

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Hartland Park Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, record review, and review of the facility's policy, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 28 sampled residents, Resident (R) 1 and R16.</p> <p>1. Observation on 06/10/2025 of R1 revealed her indwelling urinary catheter collection bag was full of urine and not covered. The collection bag could be seen from the hallway.</p> <p>2. Observation on 06/10/2025 of R16 revealed Licensed Practical Nurse (LPN) 2 administered an insulin injection to R16, in her abdomen, while the resident was seated in her wheelchair at the medication cart in the hallway. There were multiple residents and staff within sight of R16 at the time.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Resident Rights, dated 11/01/2024, revealed each resident had the right to personal privacy and to be treated with respect and dignity.</p> <p>1. Review of R1's Face Sheet, found in R1's electronic medical record (EMR), revealed the facility admitted the resident on 01/03/2022 with diagnoses including cerebral palsy, epilepsy, and neuromuscular dysfunction of the bladder.</p> <p>Review of R1's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/08/2025, revealed a Brief Interview for Mental Status [BIMS], was not assessed because the resident was rarely or never understood. Further review revealed R1 had an indwelling urinary catheter because of neuromuscular dysfunction of the bladder.</p> <p>Review of R1's Comprehensive Care Plan [CCP], dated 04/09/2025, revealed R1 would be free from complications from catheter use through the review period of 07/07/2025. Further review of the CCP revealed the facility care planned the resident as having a catheter. Interventions, dated 04/09/2025, included to maintain a catheter privacy bag.</p> <p>Observation of R1 on 06/10/2025 at 9:58 AM revealed there was no dignity cover for the resident's indwelling urinary catheter collection bag. Also, the collection bag was full of urine and could be seen from the hallway.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Unit Manager (UM) 1 on 06/10/2025 at 10:00 AM, she stated the facility used dignity bag covers, and she did not know why R1's catheter collection bag was uncovered. The UM stated the catheter collection bag should be covered to protect the dignity of the resident.</p> <p>2. Review of R16's Face Sheet, found in R16's EMR, revealed the facility admitted the resident on 11/22/2022 with diagnoses including hemiplegia and hemiparesis, cerebral infarction, and type 2 diabetes mellitus.</p> <p>Review of R16's quarterly MDS, with an ARD of 05/23/2025, revealed a BIMS, score of zero out of 15, which indicated the resident had severe cognitive impairment.</p> <p>Observation of R16 on 06/10/2025 at 11:25 AM revealed LPN2 administered an insulin injection to R16 in her abdomen while the resident was seated in her wheelchair, which was positioned next to the medication cart in the hallway. During the administration of the injection, there were other residents and staff present in the hallway.</p> <p>During an interview with LPN2 on 06/10/2025 at 11:28 AM, she stated she was aware she could not administer medication in the dining or activity rooms. However, she stated since the injection was given in the hallway near the medication cart, she believed it was appropriate to proceed with the administration. LPN2 stated she did not provide privacy for the resident while administering the insulin injection. She stated she should have taken the resident to her room to ensure privacy. LPN2 stated it was important to provide privacy to protect the resident's dignity.</p> <p>During an interview with the Director of Nursing (DON) on 06/13/2025 at 5:45 PM, she stated nurses should not administer medications in the hallway. The DON further stated it was her expectation that staff treated every resident with dignity. Additionally, she stated providing privacy was essential for safeguarding each resident's dignity.</p> <p>During an interview with the Administrator on 06/13/2025 at 6:30 PM, she stated it was her expectation that staff provided each resident with privacy during care. She stated it was important to protect the resident and ensure dignity.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 5. Review of R2's Face Sheet, found in R2's EMR, revealed the facility admitted R2 on [DATE] with diagnoses including cerebral palsy, epilepsy, and anxiety.</p> <p>Review of R2's quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of zero out of 15, indicating severe cognitive impairment.</p> <p>When requested from the facility on [DATE], [DATE], and [DATE], a copy of R2's Advance Directive was not provided. However, a document Hospitality Guide Acknowledgement was provided, which was signed by R2's resident representative on [DATE].</p> <p>The State Survey Agency (SSA) Surveyor attempted to interview R2's representative by telephone on [DATE] at 2:39 PM but was unsuccessful.</p> <p>6. Review of R92's Face Sheet, found in R92's EMR, revealed the facility admitted the resident on [DATE] with diagnoses including depression, diabetes, and dementia.</p> <p>Review of R92's quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 14 out of 15, indicating R92 was cognitively intact.</p> <p>Review of R92's Care Plan, dated [DATE], revealed the R92 had an Advance Directive, with a goal of the Advance Directive would be honored through the care plan's next review. Further review revealed interventions listed were to honor the resident's Advance Directives per physician orders and to periodically review them.</p> <p>When requested from the facility on [DATE], [DATE], and [DATE], a copy of R92's Advance Directive was not provided. However, a document Hospitality Guide Acknowledgement was provided, which was signed by R92's Power-of-Attorney (POA) on [DATE].</p> <p>During an interview on [DATE] at 9:17 AM with R92's representative, she stated a copy of R92's Advance Directive had been provided to the facility, but she was unsure of the date.</p> <p>During an interview on [DATE] at 2:39 PM with the Social Services Director (SSD), she stated it was important to have a resident's current Advance Directive information because a resident's wishes should be supported by the facility. She further stated it was important for the facility to honor the resident's wishes.</p> <p>During an interview with the Director of Medical Records (DMR) on [DATE] at 10:32 AM, she stated during the admission process, residents were allowed to provide a Power of Attorney (POA) or a Living Will. She stated she asked every resident about any Advance Directives during the admission conference, and if one was in place, she requested a copy at that time. She stated if she did not receive a copy of the Advance Directive, she contacted the family to make an additional request. The DMR stated Advance Directives were also discussed at the quarterly care plan meetings by the SSD.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Director of Nursing (DON) on [DATE] at 5:45 PM, she stated during the admission process, residents or their representatives indicated their Advance Directives, including their preferences regarding cardiopulmonary resuscitation (CPR) or do not resuscitate (DNR) orders. She stated these preferences were documented in their medical record. The DON stated having Living Wills or POAs included in the EMR were important to ensure that residents' wishes were honored.</p> <p>During an interview with the Administrator on [DATE] at 6:30 PM, she stated the facility emailed the Hospitality Guide to the resident's representatives, and the representatives were to review all the information, electronically sign it, and send it back to the facility. She stated she expected the facility to obtain and retain the Advance Directive upon admission. However, she stated if the Advance Directive was not received at that time, the team would discuss the resident's wishes during the 72-hour meeting. The Administrator stated if the resident or their representative did not provide an Advance Directive, the facility would follow up with them during the quarterly care plan meeting. She stated the importance of having an Advance Directive was to ensure the resident's wishes were respected and to enable staff to honor the resident's plan of care when they were no longer able to communicate their needs.</p> <p>Based on interview, record review, and review of the facility's policies, the facility failed to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and at the resident's option, formulate an Advance Directive for 6 of 28 sampled residents, Resident (R) 2, R12, R40, R85, R92, and R131.