STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185197	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hartland Park Health & Rehabilitation	1500 Trent Boulevard Lexington, KY 40515

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to develop a resident centered behavioral care plan for 1 of 6 sampled residents, Resident (R) 1.From 08/09/2025 to 10/16/2025, R1 had food seeking behaviors that were not addressed timely on the behavioral care plan. Refer to F743.The findings include:Review of the facility's policy titled, Care Planning-Comprehensive Person-Centered, not dated, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. The comprehensive care plan would incorporate identified problem areas, incorporate risk factor associated with identified problems, and promote resident safety. Continued review revealed a behavior intervention plan (BIP) might be developed when a resident exhibited behavior that placed the resident at risk. The BIP would be incorporated into the resident's comprehensive care plan. The BIP would clearly identify the behaviors being addressed, interventions/approaches to reduce behaviors, and expected outcomes.Review of R1's admission Record revealed the facility initially admitted the resident on 09/28/2022. The facility most recently readmitted the resident on 10/18/2025. R1's admitting diagnoses were Parkinson's disease and esophageal obstruction.Review of R1's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 09/11/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of zero out of 15, which indicated severe cognitive impairment.Review of R1's Comprehensive Care Plan [CCP], with date initiated of 03/28/2025 and revision date of 05/30/2025, revealed, under the focus of behaviors, the resident had behaviors of rejected care and services; refused meals; had hallucinations; made false allegations; had anxiety, irritability, and anger; picked at skin; and wrapped rubber bands around stump. Further review revealed the goal, initiated on 03/28/2025, revised on 07/31/2025, and with a target date of 01/19/2026, was for the resident's behaviors not to bother other residents. Review of the interventions, dated 03/28/2025, revealed for staff to monitor behavior episodes and attempt to determine the underlying cause by considering location, time of day, persons involved, and situations. However, the nutrition interventions were not updated for R1's current behaviors of trying to obtain and eat regular foods, which were not allowed on his pureed diet, after the 08/09/2025, 09/19/2025, and 10/16/2025 incidents.Review of R1's Physician's Orders, dated 07/30/2025 with an end date of 09/12/2025, revealed an order for a consistent carbohydrate diet (CCHO), pureed texture with regular thin consistency (liquid). Further review revealed the same diet was ordered for R1 on 09/21/2025 (an active order). Review of R1's Nurse Progress Note, dated 08/09/2025 at 8:51 AM and written by Registered Nurse (RN) 1, revealed the resident was lying in bed with his head elevated. Per the note, the resident was eating a granola bar, which was half gone, and the resident allowed the nurse to remove the granola bar. Per the note, RN1 asked the resident how he received the granola bar, and R1 stated to RN1, I have my connections. In an interview with the Activities Director on 10/21/2025 at 2:32 PM, she stated, during (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an activity on 09/19/2025 at 2:00 PM, R1 and R2 were watching a movie in the dining room with other residents and staff. She stated popcorn was offered to R2, and R2 shared his popcorn with R1. She stated the activities staff saw R1 with popcorn, and as they moved toward him, he started to cough. She stated staff took R1 to the nurses' station, and R1 had emesis. She stated R1 was offered water and could not swallow. In an interview with Certified Nurse Aide (CNA) 2, from Unit B, on 10/22/2025 at 1:08 PM, she stated R1 did wander occasionally over to Unit B. She stated she was present in the joint Unit B-C dining room, on 10/16/2025, at the assisted residents table when R1 visited with the male residents that sat there. She stated the male residents left the table, and she went to bring R1 to his assisted table for his food when he grabbed the pineapple off one of the male residents' trays. She stated she was not aware the resident would grab regular food off another resident's tray. Review of R1's three documents Hospital Discharge summary, dated [DATE], 09/21/2025, and 10/18/2025 revealed R1 was readmitted to the hospital, after each incident, with vomiting and the inability to swallow liquids. Per the summaries, R1 had an esophageal obstruction, chronic dysphagia, chronic esophageal strictures, and gastroesophageal reflex disease (GERD). Each time, Gastroenterology was consulted. R1 had an EGD on 10/17/2025 with removal of food from the upper esophagus as well as dilation of the esophagus. In continued interview with Certified Nurse Aide (CNA) 2, from Unit B, on 10/22/2025 at 1:08 PM, she stated R1 resided on Unit C, and she did not know where to find care plan information on Unit C. She stated she did not receive any information in report concerning R1's behavior of trying to obtain regular food. In an interview with the Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Coordinator on 10/22/2025 at 10:10 AM, she stated CCPs were updated quarterly or as needed for a change. She stated the Unit Manager could update the care plan. She stated she attended the interdisciplinary morning meeting and made changes to the care plan. She stated the other disciplines were responsible to make changes to their specific care plan area and make the changes timely. In an interview with the Director of Nursing (DON) on 10/23/2025 at 10:29 AM, she stated care plans were updated in the interdisciplinary team clinical meeting and as needed, too. She stated the different disciplines could update the care plan as needed. She stated R1's care plan should have been updated in 09/2025. She stated the Quality Assurance and Performance Improvement (QAPI) committee, at their meeting, discussed the event with R1 and formulated a plan of action. In an interview with the Administrator on 10/22/2025 at 2:32 PM, she stated she had been informed about the events of R1 choking on food. She stated the CCP interventions should be to pick up trays before R1 could collect food off another resident's tray; and R1 to sit with staff supervision at the assisted table at meals, and the daughter, when she visited, would take him over to the male residents table to talk with his friends. She stated R1's daughter voiced no concern to them and stated he just had dementia. She stated R1's Activity Care Plan intervention should be not to give popcorn. She stated the concern with R1's non-compliance in food choices resulted in hospital stays.

