and that is documented. Five milligrams of Hydrocodone is equivalent to 1 mg of Hydromorphone. Regarding R1's severe pain ratings, he stated: Pain is subjective, but I can understand based on my knowledge of that medication his report of pain. That makes sense from a clinical perspective.In an interview with the DON on [DATE] at 3:39 PM, she stated she could not speak to the specifics of R1's admission as she has only been employed by the facility for approximately two weeks. She reported she has been trying to work together with the NP if the person needs a script before they get here. The NP refers staff to [the Medical Director] if she cannot write it. Regarding her expectations for the timeliness of admission orders, she stated: You can get medications stat delivered; you can also use the EDK if the med is available [in the EDK], but reported she was not sure about the actual timeframes for resident admissions, sending orders to the pharmacy, and receiving those orders from the pharmacy. The DON stated she did not consider a 48-hour delay to be timely. Interview with the Administrator on [DATE] at 9:25 AM, revealed his statement that R1 was admitted on [DATE] sometime between 9:00 PM and 11:00 PM and he provided no explanation as why or how the staff documented that they had completed an initial admission assessment on [DATE] at 6:32 PM.In an additional interview with the Administrator on [DATE] at 2:03 PM, he reported resident medications are taken into consideration prior to admission to the facility, stating they consider the availability, the costs, [and] whether it is a rare medication. Regarding the admission process for residents discharging from the hospital, he stated: We have a nurse liaison in the field. They receive referrals from the hospital. At times they go into the hospital and review the charts, talk to the resident. However, he was uncertain if this had taken place prior to R1's admission to the facility. When asked whether it was his expectation that (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	scheduled medications be available when a new resident arrives to the facility, he stated: I expect us to follow our own policies and CMS guidelines. When asked if, for medications not on hand, the facility attempts to obtain them prior to the resident's arrival, he responded it depends on what the order is and our policies and CMS guidelines.Further interview with the Administrator, on [DATE], regarding his expectation for the timely administration of scheduled pain medication, he stated: Whatever our policies state and CMS guidelines. That would be something that a clinician would need to answer, but expressed that his expectation was that the physician orders were followed. When asked whether approximately 48 hours without a resident's scheduled pain medication would be considered timely, he stated: Depends. It is case by case. I would have to speak with the doctor. When asked about his expectation of appropriate pain management, he stated: I cannot answer that as I am not a clinician, then added: I would expect the clinician to address a resident's pain. The Administrator described the Medical Director's role at the facility as the overall clinician. The Administrator stated that it was on a case by case basis as to when in the admission process staff should reach out to the Medical Director to obtain scheduled medications, adding I did not see his referral, I don't know what medications he [R1] was on, I cannot speak to that.

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F 0776 Level of Harm - Actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility's policies, it was determined the facility failed to ensure that 1 of 11 (Resident (R)1) sampled residents received diagnostic x-ray services in a timely manner, which created a delay in reporting any abnormal results to the physician and/or Nurse Practitioner, who had ordered the x-ray. After R1 sustained a fall, the facility failed to ensure that the resident received necessary follow-up, including implementation of physician orders for bilateral lower extremity (BLE) X-rays. R1 reported having severe leg pain and displayed swelling, changes in condition, and was eventually found to have a displaced tibia and fibula fracture that remained undiagnosed for approximately three days after his fall. R1 ultimately required surgery and 10 days of hospitalization in response. The findings include:Review of the facility's policy titled Verbal Orders, revised 02/14/2024, revealed that Physician orders may be received by telephone, by a licensed nurse or other licensed or registered health care specialist who are legally authorized to do so. Per the policy, staff are to enter the order into the medical record electronically or manually, if needed, and follow through with orders by making appropriate notifications to the required provider.Review of R1's admission Record revealed the facility admitted the resident