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Advance Directives, dated [DATE], revealed Advance Directives was written instruction, such as a Living Will or Durable Power-of-Attorney (POA) for healthcare, recognized under State Law (whether statutory or as recognized by the courts of the State), relating to the provision of healthcare when the individual was incapacitated. Further review revealed upon admission, the resident would be provided with information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chose to do so. Per the policy, facility staff should verify the resident's wishes regarding cardiopulmonary resuscitation (CPR).</p> <p>Review of the facility's policy titled, [Facility Name], Hospitality Guide, no date, revealed the resident had the right to be informed of, and participate in, his or her treatment, including the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an Advance Directive. Per the policy, the facility must comply with the requirements specified in code of federal regulations (CFR) part 489, subpart I (Advance Directives). This included a written description of the facility's policies to implement Advance Directives and applicable State law.</p> <p>1. Review of R40's Face Sheet, found in R40's electronic medical record (EMR), revealed the facility admitted the resident on [DATE] with admitting diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other lack of coordination, and atherosclerotic heart disease of native coronary artery without angina pectoris.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R40's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], revealed the resident had a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of R40's Advance Directives, found in R40's EMR under the miscellaneous tab, revealed R40 had signed the [State] Emergency Services Do Not Resuscitate [DNR] document on [DATE]. However, there was no documentation of R40's Power of Attorney (POA) or Living Will present in the resident's EMR.</p> <p>When requested from the facility on [DATE] at 2:19 PM, a copy of R40's Advance Directive was not provided. However, a document Hospitality Guide Acknowledgement was provided, which was dated [DATE]. Further review revealed a family member of R40 signed the document, and there was no POA or Living Will with the document.</p> <p>During an interview on [DATE] at 8:25 AM with R40, she stated R40's family member signed the admission paper work with a DNR. R40 stated she could not remember if the facility inquired about a POA or Living Will.</p> <p>2. Review of R85's Face Sheet, found in R85's EMR, revealed the facility admitted the resident on [DATE] with admitting diagnoses including Alzheimer's dementia, unspecified; immunodeficiency, unspecified; and epilepsy, unspecified, not intractable, with status epilepticus.</p> <p>Review of R85's annual MDS, with an ARD of [DATE], revealed the resident had a BIMS score of two out of 15, which indicated severe cognitive impairment.</p> <p>Review of R85's Advance Directives, found in R85's EMR under the miscellaneous tab, revealed R85 had signed the [State] Emergency Services DNR document on [DATE]. However, there was no documentation of R85's POA or Living Will present in the resident's EMR.</p> <p>When requested from the facility on [DATE] at 2:19 PM, a copy of R85's Advance Directive was not provided. However, a document Hospitality Guide Acknowledgement was provided, which was dated [DATE]. Further review revealed R85's FM4 signed the document, and there was no POA or Living Will with the document.</p> <p>3. Review of R131's Face Sheet, found in R131's EMR, revealed the facility admitted the resident on [DATE] with admitting diagnoses including hypertensive heart disease with heart failure, paroxysmal atrial fibrillation, and atherosclerotic heart disease of native coronary artery without angina pectoris.</p> <p>Review of R131's annual MDS, with an ARD of [DATE], revealed the resident had a BIMS score of three out of 15, which indicated severe cognitive impairment.</p> <p>When requested from the facility on [DATE] at 2:19 PM, a copy of R131's Advance Directive was not provided. However, a document Hospitality Guide Acknowledgement was provided, which was dated [DATE]. Further review revealed R131's FM1 signed the document, and there was no POA or Living Will with the document.</p> <p>4. Review of R12's Face Sheet, found in R12's EMR, revealed the facility admitted the resident on [DATE] with admitting diagnoses including dementia, cerebral infarction, and aphasia.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R12's annual MDS, with an ARD of [DATE], revealed the resident had a BIMS score of zero out of 15, which indicated severe cognitive impairment.</p> <p>Review of R12's Advance Directives, found in R12's EMR under the miscellaneous tab, revealed R12 had full-code status; however, there was no documentation of an Advance Directive or Living Will. Further review of R12's EMR revealed there was no documentation in the resident's chart showing the facility reviewed the Advance Directive policy or provided written information regarding the right to create an Advance Directive.</p> <p>Review of the document Hospitality Guide Acknowledgement, found in R12's EMR and dated [DATE], revealed the resident's representative's (RR) signature line included the POA's initials with the word verbal noted in parentheses beside the initials.</p> <p>During an interview with R12's Power of Attorney (POA) on [DATE] at 9:12 AM, he stated he did not remember receiving any written information regarding his right to create an Advance Directive, nor does he recall signing any related documents. He stated R12 was a full-code and did not have an Advance Directive in place. Additionally, R12's POA stated the facility's staff had not informed him about his right to establish an Advance Directive.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on observation, interview, record review, and review of the facility's policy, the facility failed to keep residents free from misappropriation for 1 out of 3 sampled residents for misappropriation, Resident (R) 92.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse, dated 10/01/2021 and revised on 10/20/2022, defined misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of the resident's belongings or money without the resident's consent. The policy also stated, The resident has the right to be free from misappropriation of resident's property.</p> <p>Observation on 06/11/2025 at 8:26 AM revealed Registered Nurse (RN) 1 used MiraLAX (a laxative), belonging to R92, and administered it to R95.</p> <p>Review of R92's admission Record, found in R92's electronic medical record (EMR), revealed the facility admitted the resident on 03/14/2022 with diagnoses of fibromyalgia, type 2 diabetes, and constipation.</p> <p>Review of R92's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/13/2025, revealed the facility assessed the resident to have a Brief Interview Mental Status [BIMS] score of 14 out of 15, indicating R92 was cognitively intact.</p> <p>Review of R92's Physician's Orders, dated 05/07/2025, revealed R92 had an order for MiraLAX 17 grams every 12 hours as needed (PRN) for constipation.</p> <p>Review of R92's Medication Administration Record (MAR) for June 2025, revealed R92 had not received any doses of MiraLAX from 06/01/2025 to 06/13/2025.</p> <p>Review of R95's admission Record, found in R95's EMR, revealed the facility admitted the resident on 12/02/2022 with diagnoses of spinal stenosis, constipation, and depression.</p> <p>Review of R95's quarterly MDS, with an ARD of 04/04/2025, revealed the facility assessed the resident to have a BIMS score of 14 out of 15, indicating R95 was cognitively intact.</p> <p>Review of R95's Physician's Orders, dated 05/11/2024, revealed R95 had an order for MiraLAX 17 grams every morning for constipation.</p> <p>Review of R95's MAR, for June 2025, revealed R95 had received a dose of MiraLAX every morning from 06/01/2025 to 06/12/2025.</p> <p>During an interview on 06/11/2025 at 9:07 AM with RN1, she stated R95 was missing his MiraLAX, and it had been reordered by pharmacy the morning of 06/11/2025. She stated, when ordered early enough, it came within 24 hours. She stated she used R92's MiraLAX so R95 did not miss a dose. RN1 stated a medication should not be shared between residents.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/13/2025 at 5:47 PM with the Director of Nursing (DON), she stated when a medication was missing or empty, she expected staff to follow up with pharmacy and to reorder as needed. She stated staff was expected to call the provider to see if the medication should be held, administered late, or changed to something else that might be available. She stated her expectation was that staff did not borrow medications from another resident because they belonged to that specific resident, and we don't want to take things from another resident.