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a resident does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless unavoidable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's information sheet, and review of the facility's policy, the facility failed to monitor and provide ongoing assessment as to whether the care approaches were meeting the needs/behaviors of the resident for 1 of 6 sampled residents, Resident (R) 1.Interview and record review revealed on 08/09/2025, R1 obtained granola from an unknown source; on 09/19/2025, R1 obtained popcorn from another resident during an activity; and on 10/16/2025, R1 obtained pineapple from another resident's tray. The foods obtained were not allowed on the resident's ordered pureed diet.Refer to F656The findings include:Review of the facility's information sheet Pureed, not dated, revealed the standard texture for that diet resembled that of mashed potatoes or applesauce. Per the sheet, achieving that desired texture was most effectively done by pureeing foods in a food processor rather than a blender. The sheet stated the diet was appropriate for individuals experiencing swallowing difficulties, reluctance to chew, painful chewing with dentures or natural teeth, mouth pain due to lesions, or transitioning to solid foods after removal of a feeding tube. It stated a Speech Pathologist conducted swallowing evaluations for residents. Review of the facility's policy titled, Care Planning-Comprehensive Person-Centered, not dated, revealed a behavior intervention plan (BIP) might be developed when a resident exhibited behavior that placed the resident at risk. The BIP would be incorporated into the resident's comprehensive care plan. Further review revealed the BIP would clearly identify the behaviors being addressed, interventions/approaches to reduce behaviors, and expected outcomes. Review of R1's admission Record revealed the facility initially admitted the resident on 09/28/2022, and the facility most recently readmitted R1 on 10/18/2025. R1's admitting diagnoses included Parkinson's disease and esophageal obstruction.Review of R1's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 09/11/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of zero out of 15, indicating severe cognitive impairment. Review of R1's Comprehensive Care Plan [CCP], with date initiated of 03/28/2025 and revision date of 05/30/2025, revealed, under the focus of behaviors, the resident had behaviors of rejected care and services; refused meals; had hallucinations; made false allegations; had anxiety, irritability, and anger; picked at skin; and wrapped rubber bands around stump. However, the interventions were not updated for R1's current behaviors of trying to obtain and eat regular foods, which were not allowed on his pureed diet, after the 08/09/2025, 09/19/2025, and 10/16/2025 incidents.Review of R1's Physician's Orders, dated 07/30/2025 with an end date of 09/12/2025, revealed an order for a consistent carbohydrate diet (CCHO), pureed texture with regular thin consistency (liquid). Further review of R1's Physician's Orders with an active/revision date of 09/21/2025, revealed the same order was renewed. 1. Review of R1's Nurse Progress Note, dated 08/09/2025 at 8:51 AM and written by Registered Nurse (RN) 1, revealed the resident was lying in bed with his head elevated. Per the note, the resident was eating a granola bar, which was half gone, and the resident allowed the nurse to remove the granola bar. The note stated RN1 told the resident the granola bar was not appropriate for his ordered diet, and she encouraged oral fluids. Per the note, RN1 asked the resident how he received the granola bar, and R1 stated to RN1, I have my connections. The note stated the nurse practitioner was notified, with no new orders received. It also stated R1's Power of Attorney (POA) was notified. In an interview with RN1 on 10/22/2025 on 1:37 PM, she stated she entered R1's room early before breakfast. She stated R1 was lying over the bed with a granola bar. She stated she took the granola from him, and R1 had just started to eat the granola bar.Review of R1's Nurse Progress Note, dated 08/09/2025 at 9:10 PM and written by Licensed Practical Nurse (LPN) 3, revealed the resident was trying to use the urinal, so the nurse provided privacy and left. Per the note, when the nurse returned, she noted blood around R1's gastrostomy tube site. The note revealed LPN3 called the (continued on next page)

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider and the POA, and R1 was sent to the emergency room (ER). Review of R1's Hospital Discharge summary, dated [DATE], revealed his diagnoses were food impaction of the esophagus, esophageal stenosis, dementia, Parkinson's disease, esophageal stent, with the most recent stent placement 05/24/2025, with PEG (gastrostomy) tube replacement. The computed tomography (CT) scan revealed an impaction of the esophageal stricture, reportedly due to him being given access to granola bars, which were not part of his prescribed diet. Per the summary, R1 was discharged on a full liquid diet for 48 hours with advancement to pureed diet thereafter.2. In an interview with the Activities Director on 10/21/2025 at 2:32 PM, she stated, during an activity on 09/19/2025 at 2:00 PM, R1 and R2 were watching a movie in the dining room with other residents and staff. She stated popcorn was offered to R2, and R2 shared his popcorn with R1. She stated the activities staff saw R1 with popcorn, and as they moved toward him, he started to cough. She stated staff took R1 to the nurses' station, and R1 had emesis. She stated R1 was offered water and could not swallow. She stated the physician was contacted, and R1 was sent to the emergency room (ER). Review