STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calvert City Convalescent Center	1201 Fifth Ave Calvert City, KY 42029

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 45914 Based on observation, interview, record review and facility policy review, the facility failed to ensure its policy was followed regarding the prompt resolution of all grievances related to residents' rights, including those with respect to care and treatment furnished by the facility, which had the potential to affect all residents expressing a grievance. When conducting the entrance conference with the Administrator, the prior six months of resident grievances were requested as part of the survey process. The Administrator stated there were no resident grievances formally documented or logged other than resident council. The findings include: Review of the facility policy titled, Resident and Family Grievances, dated 02/01/2023, revealed it was the facility's policy to support each resident's and family member's right to voice grievances. Continued review revealed staff members receiving a resident's grievance was to record the nature and specifics of the grievance on a designated grievance form, or verbally route the grievance up to the appropriate department. Further review revealed the department manager over the specific area of concern was to keep the resident appropriately apprised of progress towards resolution of their grievances. In addition, review further revealed the facility was to make prompt efforts to resolve (residents') grievances. During a resident council meeting, on 10/01/2024 at 2:09 PM, the residents (all in attendance) stated the council met the first Tuesday of each month. Per the residents in the meeting, the Social Services Director (SSD) was always involved with the council and assisted the residents as needed. In an interview with R45, during the resident council meeting, she stated residents reported their requests or grievances to the Activities Director (AD) or SSD. R45 stated the AD or SSD had acted on the residents' requests; however, residents were not provided the status on the action taken while waiting for a resolution. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with SSD, on 10/03/2024 at 11:30 AM, she stated she and the AD were in the resident council meetings the majority of the time. She stated other department heads attended as well if there were concerns in those areas. The SSD stated resident council was the formal meeting in which all residents could attend, but she had discussed with residents that grievances or complaints could be made at any time to any department staff. She stated she ensured residents' concerns were given to the appropriate department. Per the SSD in interview, the facility had addressed residents' concerns, but had failed to have a system of documentation in place to track the grievances, actions taken, resident updates, and resolutions. She stated she understood that was not an acceptable process. The SSD stated once a grievance or concern was reported her expectation was that the department head would be responsible for addressing and seeking a resolution for the resident. She further stated the department head was to share the progress or delay of grievances with residents, until a resolution was found. In an interview with the Administrator, on 10/03/2024 at 4:31 PM, he stated regarding family grievances many family members had called him directly with their concerns. He stated if it was something related to a specific department the grievance was routed to the correct department. The Administrator stated that allowed the department head to address the concern and provide a resolution. He stated it was his practice to follow-up by contacting the family members with an update; however, he said he had no documentation process other than a progress note. The Administrator stated depending on the area of concern, management might note the investigation details in their department. Per the Administrator in interview, historically, the department head over the area of concern was responsible to investigate and find a resolution to grievances. In continued interview on 10/03/2024 at 4:31 PM, with the Administrator, he stated moving forward with the Performance Improvement Project (PIP) that had been initiated on 09/30/2024, the SSD would be the grievance official. He stated however, the grievance form utilized going forward included a space for the Administrator as the final signer to ensure the grievance process was completed from beginning to end. The Administrator stated having a grievance process in place was important to ensure residents' concerns had not fallen through the cracks. He said residents and their families would be provided a more formal follow-up. The Administrator stated all department heads were provided the new grievance forms which included a monthly log. According to the Administrator, once implemented any grievance reported to any department would not have to wait to notify the SSD of the grievance. He stated the departments could initiate the grievance process by completing the document and start investigating to determine a root cause analysis. The Administrator further stated the SSD was to follow up with the departments to ensure outcomes, but his signature was the final confirmation once a resolution was reached.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45914 Based on observation, interview, record review and facility policy review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Observation of the kitchen revealed food items not dated, labeled, or stored properly to prevent potential contamination. The findings include: Review of the facility policy titled, Food Storage, revised 07/11/2024, revealed food items should be stored in accordance with good sanitary practice. Per review, all products were to be dated upon receipt, when opened, and when prepared. Continued review revealed staff were to use the Use-By dates on all food stored in refrigerators. Review revealed leftovers were to be dated according to policy by remembering to cover, label, and date when being stored. Additionally, review revealed freezer food items were to be stored in the original containers, but foods to be frozen were to be stored in airtight containers and all to be labeled and dated. Observation of the kitchen on 09/30/2024 at 10:00 AM, revealed staff preparing pie slices for the lunch meal; however, there were six full pies stored uncovered on a cart. Observation of the reach-in refrigerator revealed a metal pan on an upper shelf with prepared sandwiches that were individually bagged in flip top storage bags, with two sandwich bags not sealed. Observation of the freezer revealed a bag of tator tots and a bag of frozen biscuits in their original box; however, they were not sealed or dated. Further observation of the walk-in refrigerator revealed a box of sausage links not sealed properly which had not been dated. In interview with Dietary 2, on 