</p> <p>During an interview on 06/13/2025 at 6:31 PM with the Administrator, she stated her expectation was that staff did not borrow another resident's medications, but they should notify the provider for direction on what steps should be taken. She stated, The issue is that you shouldn't borrow from another resident.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 4 of 28 sampled residents, Resident (R) 2, R17, R36, and R47.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Care Planning-Comprehensive Person-Centered, undated, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet the residents medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive resident assessment instrument (RAI) process. The policy defined person-centered care meant to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.</p> <p>1. Observation on 06/11/2025 at 9:45 AM revealed R36 was sleeping in bed with an indwelling urinary catheter leg bag noted to be strapped to the resident's leg.</p> <p>Review of R36's admission Record, found in R36's electronic medical record (EMR), revealed the facility admitted R36 on 10/12/2023 with a diagnoses of seizures, obstructive and reflux uropathy, and overactive bladder.</p> <p>Review of R36's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/02/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating the resident was cognitively intact.</p> <p>Review of R36's Physician's Orders, dated 11/15/2023, revealed R36 had an order for an indwelling urinary catheter.</p> <p>Review of R36's Care Plan revealed the indwelling urinary catheter was initially care planned on 11/15/2023. However, further review revealed the Care Plan was not updated until 06/10/2025 to add R36's preference for a leg bag.</p> <p>During an interview on 06/10/2025 at 10:01 AM with Registered Nurse (RN) 1, she stated R36 had always preferred his leg bag.</p> <p>During an interview on 06/10/2025 at 3:37 PM with Certified Nurse Aide (CNA) 6, she stated R36 always kept his leg bag on and would not use a regular urinary collection bag when he was in bed.</p> <p>During an interview on 06/11/2025 at 8:21 AM with R36, he stated he was having an episode of low sodium and imagining things. He was unable to answer questions related to his indwelling urinary catheter and preference for the leg bag at the time of the interview.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Observation on 06/11/2025 at 2:19 PM revealed R47 lying in bed sleeping. R47 had a colostomy.</p> <p>Review of R47's admission Record, found in R47's EMR, revealed the facility readmitted R47 on 08/27/2024 with a colostomy after a bowel resection done for a colovesicular fistula which caused frequent urinary tract infections and sepsis.</p> <p>Review of R47's quarterly MDS, with an ARD of 05/24/2025, revealed the facility assessed the resident to have a BIMS score of 13 out of 15, indicating R47 was cognitively intact.</p> <p>Review of R47's Physician's Orders, dated 09/12/2024 and 12/16/2024, revealed an order for ostomy care.</p> <p>Review of R47's Care Plan, dated 01/27/2025, revealed this was the first time R47 was care planned for an alteration in elimination related to a need for a colostomy, even though the resident returned to the facility on [DATE] with a colostomy.</p> <p>During an interview on 06/11/2025 at 2:19 PM, R47 stated she had the colostomy done last August. She stated the staff cared for her colostomy.</p> <p>During an interview on 06/10/2025 at 3:45 PM with Licensed Practical Nurse (LPN) 3, she stated R47 had a colostomy prior to being admitted to the facility.</p> <p>During additional interview with LPN3 on 06/12/2025 at 2:13 PM, she stated care plans were worked on by the MDS Nurse. She stated nurses were expected to update care plans when the MDS Nurse was not in the building.</p> <p>During an interview on 06/13/2025 at 7:45 AM with the MDS Nurse, she stated nurses updated care plans, and the MDS nurse reviewed them.</p> <p>During additional interview on 06/13/2025 at 10:41 AM with the MDS Nurse, she stated R47 should have been care planned for her colostomy upon her readmission in August 2024. The MDS nurse stated R47 did not have a colostomy when she originally came into the facility, and she was sent to the hospital and then returned with the colostomy in August 2024. She stated upon readmission, the nurse missed updating the care plan, and she did not recall if it was mentioned in their daily meetings. She stated she discovered it was missing from R47's Care Plan in January 2025, and she added it at that time. She stated the risk of not having it there was the resident might not receive the proper care.</p> <p>3. Observation on 06/12/2025 at 1:49 PM revealed R17 was sleeping in bed with an indwelling urinary catheter leg bag noted to be strapped to the resident's leg.</p> <p>Review of R17's admission Record, found in R17's EMR, revealed the facility admitted the resident on 04/08/2025 with a diagnoses of Alzheimer's disease, anxiety, and hypertension.</p> <p>Review of R17's admission MDS, with an ARD of 04/12/2025, revealed the facility assessed the resident to have a BIMS score of two out of 15, indicating the resident was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hartland Park Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1500 Trent Boulevard Lexington, KY 40515	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R17's Physician's Orders, dated 04/15/2025, revealed an order for an indwelling urinary catheter.</p> <p>Review of R17's Progress Note, dated 05/20/2025, revealed R17 now had a leg bag for the catheter because the resident got up to go to the restroom and ripped the catheter out.</p> <p>Review of R17's Care Plan revealed the indwelling urinary catheter was initially cared planned on 04/08/2025 and revised on 05/01/2025. However, further review revealed the Care Plan was not updated to add R17's preference for a leg bag until 06/10/2025.</p> <p>During an interview on 06/10/2025 at 4:55 PM with R17's representative, she stated R17 was not voiding properly and required an indwelling urinary catheter to be placed. She stated R17 would forget about the catheter, and she accidentally pulled it out twice. She stated she and the facility decided to try a leg bag, and since changing to the leg bag, R17 had not pulled it out anymore. She stated she could not remember the exact date the decision was made to only use a leg bag.</p> <p>During an interview on 06/12/2025 at 1:49 PM with CNA10, she stated R17 wore the leg bag all the time.</p> <p>During an interview on 06/12/2025 at 2:00 PM with LPN5, she stated R17 had the indwelling urinary catheter placed for urinary retention. She stated she was unsure of the exact date the leg bag was placed. She stated the resident was care planned for the leg bag.</p> <p>During continued interview on 06/13/2025 at 10:41 AM with the MDS Nurse, she stated R17 should have been care planned sooner for the leg bag to decrease her risk of infection.</p> <p>During an interview on 06/13/2025 at 2:08 PM with LPN1, she stated she could not remember the date R17 was switched to a leg bag. She stated updating the care plan was a team effort, and she was not sure why it was not done. She stated it was important to keep care plans updated so staff was aware of how to care for residents. She stated the risk of always using the leg bag was that it might not drain properly and lead to an infection.</p> <p>4. Review of R2's admission Record, found in R2's EMR, revealed the facility admitted the resident on 02/23/2022 with diagnoses of cerebral palsy, epilepsy, and anxiety.</p> <p>Review of R2's quarterly MDS, with an ARD of 04/24/2025, revealed the facility assessed the resident to have a BIMS score of zero out of 15, indicating severe cognitive impairment.</p> <p>Review of R2's Care Plan revealed she was not care planned for activities until 06/12/2025. Activities was added to the Care Plan with a focus of the resident prefers to participate in activities such as 1:1 activities, reading books, watching television programs in room, music therapy.</p> <p>During an interview on 06/12/2025 at 8:39 AM with the Activities Director, she stated R2 did not come out of her room for activities because she remained in bed all the time. She stated R2's family member preferred to do activities with R2. She stated R2 was a part of a program where she received music therapy every other week at the bedside. She stated she could add a temporary 1:1 for activities to work with R2 while her family member was hospitalized . She stated she would call R2's representative about activities.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/13/2025 at 1:53 PM with the Activities Aide, he stated he did bedside activities with R2, who was responsive to music and enjoyed being read to. He stated he had been doing them while her family member had been hospitalized . He stated when R2's family member was at the facility, the Activities Aides stopped by R2's room to visit and to make sure the resident had some sort of activity. He stated he usually did independent activities, but in a meeting with his Director yesterday, they discussed making R2's activities 1:1 while her family member was not present to ensure that R2 received at least 15 minutes a day.