from the hospital on [DATE], with diagnoses including paraplegia and muscle weakness.Review of a Change in Condition (CIC) evaluation, dated 10/29/2025 at 11:37 PM and documented by Licensed Practical Nurse (LPN) 3, revealed that R1 sustained a fall. Under Nursing observations, evaluation, and recommendations, the note documented the resident stated his feet were awkward in position. In response, the Nurse Practitioner (NP) provided a new, verbal order for X-rays to the bilateral lower extremities (BLE), with orders received and noted. The provider feedback section of this form documented new testing orders for an X-ray to the BLE and to continue to monitor.Review of R1's progress notes for the remainder of 10/2025 revealed no further information regarding the need for X-rays. An entry dated 10/31/2025 at 3:53 AM by Registered Nurse (RN) 4 documented the resident told the nurse he had fallen two days ago, and RN4 instructed the incoming nurse to follow up and report to the NP in the morning; however, the note failed to address that X-rays were ordered but had not been obtained. A progress note dated 11/01/2025 by LPN3 documented the resident complained that both feet appeared awkward and that the nurse encouraged the resident to go to the hospital for evaluation; however, the resident declined at that time, stating: I'm ok, I'll be ok until I get back. There was no evidence that the order for the X-rays was acted upon, or that staff identified that it had not yet been completed. Further review of the record revealed a CIC evaluation, dated 11/01/2025 at 11:15 PM, and documented by the Infection Preventionist/Staff Development Coordinator (IP/SDC). The note documented the resident complained of severe [right] leg pain from the thigh down to the foot. Per the note, the resident's pain was rated at 9/10 (with 0 meaning no pain, and 10 being worst pain imaginable), and that after receiving his bedtime medication pass, he was still inconsolable. The nurse assessed the leg and noted it was notably more swollen than [the] other extremity. The note documented the resident requested to go to the hospital and approached the nurse fully dressed with face flushed and red, grimacing, holding onto leg. The entry further reflected the resident stated, An X-ray was ordered but company never came, and the nurse was extremely concerned about [the] patient's disposition, not being at baseline and the possibility of a deep vein thrombosis (DVT) worsening and dislodging into his blood stream due to patient history. The note documented the resident stated the pain was getting worse and worse over the course of the past few days, and the nurse decided based upon the findings that an emergency send was warranted based upon [the] patient's [resident's] request. Vital signs obtained at that time included elevated blood pressure (186/95) and pulse (105). The entry documented the resident's change in condition included uncontrolled pain and elevated vital signs, that the NP and Director of Nursing (DON) were notified, the emergency contact was notified, and (continued on next page)

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F 0776 Level of Harm - Actual harm Residents Affected - Few	report was called to the hospital.A progress note dated 11/01/2025 at 11:26 PM documented the IP/SDC spoke with an RN at the hospital's emergency room, who reported the resident would likely be admitted and that imaging had identified a displaced fracture of the tibia and fibula, with the bone having shifted. The note documented that the DON and Medical Director were notified of these findings. There was no evidence in the clinical record that the ordered BLE X-rays were completed at the facility prior to the resident's transfer on 11/01/2025, approximately 72 hours after the need for the X-ray was first identified.Review of the hospital Final Report, dated 11/11/2025, revealed the hospital admitted R1 on 11/01/2025 and discharged him back to the facility 10 days later, on 11/11/2025. Per the Final Report, the resident required surgery for a primary discharge diagnosis of tib-fib fracture, right. Review of the facility's fall incident report for the 10/29/2025 fall, completed by the Interim Director of Nursing (IDON) on 11/02/2025, and a written statement from LPN3 dated 11/02/2025, was consistent with the clinical record and interviews regarding the date and circumstances of the fall, the NP being notified, and the order for BLE X-rays.In an interview with R1 on 11/12/2025 at 11:49 AM, he stated the fall on 10/29/2025 occurred when he was trying to get to his wheelchair, and he fell from the bed onto the floor. He reported that after the fall, he remained in the facility until staff later arranged for him to be sent to the hospital by ambulance. R1 stated RN2 informed him that an order for a portable X-ray at the facility was given after his fall; however, the facility failed to obtain it, and the X-rays were not completed