10/03/2024 at 11:40 AM, she stated she had worked in the facility for [AGE] years. She stated she had received training yearly and the Dietary Manager conducted monthly in-services or reeducation whenever necessary. She stated refrigerated food such as sandwiches should be dated when prepared and sealed properly to prevent bacterial growth or contamination. Dietary 2 stated food items in the freezer in bulk were to be in the original containers, but the items should have the received date noted. She said all packaging must be sealed to prevent freezer burn or other contamination. Dietary 2 stated all opened and stored food items should be sealed and include the opened date and disposal date. She further stated that would ensure residents were not served contaminated food and prevent residents from getting sick. In an interview with Dietary 1, on 10/03/2024 at 11:55 AM, he stated he was aware of the food storage process and had received training and in-services as needed. He stated all stored food should be dated when opened and include the use by date. Dietary 1 stated any opened food items in the refrigerator or freezer should be sealed properly to prevent contamination and ensure residents received food of good quality, but also safe for them. He stated anything dietary staff prepared and stored was to be sealed, labeled, and dated for overall resident safety. Dietary 1 further stated the reality was that if staff were not following the facility's policy and procedures for food safety, residents could get sick or potentially suffer more serious harm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Dietary Manager (DM), on 10/03/2024 at 3:00 PM, she stated she had been in her position since 11/02/2023. She stated processes for food safety included dating food items, temperature control, properly securing packaging, dry goods storage; off the floor, labeled, dated, and rotated to ensure freshness. The DM stated any opened food item, whether packaged or prepared, required an opened by and use by date. She said if food items were out of the original package they should be stored in a new container. Per the DM in interview, refrigerated foods that were prepared were kept for no more than five days; however, other purchased food items that were opened were good for seven days. She stated those procedures were very important to prevent contamination, ensure good quality of the food, and reduced the likelihood of pathogens and bacteria growth that could make residents ill. The DM stated she had an in-service weekly on different topics. She stated the current awareness of food (not stored properly), was an opportunity to complete an in-service and provide a demonstration on how to properly seal, label, date the food items to ensure staff were practicing food safety skills. The DM further stated her expectation for the dietary department and dietary staff was to follow the facility's policy and procedures to provide residents the best quality of care and service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47567 Based on observation, interview, and facility policy review, the facility failed to ensure it maintained an infection control and prevention program staff to provide a safe and sanitary environment for 3 of 13 residents. (Residents (R)5, R71, and R73). Facility policy revealed oxygen tubing, masks, or cannulas were to be changed weekly as an infection control measure. However, observation on 10/01/2024, revealed R71's oxygen tubing was dated 09/20/2024, and the oxygen tubing and cannula for R5 and R73, were not dated to indicate when they were last changed. The findings include: Review of the facility policy titled, Infection Prevention and Control Risk Assessment , revised 06/21/2022, revealed the facility documents a risk assessment that utilizes an all-hazards approach. This risk assessment will be used for prioritizing activities of the facility's infection prevention control program. Review of facility policy titled, Oxygen Administration, revised 04/01/2024, revealed the facility is to change oxygen tubing and mask or cannulas weekly and also as needed if it becomes soiled or contaminated as a measure of infection control. During observation on 10/01/2024 at 9:15 AM, the State Survey Agency (SSA) Surveyor Agency observed R71's oxygen tubing was dated 09/20/2024. Further observation revealed R5's and R73's, oxygen tubing cannula did not have a date listed for when the tubing and cannulas were last changed. In an interview with Licensed Practical Nurse (LPN) 5 on 10/03/2024 at 1:33 PM, she stated a resident's oxygen tubing was changed weekly by an outside vendor. She stated sometimes when a resident was newly admitted or had switched oxygen containers they might have tubing that was not dated. LPN 5 stated it was the nurse's responsibility to check the oxygen tubing behind the vendor to make sure the tubing was dated, clean and in good repair. She further stated that if a resident was found with no date on their oxygen tubing it was facility policy to get new tubing and date it. In an interview with Registered Nurse (RN) 3 on 10/03/2024 at 10:40 AM, she stated the oxygen and tubing was supplied by an outside vendor, who came to the facility weekly. She further stated that nursing was responsible for making sure the tubing was dated. In an interview with the Infection Preventionist (IP) Nurse on 10/03/2024 at 4:02 PM, she stated she would have to contact the oxygen vendor to see if their policy on the tubing co-existed inside of the facility policy and ask what they recommended. She further stated if it was not being changed out as scheduled it could potentially cause infections to residents wearing the tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 10/03/2024 at 1:50 PM, she stated it was possible the resident was a newer resident and might not have been seen by the vendor yet and it had gotten missed by the nurse. She stated if a resident was found with tubing that was not dated the nurse should have changed it out and placed the correct date on it. She further stated the vendor came to the facility weekly and the nurses were to go behind them to check and make sure the tubing was being changed. In a follow up interview with the DON on 10/03/2024 at 4:19 PM, she stated she expected her staff to follow the facility's infection control policies as they trained them, and try to follow the Centers for Disease Control and Prevention (CDC) guidelines. In an interview with the Administrator on 10/03/2024 at 4:41 PM, he stated an outside vendor supplied oxygen to the facility and they were responsible for replacing portable oxygen tanks, oxygen tubing, servicing the concentrators, and changing the filters out. He stated nursing was to follow up behind them as well when they were doing their checks. The Administrator stated the standard was for weekly checks and if they went past that weekly time frame he expected staff to change out any tubing that was found not dated and get a new one and put the new date on it.