</p> <p>The State Survey Agency (SSA) Surveyor attempted to interview R2's representative by telephone on 06/11/2025 at 2:39 PM but was unsuccessful.</p> <p>During an interview on 06/13/2025 at 5:47 PM with the Director of Nursing (DON), she stated everyone was responsible for updating care plans to make sure they were up-to-date with the care being provided. She stated care plans were discussed in the staff interdisciplinary morning meetings to ensure there were no delays in care planning. She stated the morning meeting process was changed in March 2025 to eliminate things being missed on the care plan. She stated activities should be assessed upon admission and updated quarterly and as needed to make sure they kept residents engaged and involved for their psychosocial well-being.</p> <p>During an interview on 06/13/2025 at 6:31 PM with the Administrator, she stated it was her expectation that care plans were developed when there were changes to the resident's condition or care. She stated fully developed care plans were important to ensure the facility was providing care the residents needed.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observation, interview, record review, review of a Centers for Disease Control and Prevention (CDC) website, and review of the facility's policy, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 1 sampled residents with enteral feeding, Resident (R) 2.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Enteral Tube Feeding via Continuous Pump, dated 10/01/2021, revealed residents receiving enteral feedings should have their head of bed (HOB) positioned 30 to 45 degrees (Semi-Fowlers position) for feeding, unless medically contraindicated.</p> <p>Review of the CDC's guidance at <a href="http://www.cdc.gov">www.cdc.gov</a>, Guidelines for Preventing Health-Care--Associated Pneumonia, 2003, Prevention of Aspiration Associated with Enteral Feeding, revealed, In the absence of medical contraindication(s), elevate at an angle of 30-45 degrees of the head of the bed of a patient at high risk for aspiration (e.g., a person receiving mechanically assisted ventilation and/or who has an enteral tube in place).</p> <p>Observation on 06/10/2025 at 9:18 AM and 06/11/2025 at 9:10 AM revealed R2 was lying in bed with her tube feeding infusing, and the head of bed (HOB) was not elevated to help decrease the risk of aspiration.</p> <p>Review of R2's admission Record, found in the electronic medical record (EMR), revealed the facility admitted the resident on 02/23/2022 with diagnoses of cerebral palsy, epilepsy, and dysphagia.</p> <p>Review of R2's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/24/2025, revealed a Brief Interview for Mental Status [BIMS] score of zero out of 15, indicating R2 was severely cognitively impaired.</p> <p>Review of R2's Care Plan, initiated on 09/11/2023 and revised on 01/29/2024, revealed R2 was care planned for impaired gastrointestinal status related to feeding tube, gastroesophageal reflux disease (GERD), and history of constipation.</p> <p>Review of R2's Physician's Orders, dated 05/31/2024, revealed an order for enteral feeding every day related to dysphagia.</p> <p>During an interview on 06/11/2025 at 9:10 AM with Licensed Practical Nurse (LPN) 4, she stated residents receiving tube feeding should have the HOB be elevated 35 to 40 degrees. She stated R2 had pain and yelled out when her head was elevated, so she raised her head of bed slowly throughout the shift.</p> <p>During an interview on 06/13/2025 at 8:12 AM with the Infection Preventionist/Staff Development Coordinator(IP/SDC), she stated staff should follow the facility's policies and CDC guidelines on HOB placement for residents receiving enteral feedings.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/13/2025 at 5:47 PM with the Director of Nursing (DON), she stated it was her expectation that the HOB angle for any resident receiving tube feedings was to be kept at 30 degrees or greater to decrease the risk of aspiration.</p> <p>During an interview on 06/13/2025 at 6:31 PM with the Administrator, she stated it was her expectation for staff to follow professional standards when administering tube feedings to residents.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on interview and record review, the facility failed to consistently provide respiratory treatments twice daily as ordered for 1 of 28 sampled residents, Resident (R) 12.</p> <p>Review of R12's digital respiratory therapy log on 06/12/2025 at 7:40 PM, revealed multiple missed treatments over the past month.</p> <p>The findings include:</p> <p>On 06/12/2025, a verbal request was made for the facility's Respiratory Policy. However, the facility did not provide the State Survey Agency (SSA) Surveyor with the requested document.</p> <p>Review of an admission Record, found in R12's electronic medical record (EMR), revealed the facility admitted the resident on 04/03/2024 with diagnoses including dementia, cerebral infarction, and aphasia.</p> <p>Review of R12's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/03/2025, revealed the resident had a BIMS score of zero out of 15, which indicated severe impairment.</p> <p>Review of an Order Summary Report, for May 2025 and June 2025 and found in R12's EMR, revealed the resident was ordered use of the Volara System (used for lung expansion therapy and the mobilization of secretions) as tolerated for 10 to 20 minutes with sodium chloride inhalation every day and night shift.</p> <p>Review of the Volara device's digital history therapy log on 06/12/2025 at 7:43 PM revealed a history of the days and time the respiratory treatment was administered to R12. Further review revealed the facility failed to provide R12 with 22 respiratory treatments between 05/15/2025 and 06/12/2025. The dates were as follows: 05/17/2025 AM dose; 05/18/2025 PM dose; 05/24/2025 PM dose; 05/25/2025 AM and PM doses; 05/26/2025 PM dose; 05/27/2025 PM dose; 05/28/2025 PM dose; 05/29/2025 PM dose; 05/31/2025 AM dose; 06/01/2025 PM dose; 06/02/2025 AM and PM doses; 06/03/2025 PM dose; 06/04/2025 PM dose; 06/05/2025 PM dose; 06/06/2025 PM dose; 06/08/2025 AM dose; 06/09/2025 PM dose; 06/10/2025 PM dose; 06/11/2025 PM dose; and 06/12/2025 PM dose.</p> <p>Review of a Progress Note, found in R12's EMR, dated 06/11/2025 at 2:35 PM, revealed a chest x-ray was ordered due to wheezing lung sounds.</p> <p>During an interview with R12's Power-of-Attorney (POA) on 06/12/2025 at 9:13 AM, he stated he was concerned because his mother did not receive her Volara respiratory therapy as prescribed by her pulmonologist. He stated the nursing staff was inconsistent in providing her evening treatments. Additionally, he stated on 06/11/2025, his mother experienced increased congestion and began wheezing, which necessitated a chest x-ray. He stated R12 tended to develop increased congestion when she did not consistently receive her respiratory treatments.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Respiratory Therapist (RT) on 06/13/2025 at 2:16 PM, she stated the Volara respiratory treatment controlled R12's secretions by providing an aerosol treatment in a delivery system to enhance therapy effectiveness. She stated the system was indicated for the treatment and prevention of increased secretions and to soften R12's bronchi (tubes in the lungs). She stated the respiratory treatments were very important to mobilize R12's secretions. She stated the resident's pulmonologist ordered the treatments for twice daily. She stated she would provide the treatments when she was in the building from Monday to Thursday. She stated nursing was responsible for administering treatments when she was not available, including during nights and weekends. The RT stated it was her expectation that the specific treatment orders written by a provider were followed and administered to the resident.</p> <p>During an interview with the Nurse Practitioner on 06/12/2025 at approximately 3:00 PM, she stated it was her expectation that nurses administered medication as ordered by the provider. She stated following provider orders was important to maintain the resident's health, quality of life, and ensure their well-being.</p> <p>During an interview with the Administrator on 06/13/2025 at 5:50 PM, she stated it was her expectation for nursing staff to follow provider orders as written to maintain the health and well-being of the resident.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview, record review, and review of the facility's policies, the facility failed to store drugs and biologicals in the packaging, containers, or other dispensing systems in which they were received for 2 out of 28 sampled residents, Resident (R) 52 and R36 and 2 out of 7 medication carts, Cart 1 and Cart 2 on the Combs unit.