until after he was transferred to the hospital in severe pain. Review of R1's Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/17/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition.In an interview with the Administrator on 11/13/2025 at 11:04 AM, he stated R1 fell on [DATE] and that the NP placed an order for an X-ray. The Administrator stated he was under the impression [R1] did not want an X-ray, and that R1 told him he was going out with his family. He confirmed there was no documentation in the record that R1 had refused the portable X-ray and the Administrator acknowledged he did not verify that the ordered X-ray had been completed.During an additional interview with R1 on 11/18/2025 at 12:12 PM, he denied that Administrator's allegation that he refused an X-ray. He stated: I didn't refuse an X-ray [on 10/29/2025]. I did not go out with my family [on 10/29/2025]. In an interview with LPN3 on 11/15/2025 at 8:53 PM, she stated the fall on 10/29/2025 occurred in the middle of the night. She stated Certified Nursing Assistants (CNAs) (she was unable to recall the specific CNAs) notified her that R1 was on the floor on the side of his bed, and staff assisted him off the floor with a Hoyer lift and back to bed. She stated that following the fall, R1 complained his foot was awkward. She stated the NP was notified after the fall, between midnight and 1 AM and that the NP agreed to a bilateral legs X-ray and ordered X-ray only. LPN3 was able to verbalize each of the steps in the protocol, explaining that staff should place [the] order in Point Click Care (PCC), print it, and place it on the nurse's cart until [the X-ray company] arrives. Then give them a copy, and that a progress note should be completed, with the nurse who puts the order in responsible for following up and passing that information on to the oncoming nurse in report. Although LPN3 was able to verbalize each of the steps, she stated she was not oriented on how to place an X-ray order, and so, instead, asked RN2 to place the order. Further interview with LPN3 revealed that after this, she was then off for a couple of days and did not follow up on whether the X-ray was completed when she returned, adding that she did not have [R1] as a patient [resident]. In an interview with RN2 on 11/13/2025 at 2:40 PM, she described her general process for verbal orders as: I would repeat it back to make sure it is correct and then put it in PCC. Regarding X-ray orders, she stated: Put it in PCC then call [the X-ray company]. Some people have access to put them in online, but I don't so I call, and stated she would definitely complete this within her shift and that documenting it in a progress note is important so everyone can know what is being done on previous shifts. She reported she was not working at the time of R1's 10/29/2025 fall and learned about it on the next shift from LPN3.In follow-up interviews with RN2 on 11/18/2025 at 1:00 PM and 11/19/2025 at 1:23 PM, she stated that with respect to R1's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185176	A. Building B. Wing	11/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Heights	446 Mt. Holly Avenue Louisville, KY 40206

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F 0776 Level of Harm - Actual harm Residents Affected - Few	X-ray, [LPN3] did not know how to do it and asked her to place the X-ray order. She stated the Unit Manager (UM) used to put them in but we did not have one [a UM] at that point. She reported that neither she nor LPN3 had a login for the X-ray company's portal and that she therefore called them. She stated the X-ray company told her they could not find R1's name in their system and instructed her to go back and put it in PCC, and that she did what [they] said. She stated she did not call back and confirm the X-ray because it was the end of my shift, and that she passed the X-ray information on to the next nurse in report. She stated she did not get an X-ray order number. RN2 stated that LPN3 did not tell me he fell and just said he needed an X-ray. [he] was complaining of his legs. She stated she couldn't put a progress note regarding R1's pending X-ray because [she] had to leave, adding she, was trying to figure it out because the UM usually does it. She further stated this was the only one [X-ray order] I have ever done, that she was unsure who does them now, and that she did not clarify if [she] did it right. She stated it was her understanding that the nightshift nurse would be the one to follow up to confirm the X-ray got completed, and reported she was off for the next two days. In interviews with the X-ray company's staff on 11/18/2025 at 1:30 PM and 11/19/2025 at 2:13 PM, Customer Service Representatives stated they searched their system for R1 using his date of birth and various combinations of his last name and found no record at all, ever, of an X-ray order for this resident, meaning we never received an X-ray [request] for this