of R1's Hospital Discharge summary, dated [DATE] revealed R1 was admitted with an esophageal stricture, and a gastroenterologist was consulted. Per the summary, R1 had an esophagogastroduodenoscopy (EGD) for dilatation of the esophageal stricture. R1 was discharged on 09/21/2025 back to the facility tolerating a pureed diet. In continued interview with the Activities Director on 10/21/2025 at 2:32 PM, she stated the type of snacks offered varied for different activities, such as a birthday party, Bingo, a coffee corner, or a movie. She stated the textured diets included chocolate/vanilla pudding and applesauce at every event. She stated the activities staff had a copy of the diet sheet from Point Click Care (PCC, a computer software), and all the aides had a copy. She stated the activities staff received training during the orientation process for diet textures to understand the types of food residents could have during an activity. She stated the resident on a pureed diet could have pudding, applesauce, ice cream, and chocolate pie, the pudding portion. She stated 09/19/2025 was the first time she saw R1 take popcorn offered from another resident. 3. Review of the facility's menus revealed pineapple was served on 10/16/2025 at the supper meal for regular diets. The menu for the pureed diet stated applesauce was served. In an interview with Certified Nurse Aide (CNA) 2, from Unit B, on 10/22/2025 at 1:08 PM, she stated R1 resided on Unit C but did wander occasionally over to Unit B. She stated she was present in the joint Unit B-C dining room at the assisted residents table when R1 visited with the male residents that sat there. She stated the male residents left the table, and she went to bring R1 to his assisted table for his food when he grabbed the pineapple off one of the male residents' trays. She stated she was not aware the resident would grab regular food off another resident's tray. Review of R1's Hospital Discharge summary, dated [DATE], revealed R1 was readmitted with vomiting and the inability to swallow liquids. Per the summary, R1 had an esophageal obstruction, chronic dysphagia, chronic esophageal strictures, and gastroesophageal reflex disease (GERD). Per the summary, Gastroenterology was consulted, and R1 had an EGD on 10/17/2025 with removal of food from the upper esophagus as well as dilation of the esophagus. In an interview with Registered Nurse (RN) 1 on 10/22/2025 at 1:35 PM, she stated R1 took items off trays, and other residents liked to share food. She stated R1 was active and moved around the unit, moving around tables in the dining room. She stated he sat at the assist table and was provided cues as needed. She stated he was known to hide food from trays into his prothesis. She stated R1 took off his leg in the dining room, and staff found cookies in his leg. She stated R1 required constant supervision. In an interview with the Registered Dietitian (RD) Licensed Dietitian (LD) on 10/22/2025 at 4:00 PM, she stated she was made aware of the incidents when R1 was offered or asked for foods from other residents. She stated R1 had an esophageal stricture and had the esophageal area stretched as needed. She stated foods not allowed on a pureed diet included popcorn, a granola bar, and pineapple. In an interview with the Speech Therapist on 10/21/2025 at 1:33 PM, she stated she had seen R1 for cognition and speech. She stated, at the time of the evaluation, she was not aware there were any concerns with R1's swallowing. She stated she asked the daughter about that, and she told her there (continued on next page)

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F 0743 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were no concerns with his swallowing. She stated a Speech reevaluation was done on 10/02/2025, and there were no concerns for swallowing. She stated with R1, all foods were pureed, with no whole foods allowed on the diet. She stated she followed the orders from the Hospital Discharge Summary for R1 to follow a pureed diet. In an interview with the Director of Nursing (DON) on 10/22/2025 at 3:00 PM, she stated R1 did not move around as much as he used to. She stated he took himself to the dining room (DR) and would return. She stated she was told RN1 found a granola bar in his room and got it away from him. She stated the incident about the popcorn occurred while doing activities, and activities reported that to nursing. She stated the Activity Director instructed the residents not to share food with others. She stated R1 was quick to take food off the other residents' trays when the opportunity was available at the other or his own table. She stated he liked to sit with his male resident friends, and they would offer him food. The DON stated they had educated staff that R1 needed to stay at the assist table to be monitored, and staff was to sit and supervise him. The DON stated R1's last esophageal stent placement was on 05/22/2024, and R1 had received several esophageal dilatations over the years as his esophagus needed to be stretched. In an interview with the Administrator on 10/22/2025 at 2:32 PM, she stated she had been informed about the events of R1 choking on food. She stated the CCP interventions should be to pick up trays before R1 could collect food off another resident's tray; and R1 to sit with staff supervision at the assisted table at meals, and the daughter, when she visited, would take him over to the male residents table to talk with his friends. She stated R1's daughter voiced no concern to them and stated he just had dementia. She stated R1's Activity Care Plan intervention should be not to give popcorn. She stated the concern with R1's non-compliance in food choices and staff not preventing it resulted in hospital stays.