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Medication Administration, dated 09/2018, revealed, Medications are to be administered at the time they are prepared, and the resident is always observed after administration to ensure that the dose was completely ingested. Once removed from the package/container, unused medication doses shall be disposed of according to the nursing care center policy.</p> <p>Review of the facility's policy titled, Medication Storage, undated, revealed the nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner, and drugs and biologicals shall be stored in the packaging, containers or dispensing systems in which they are received.</p> <p>1. Observation on 06/10/2025 at 9:52 AM revealed R52 had five unidentified pills sitting on the bedside table.</p> <p>Review of R52 admission Record, in the electronic medical record (EMR), revealed the facility admitted the resident on 08/06/2021 with diagnoses of rheumatoid arthritis, hypertension, and anxiety.</p> <p>Review of R52's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/28/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 13 out of 15, indicating intact cognition.</p> <p>During an interview on 06/10/2025 at 9:52 AM with R52, she stated she was not sure what the medications were for or when or where they came from. She stated she thought they could have been vitamins. She also stated she was not sure how long they had been on the bedside table.</p> <p>During an interview on 06/10/2025 at 10:00 AM with Registered Nurse (RN) 1, she stated she was unsure what the unidentified pills were that were found on R52's bedside table. She stated she thought they were from the previous night.</p> <p>During an interview on 06/12/2025 at 3:40 PM with the Nurse Practitioner (NP), she stated she received a call yesterday from staff regarding R52 self-administering medications and was okay with that decision because she had worked with R52 for three years. She stated, She [R52] pretty much takes care of herself. The NP stated R52 is going to do what she wants to do. If she doesn't take them then that's on her because she makes her own decisions. When asked if other residents would be safe to find medications left out, the NP stated, I suppose not. When asked what could happen if another resident walked into R52's room and took medications that did not belong to them, she stated depends on what medication it is, and it could cause an adverse response. She stated her expectation of staff was to follow facility policy and standards of care.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Observation on 06/11/2025 at 8:15 AM of the Combs Unit Medication Cart 2 revealed 12 loose pills in the bottom of the second drawer.</p> <p>During an interview on 06/11/2025 at 8:15 AM with Licensed Practical Nurse (LPN) 4, she stated she was not sure how so many pills were at the bottom of the drawer, but sometimes they fell out of the blister packs. When asked what the concern would be about the loose pills, she stated someone could give the wrong medication. She then stated she would not give medication from the bottom of the drawer. She stated loose pills could mean a resident was charged for something they did not receive.</p> <p>3. Observation on 06/11/2025 at 8:21 AM revealed RN1 prepared R36's medications by placing them into a medication cup and then placing the cup into the medication cart. Medications were not administered until 9:00 AM.</p> <p>4. Observation on 06/11/2025 at 9:06 AM of the Combs Unit Medication Cart 1 revealed an unidentified, pinkish-colored tablet in a cup in the back of the top drawer.</p> <p>During an interview on 06/11/2025 at 9:06 AM, Kentucky Medication Aide (KMA) 1 stated the pill was a Midodrine (used to treat hypotension) for R35. She stated it fell from the package, and she did not want to waste it. She then stated she would put it back in the drawer, then corrected herself, and decided to waste it. When asked what the concern would be about leaving the medication loose in the cart without proper identification, she stated there was no way for someone to know for sure what it was or who it was for. She also stated the dose might be forgotten in the back of the drawer.</p> <p>During an interview on 06/13/2025 at 5:47 PM with the Director of Nursing (DON), she stated it was her expectation that staff who were administering medications verified the residents swallowed the medication. She stated this was important to ensure medications were taken at the correct time. She stated if a resident did not swallow the medicine and set it in the room, it would be a concern if another resident came into the room. She also stated staff should waste medications appropriately. She stated it was important to take care in removing medications from the cart because it wasted medications the resident had paid for.</p> <p>During an interview on 06/13/2025 at 6:31 PM with the Administrator, she stated it was her expectation that staff followed professional standards and guidelines to ensure residents were getting the appropriate medications at the correct time.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and review of the State Operations Manual (SOM), the facility failed to store food in a safe manner in a nourishment refrigerator on 1 of 3 resident units, the [NAME] Unit.</p> <p>The findings include:</p> <p>Review of the SOM definitions revealed the Danger Zone meant food temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allowed the rapid growth of pathogenic microorganisms that could cause foodborne illness. Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) might cause a foodborne illness outbreak if consumed.</p> <p>Review on 06/12/2025 at 2:50 PM of the Refrigerator Temperature Log for the [NAME] Unit, dated June 2025, revealed documentation of multiple dates the temperatures were measured above 41 degrees F. Further review revealed on 06/03/2025, the temperature was recorded as 46 degrees F; on 06/04/2025, the temperature was recorded as 42 degrees F; on 06/05/2025, the temperature recorded was 48 degrees F; and on 06/06/2025, the temperature recorded was 46 degrees F.</p> <p>During an interview on 06/12/2025 at 2:53 PM with Certified Nurse Aide (CNA) 2, she stated she was not sure but thought the temperature range should be between 35 degrees F and 45 degrees F. She stated if the refrigerator was not working, she would contact the maintenance person or the nurse. She stated food that was not kept at the proper temperature could spoil and cause the residents to get sick.</p> <p>During an interview on 06/12/2025 at 3:04 PM with Licensed Practical Nurse (LPN)/Unit Manager (UM) 1, she stated she thought the temperature range for the unit nutrition refrigerator should fall between 36 degrees F and 46 degrees F. She stated it was the responsibility of night shift staff to record the temperatures and to ensure the safety of the contents, but it was her responsibility to make sure it had been done. She stated if the food was not kept at the right temperature, food could spoil, and residents could get sick as a result.</p> <p>During an interview on 06/13/2025 at 5:07 PM with the Director of Nursing (DON), she stated she expected the night shift staff to monitor and record temperatures of the nutrition room refrigerators and to ensure the safety of its contents. She stated if there was a concern about the working condition of the refrigerator, staff was expected to reach out to maintenance or to notify their supervisor for further direction. She stated the appropriate refrigerator temperature was no greater than 41 degrees F.</p> <p>During an interview on 06/13/2025 at 6:10 PM, the Administrator stated it was her expectation that the staff would monitor and document the refrigerator temperatures and report any concerns to their supervisor. She stated if food got too warm, it could cause it to spoil and could cause the residents to get sick.</p>		