resident. When asked whether they would tell a nurse who calls to order an X-ray that they could not proceed because the resident was not in [their] system and must first be entered via PCC, the representative stated that not being in their system would not be a roadblock to having an order placed with us over the phone, and that they would just add their name if they aren't in our system. The representative further stated that when an X-ray is ordered by phone, they provide an X-ray order number as confirmation, and confirmed that they had received no orders from the facility to provide a portable X-ray for R1.In interviews with LPN4 on 11/14/2025 at 4:02 PM, RN3 on 11/14/2025 at 3:00 PM, LPN5 on 11/17/2025 at 3:16 PM, and UM2 on 11/14/2025 at 4:25 PM, they were able to verbalize the process for verbal orders, as well as the need for progress notes for communication between shifts, and monitoring for follow up and completion of orders. In an interview with RN4 on 11/17/2025 at 3:00 PM, he stated R1 told him he had fallen a couple of days ago and that he had a little pain and he observed his leg to be a little swollen. He stated he passed it along but did not notify the NP himself, explaining it was in the middle of the night and that in his experience if it's not an emergency, we don't call the NP. Further interview revealed his Progress Note on 10/31/2025 at 3:53 AM did not mention a pending X-ray because he did not know one was pending. In an interview with the IP/SDC on 11/14/2025 at 12:22 PM, she stated that on 11/01/2025, R1 approached her on the unit complaining of severe leg pain and that she had not seen him earlier in her shift. She stated R1 reported an X-ray had been ordered but that they never came, and that based on his condition and complaints, she completed the 11/01/2025 change in condition assessment and arranged for him to be sent to the hospital. She stated clinical staff were responsible for following up on X-rays.In an interview with the NP on 11/13/2025 at 10:07 AM, she stated that on 10/29/2025 R1 fell out of bed and was complaining of leg pain, so she ordered a bilateral leg X-ray in response. She stated that she did not order the X-ray stat (with an expected time frame of four hours.) Instead, it was a routine order, for which she believed that 24 hours is reasonable. Further interview revealed she looked in the computer to see whether orders such as X-rays had been completed and that if something was not done, nursing staff or the UM would usually follow up with her. The NP reported that by the time she would have known there was an issue with not obtaining R1's X-ray, He had gone to the hospital. In a follow-up interview on 11/21/2025 at 12:54 PM, when asked who staff should reach out to at night for provider issues, she stated: It is me.In an interview with the DON on 11/17/2025 at 4:02 PM, she stated there was a form used for auditing and oversight of orders and believed It is being used during the clinical meeting, which is held daily, adding whoever is leading the meeting that day would fill it out. She stated presently she is the one reviewing charts to make sure there are no pending orders, but that she was (continued on next page)

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F 0776 Level of Harm - Actual harm Residents Affected - Few	not working at the facility at the time of R1's X-ray order and could not identify who was responsible for ensuring his ordered X-ray was completed and followed up during that period, and was unable to provide evidence that the chart had been audited to identify the pending order. In a subsequent interview on 11/21/2025 at 3:44 PM, she stated nurses that have been trained can order X-rays but acknowledged there were recent changes in the process for ordering X-rays and that a lot of staff, including her, were new. She stated a staff member could confirm an X-ray had been ordered correctly by calling [the X-ray company] for confirmation. She stated possible routes for ordering an X-ray included calling it in, placing it in PCC, or going into the X-ray company's system, and that follow-up to ensure X-rays were completed should be passed in report from nurse to nurse. The DON was unable to say whether there was any follow up on R1's X-ray, adding, I was not here during that time.In an interview with the Administrator on 11/21/2025 at 2:03 PM, he stated practitioners, such as doctors and NPs, and nurses that have been trained have the ability to order X-rays. When asked how staff confirm an X-ray had been ordered correctly, he stated, I do not know that process, then added The clinicians would know. He stated leadership, the clinical team, and the Interdisciplinary Team [IDT] follow up that X-rays are completed. The Administrator again repeated that he was under the impression that R1 did not want an X-ray and told him he was going out with his family; however, he then acknowledged there was no such documented refusal.