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NAME OF PROVIDER OR SUPPLIER  Hartland Park Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1500 Trent Boulevard Lexington, KY 40515	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's 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 the development and transmission of communicable diseases and infections affecting 4 of 28 sampled residents, Residents (R) 1, R12, R22, and R68. Additionally, the deficient practice of not handling trash and linens appropriately and failure to perform hand hygiene and wear appropriate personal protective equipment (PPE) had the potential to affect all 139 current residents.</p> <p>Observation on 06/10/2025 of R12's room revealed an opened package of skin wipes and gloves on the sink. R12's respiratory equipment supplies, including a mask and tubing, as well as a single denture, were drying on a stained towel on a table located in the resident's bathroom. Additional observation on 06/10/2025 revealed Certified Nurse Aide (CNA) 1 was at the bedside, holding a brief, with her uniform pressed against R12. CNA1 was not wearing the appropriate personal protective equipment (PPE) for providing direct care in an enhanced barrier precaution (EBP) room.</p> <p>Observation on 06/10/2025 revealed the Restorative Aide ambulated R68 with a gait belt to the dining room, then removed the gait belt from R68 and placed the gait belt in her pocket without cleaning it.</p> <p>Observation on 06/11/2025 revealed Licensed Practical Nurse (LPN) 2 performed a blood sugar fingerstick for R22. LPN2 failed to follow any infection control practices while performing the procedure and failed to properly clean and disinfect the blood glucose meter before storage.</p> <p>Observation on 06/11/2025 revealed R1's indwelling urinary catheter collection bag was anchored under her recliner, and the bottom surface of the collection bag was touching the ground. Continued observation revealed LPN2 repositioned R1's catheter collection bag without first donning (putting on) PPE. Additionally, LPN2 did not perform hand hygiene before she sat at the nurses' station to type on the computer.</p> <p>The findings include:</p> <p>Review of the Centers for Disease Control and Prevention (CDC) Guidelines titled, Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed hand hygiene should be performed immediately before providing resident care and after care was completed. It stated staff should ensure the proper selection and use of PPE based on the nature of the patient interaction and potential for exposure to blood, body fluids, and/or infectious materials.</p> <p>Review of the facility's policy titled, Infection Control Program [ICP], undated, revealed the facility maintained an infection prevention and control program designed to address surveillance, prevention, and control of disease and infection that was consistent with CDC guidelines.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy titled Enhanced Barrier Precautions [EBP], dated 03/38/2024, revealed staff would implement EBP precautions in conjunction with standard precautions to include targeted gown and glove use during high contact care activities for residents known or suspected to be infected with multi drug-resistant organisms (MDRO).</p> <p>Review of the facility's policy titled, Point of Care Blood Glucose Meters/PT/INR Meters Use and Cleaning, dated 03/11/2019, revealed the facility would maintain processes to prevent the spread of infection and disease and to ensure that point of care devices were utilized safely when used on multiple residents by properly cleaning the devices between each resident.</p> <p>Review of the facility's competency titled Assure Platinum Blood Glucose Cleaning and Disinfecting Competency, dated 02/01/2024, revealed the blood glucose meter must be cleaned and disinfected after each use. According to the instructions, this should be done using a disinfectant or germicide registered with the Environmental Protection Agency (EPA) and approved for healthcare settings. Additionally, the competency guidelines stated that to clean the meter, a disinfectant cloth should be used to wipe its surface to remove the blood and other bodily fluids. To disinfect the meter, a fresh disinfectant cloth should be used to wipe the entire surface and ensure that it remained wet for the recommended contact time according to manufacturer's instructions.</p> <p>Review of the Sani-Cloth Germicidal Wipe package instructions revealed to thoroughly clean and disinfect, the glucometer surface must be thoroughly wet and allow treated surfaces to remain wet three minutes, then air dry.</p> <p>Review of the facility policy's titled, Cleaning and Disinfecting Resident Care Items and Equipment, dated 10/01/2021, revealed reusable items were cleaned and disinfected or sterilized between residents.</p> <p>Review of the facility's policy titled, Gait Belt Policy Staff Acknowledgement, undated, stated gait belts must be laundered as necessary and must be clean at all times.</p> <p>1.a. Observation of R12's room on 06/10/2025 at 9:15 AM revealed an opened package of skin wipes and gloves on the sink. On the floor, there were two plastic bags containing linen and trash. Further observation revealed R12's respiratory equipment supplies, including a mask and tubing, as well as a single denture, were drying on a stained towel on a table located in the resident's bathroom.</p> <p>b. Observation of CNA1 on 06/10/2025 at 9:32 AM revealed she was at R12's bedside, holding a brief, with her uniform pressed against the resident's bed. The CNA was wearing gloves. She stated to R12, Let's change your brief. CNA1 was not wearing a gown when she touched R12 and began high-contact direct care to R12 who was in EBP.</p> <p>Review of an admission Record, found in R12's electronic medical record (EMR), revealed the facility admitted the resident on 04/03/2024 with diagnoses including dementia, cerebral infarction, and aphasia.</p> <p>Review of R12's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/03/2025, revealed the resident had a Brief Interview for Mental Status [BIMS] score of 00 out of 15, which indicated severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of an Order Summary Report, found in R12's EMR, revealed the resident was placed on EBP related to a gastrostomy-tube and wounds on 04/19/2025.</p> <p>During an interview with CNA1 on 06/10/2025 at 9:32 AM, she stated she was going to get a gown. She stated there should be gowns in the hall. However, she stated there were none when she looked. CNA1 stated gowns were also kept in the shower room. When asked why she did not don a gown before she provided direct care, she stated, I wasn't providing direct care. CNA1 stated she received ICP training upon hire and had received periodic in-service training. She stated it was important to follow infection control to help everyone from getting sick.</p> <p>During an interview with Unit Manager (UM) 1 on 06/10/2025 at 10:05 AM, she stated there was one PPE container on each hall for staff to use for EBP rooms. She stated staff should wear the appropriate PPE in EBP and isolation rooms. She stated a gown and gloves were necessary when providing any type of high-contact direct care for a resident under EBP. She stated according to CDC guidelines, changing briefs was considered high-contact resident care. Additionally, UM1 stated clean equipment should not be stored in the bathroom as this was unsanitary. Instead, she stated it should be cleaned, dried, and placed in a bag to prevent cross-contamination. The UM stated following ICP practices was important for the health and safety of all residents and staff.</p> <p>2. Observation of the A-Hall on 06/10/2025 at 9:26 AM revealed two bags of laundry and trash were outside of a room on the floor in the hall.</p> <p>3. Observation of CNA3 on 06/10/2025 at 9:39 AM revealed she was holding a bag of dirty linen and then doffed (took off) her gloves. She did not perform hand hygiene. The CNA pushed a wheelchair holding the contaminated trash bag against the wheelchair. She disposed of the trash in the dirty utility room, but did not perform hand hygiene before she continued to move the wheelchair.</p> <p>During an interview with CNA3 on 06/10/2025 at 9:39 AM, she stated she should not wear gloves in the hall. She stated she should have doffed her gloves and performed hand hygiene before she exited the room. She stated she should have performed hand hygiene after disposing of the contaminated trash. CNA3 stated she received training on infection control policies and procedures during orientation and multiple in-service trainings. CNA3 further stated that following ICP was important to prevent the spread of infection and cross-contamination.</p> <p>4. Observation of the A-Hall on 06/10/2025 at 9:42 AM revealed Housekeeper (HSK) 1 was holding a clean privacy curtain over her shoulder. The curtain was dragging on the ground as she walked down the hall. Continued observation revealed HSK1 began to hang the curtain.</p> <p>During an interview with HSK1 on 06/10/2025 at 9:42 AM, she stated she was unaware the curtain was dragging on the floor and believed a bag was covering the curtain. When asked if she should hold clean linen against her person, she did not respond. When questioned why dragging a clean item on the floor could pose an infection control issue, she stated that it could spread germs. When asked if she had received ICP training, she stated, Yeah, and walked away.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Environmental Services Supervisor (EVS) on 06/13/2025 at 8:05 AM, she stated HSK1 should not have dragged the curtain through the hall or against her person. She stated the housekeeper should not hang a contaminated curtain. She stated her staff had received ICP training, and it was her expectation that all housekeeping staff followed facility policy related to ICP to prevent the spread of infection.</p> <p>5. Observation of Room A5 on 06/10/2025 at 9:58 AM revealed wash cloths on the floor. Also, clean linen was piled on top of the vanity and in the sink.</p> <p>During continued interview with Unit Manager (UM) 1 on 06/10/2025 at 10:05 AM, she stated linen and trash should not be left on the floor or on any surfaces in the room or hallway. She stated staff was trained to only bring in the necessary linen and to remove trash and contaminated linen after care was completed. The UM stated it was her expectation that nursing staff should conduct audits of resident rooms to ensure they were kept clean and tidy to prevent the spread of infection. UM1 stated she could not explain why the rooms were unkempt.</p> <p>6. Observation of CNA4 on 06/10/2025 at 11:30 AM revealed she entered and exited three resident rooms, who residents were gone (A16, A21, and A23), while carrying a large black garbage bag and collecting water pitchers and cups for disposal. CNA4 did not wear gloves while handling the dirty pitchers, cups, straws, and trash. Furthermore, CNA4 did not perform hand hygiene between rooms.</p> <p>During an interview with CNA4 on 06/10/2025 at 11:30 AM, she stated every Tuesday she changed the pitchers and cups in all the resident rooms. She stated she should have worn gloves, especially when touching straws, and should have performed hand hygiene. CNA4 stated she was not aware she could not take a contaminated bag in and out of rooms.</p> <p>7. Observation on 06/10/2025 at 12:07 PM revealed the Restorative Aide ambulated R68 with a gait belt to the dining room, then removed the gait belt from R68 and placed the gait belt in her pocket without cleaning it.</p> <p>Review of an admission Record, found in R68's EMR, revealed the facility admitted the resident on 01/20/2020 with diagnoses including hypertension, anxiety, and depression.</p> <p>Review of R68's quarterly MDS, with an ARD of 04/24/2025, revealed the BIMS could not be performed because of memory problems.</p> <p>During an interview on 06/10/2025 at 12:25 PM with the Restorative Aide, she stated she used her own gait belt and wiped it down with purple wipes between uses. She stated wipes were kept at the nurses' stations, and she kept it in her pocket. She stated if she needed a second one, then she could get another one from the therapy department. She stated that storing it in her pocket before and after cleaning could contaminate it.</p> <p>8. Observation of CNA3 on 06/10/2025 at 3:30 PM, revealed she walked down the A-Hall holding a bag of contaminated linen and a bag of trash. CNA3 did not doff her gloves or perform hand hygiene prior to leaving the room and going into the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with CNA3 on 06/10/2025 at 3:30 PM, she stated, I already told you I shouldn't wear gloves in the hall. When asked why she did not doff the gloves and perform hand hygiene, she stated she was not finished with what she was doing. CNA3 then walked away from the State Survey Agency (SSA) Surveyor.</p> <p>9. Observation of CNA3 on 06/11/2025 at 7:35 AM revealed CNA3 transported a bag of dirty linens with gloved hands down the hall while pushing a wheelchair. After disposing of the trash in the dirty utility room, the CNA removed her PPE, however she did not perform hand hygiene before she continued to push the wheelchair down the hall.</p> <p>During an interview with CNA3 on 06/11/2025 at 7:39 AM, she stated she should not wear contaminated gloves in the hall due to cross contamination. When asked about the importance of hand hygiene and PPE use, she stated they were important to prevent germs from spreading.</p> <p>10. Observation of CNA4 on 06/11/2025 at 7:40 AM revealed she walked down the A-Hall holding a contaminated pair of gloves and a bag of dirty linen.</p> <p>11. Observation of LPN2 perform a fingerstick on 06/11/2025 at 7:50 AM revealed she took her supplies into R22's room and placed the lancet, blood glucose meter (glucometer), and the testing strip on the bedside table without first placing a barrier. Without performing hand hygiene, LPN2 donned gloves. LPN2 stuck the resident's finger with a lancet and then placed the lancet on the bedside table without a barrier. She obtained the drops of blood on the test strip and took an alcohol wipe and wiped blood from R22's finger and discarded it directly on the bare table. Further observation revealed LPN2 discarded the lancet and test strip, removed her gloves and did not perform hand hygiene before she exited the room. LPN2 placed the contaminated glucometer on the medication cart without a barrier. She then wiped the contaminated glucometer with one SaniCloth Prime wipe for 6.8 seconds and placed it on a tissue. She then put the glucometer in the medication cart drawer on top of other glucometers. She did not wear gloves or perform hand hygiene.</p> <p>Review of an admission Record, found in R22's EMR, revealed the facility admitted R22 on 05/04/2022 with diagnoses that included type 2 diabetes, cerebral palsy, and neuropathic bladder.</p> <p>Review of R22's annual MDS, found in R22's EMR, with an ARD of 05/21/2025, revealed a BIMS score of six out of 15, which indicated the resident was severely cognitively impaired.</p> <p>Review of an Order Summary Report, found in R22's EMR, revealed the resident was placed on EBP related to a urinary catheter and colostomy.</p> <p>During an interview with LPN2 on 06/11/2025 at 8:00 AM, she stated she left the glucometer on top of the cart to dry. When asked what the proper kill/dwell-time was for the disinfectant wipes she used, she stated she was taught to wipe the glucometer clean and let it dry for three to five minutes. When asked to explain what kill/dwell time meant, LPN2 was unable to explain. Continued interview revealed LPN2 reviewed the Sani-Cloth Germicidal Wipe instructions and stated the object must remain wet for a full three minutes and then be left to air dry for complete disinfection to take place. LPN2 further stated she had received training to perform fingersticks and clean and disinfect glucometers and had passed competencies during her orientation period at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 06/11/2025 at 8:15 AM, she stated she had been in her position since March 2025. She stated she had not seen any major issues of staff failing to perform ICP to include hand hygiene or wearing appropriate PPE. She stated nursing leadership recently performed an infection control audit, and the staff performed procedures with no issues. The IP/SDC stated nurses needed to focus on the product instructions to know the exact kill-time for that particular product. The IP/SDC stated following ICP was important to prevent the spread of infection and cross contamination. Furthermore, she stated all staff received infection control training upon hire, and it was reviewed many times throughout the year.</p> <p>12. Observation on 06/11/2025 at 8:09 AM revealed Registered Nurse (RN) 1, when administering medications, touched all medications with hands and without performing hand hygiene consistently and did not clean the blood pressure (BP) cuff between use on multiple residents.</p> <p>During an interview on 06/11/2025 at 9:07 AM with RN1, she stated Honestly, I don't clean the BP cuff between residents unless I have a resident in contact [precautions]. However, she stated cleaning it between uses would decrease the risk of cross contamination. She stated hand hygiene and not touching residents' medications with bare hands would also decrease the risk of cross contamination.</p> <p>13. Observation on 06/11/2025 at 9:15 AM revealed CNA8 and CNA9 were observed going into Room C8 with a Hoyer lift (a mechanical lift used to transfer residents between surfaces shared between residents). When they exited, the Hoyer was placed in the hallway without being cleaned.</p> <p>During an interview on 06/11/2025 at 9:42 AM with CNA8, she stated, We might've thought each other cleaned it. She stated that cleaning between resident use decreased risks of contamination.</p> <p>During an interview on 06/12/2025 at 2:05 PM with CNA9, she stated she thought CNA8 had cleaned the Hoyer lift when they were finished using it. She stated this should be done between resident use for sanitation because staff did not want to spread germs.</p> <p>During an interview on 06/13/2025 at 6:31 PM with the Administrator, she stated it was her expectation for staff to clean shared equipment per policy, and they should not be touching residents' medications without hand hygiene and donning gloves to decrease any risks that could arise.</p> <p>14. Observation of the dumpster on 06/11/2025 at 12:53 PM revealed infectious trash with used gloves, clear plastic bags opened with used briefs, and dirty gowns lying on the ground around the trash compactor dumpster.</p> <p>Observation of the same area on 06/11/2025 at 4:35 PM revealed the area still had the same debris scattered around the trash compactor dumpster.</p> <p>During an interview with the Maintenance Director on 06/13/2025 at 1:23 PM, the Director stated the maintenance department was responsible to take out the red barrel/ hazmat trash. The Director stated other trash was housekeeping's responsibility to take to the trash compactor. The Director stated the trash on the ground was a concern because of the potential for cross contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Environmental Services Supervisor (EVS) on 06/13/2025 at 11:33 AM, she stated nursing took the trash out of the residents' rooms to the soiled utility room. Then, she stated housekeeping took the trash to the dumpster. She stated there was an infection control concern for cross contamination with trash lying on the ground. She stated it was maintenance's responsibility to clean up the dumpster area. She stated the dumpster was emptied every week on Wednesday.</p> <p>During an interview with the Director of Nursing (DON) on 06/13/2025 at 4:40 PM, she stated the CNAs took the residents' rooms trash to the dirty utilities, and housekeeping emptied it to the dumpster. She stated her expectation was for all staff to pick up trash off the ground and dispose of it properly into the dumpster.</p> <p>During an interview with the Administrator on 06/13/2025 at 4:43 PM, she stated her expectation for staff was to discard trash into the dumpster.</p> <p>15. Observation of the [NAME] Unit on 06/11/2025 at 3:30 PM revealed R1's catheter collection bag was anchored under her recliner, and the entire bottom surface of the collection bag was touching the ground. Further observation revealed that LPN2 repositioned R1's catheter collection bag without donning PPE first. Additionally, LPN2 did not perform hand hygiene before sitting down at the nurses' station to type on the computer.</p> <p>Review of an admission Record, found in R1's EMR, revealed the facility admitted the resident on 01/03/2022 with diagnoses including cerebral palsy, epilepsy, and neuromuscular dysfunction of the bladder.</p> <p>Review of R1's quarterly MDS, with an ARD of 04/08/2025, revealed a BIMS, was not assessed because the resident was rarely or never understood.</p> <p>Review of an Order Summary Report, found in R1's EMR, revealed the resident was placed on EBP related to a urinary catheter on 04/28/2025.</p> <p>During an interview with LPN2 on 06/11/2025 at 3:35 PM, she stated the collection bag should not touch the ground due to cross contamination. When asked if there was a concern when she touched the urine collection bag of a resident on EBP, LPN2 stated, That's not my resident; I didn't know they were on EBP. When asked if it was ever acceptable to touch a urine drainage bag without PPE, she replied, No. Furthermore, when asked what additional steps she should have taken after providing care to R1, she stated she should have immediately performed hand hygiene.</p> <p>During an interview with the IP/SDC on 06/11/2025 at 4:15 PM, she stated urine collection bags should not touch the ground due to cross contamination. She stated the facility had suspended LPN2 for failure to consistently follow facility ICP policies. She stated LPN2 had completed her three week orientation and had passed her competencies, but there were continued concerns with her inability to retain training/education and perform appropriate ICP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During additional interview on 06/13/2025 at 8:11 AM with the IP/SDC, she stated all competencies were audited at hire and bi-annually. She stated skill audits for nurse aides covered bathing, hair and nail care, brief change, mechanical lift transfer, and gait belts. She stated EBP education was done on-line and in-person. She stated the facility now stored PPE in the hall to provide better accessibility for staff. She stated every time a policy was changed, staff were re-educated. She stated staff was educated on the meaning of the dot next to the resident's name in the hall; told to use a face shield when emptying the catheter bag or providing catheter care; and should know contact precaution and PPE's and droplet precaution. She stated she expected staff to provide safe care, and failure to do so was not from a lack of training.</p> <p>During additional interview with the IP/SDC on 06/13/2025 at 10:23 AM, she stated the facility adhered to the CDC's guidelines and followed the facility's infection prevention and control policies. She stated all EBP rooms had a red dot on the door leading into the room next to the resident's name on precautions. She stated that transmission based precaution (TBP) rooms had signs on the doors leading into the room. The IP/SDC stated gowns and gloves must be worn whenever staff entered an EBP room if they provided high-level care. She stated staff should remove gloves when contaminated or after care and perform hand hygiene before they exited a resident's room. She stated new PPE should be donned if they provided additional care. According to the IP/SDC, all staff members received education related to ICP. The IP stated nursing staff should follow the facility's policies and manufacturer's guidelines to clean and disinfect the glucometer. Additionally, the IP/SDC stated she was unsure why staff did not follow EBP and infection control practices despite being educated on the importance of ICP. She stated all staff members were trained upon hire in the use of PPE and isolation precautions, including EBP. The IP/SDC stated it was her expectation that all staff adhered to the facility's policies and procedures to help prevent the spread of infections. She stated it was important for the health and safety of the residents.</p> <p>During an interview with the Nurse Practitioner on 06/12/2025 at approximately 3:00 PM, she stated it was her expectation that staff performed infection control and prevention processes when caring for the residents. She stated it was important to prevent the spread of infection and maintain the residents' safety and well-being.</p> <p>During an interview with the Director of Nursing (DON) on 06/13/2025 at 5:50 PM, she stated staff received ICP training during orientation and then annually. She stated the UMs rounded on their units frequently, ideally at least once in the morning and once in the afternoon and possibly even more often than twice a day. The DON stated UMs should actively oversee their units, assist staff as needed, and consistently monitor staff activities. She stated while they might not be present on the unit for extended periods, nursing leadership should engage with staff and monitor conditions while they were there. She stated it was her expectation that staff would reach out for guidance whenever they had questions. The DON stated, I expect them to come to us if they need clarification. Additionally, the DON stated cleaning and disinfecting shared equipment was important to prevent the spread of infection. Furthermore, she stated it was her expectation that nurses were competent in performing procedures such as glucose monitoring, ensuring they not only performed the procedures correctly but also adhered to infection control protocols while doing so. She stated it was her expectation that all staff adhered to the facility's ICP policies and followed CDC guidelines at all times to prevent the spread of infection and to maintain the safety and well-being of the residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Hartland Park Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Administrator on 06/13/2025 at 6:32 PM, she stated staff should adhere to ICP protocols, including EBP, to protect both residents and staff from the spread of infections. Additionally, she stated staff should be educated and complete their competencies. The Administrator stated it was her expectation that all staff followed ICP policies. Furthermore, she stated nurse managers were expected to round as often as needed to oversee staff to ensure they were wearing the correct PPE and following facility policy. The Administrator stated it was her expectation that staff performed hand hygiene between resident care and followed established CDC guidelines and standards of care related to ICP. She stated nursing staff should adhere to all facility policies and procedures, along with CDC recommendations, for infection control during glucose checks and the cleaning and disinfection of shared equipment. She stated ICP was important for the safety and well-being of both residents and staff.</p>		