STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Care Center	125 Sterling Way Mount Sterling, KY 40353

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46710 Based on interview, record review, and review of the facility's policy, the facility failed to refer the resident for a level II pre-admission screening and resident review (PASARR) with a newly evident, serious mental illness for 1 of 1 residents sampled for PASARR review (Resident (R) 94). The findings include: Review of the facility's policy titled, Resident Assessment-Coordination with PASARR Program, dated 2023, revealed the facility coordinated assessments with the PASARR program to ensure individuals with a mental disorder received care and services in the most integrated setting appropriate for their needs. Further review revealed any resident who was readmitted to the facility following an inpatient psychiatric admission would be referred promptly to the state mental health authority for a level II review. Review of R94's Admission Record revealed the facility admitted the resident on 03/10/2023 with diagnoses including metabolic encephalopathy (altered consciousness due to brain dysfunction), dementia with agitation, and anxiety disorder. Further review revealed, on 02/21/2024, the facility added the diagnosis unspecified psychosis to R94's diagnosis list. Review of R94's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/11/2023, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of six out of 15, indicating severe cognitive impairment. Further review revealed the facility assessed R94 as free of aggressive behavior during the look-back period. Review of R94's Care Plan, dated 03/10/2023, revealed the facility identified R94 as having a behavior problem, including yelling at other residents. Further review revealed the interventions included intervening as necessary to protect the rights of others, redirecting the resident to an alternate location, reminiscing with the resident about fishing, and offering a snack. Continued review revealed the facility added a care plan section following an altercation with another resident (R368) on 07/12/2023, and included interventions such as 15-minute checks, intervening before agitation escalated, and offering diversional activities, such as television (TV). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R94's level I PASARR, dated 03/10/2023, revealed the facility did not identify the resident as having a serious mental disorder at the time of admission. Further review revealed the facility failed to provide documented evidence of a new PASARR submission following R94's diagnosis of psychosis on 02/21/2024. Review of the facility document Social Services Note, dated 02/05/2024, revealed the Social Services Director (SSD) arranged for transportation for R94 to receive inpatient psychiatric treatment at a hospital. Review of the facility document, Health Status Note, dated 02/21/2024, revealed R94 returned to the facility on [DATE] and exhibited hallucinations and delusions. Review of the facility document, Health Status Note, dated 02/26/2024, revealed the facility held a care conference with the Unit Manager (UM), Director of Nursing (DON), and Administrator present with R94's family, to discuss the resident's behaviors. R94's behaviors included making animal noises, screaming, kicking, and refusing medication. Further review revealed R94 had recently returned from an inpatient psychiatric stay. In an interview with the SSD on 05/02/2024 at 11:05 AM, she stated she should have resubmitted PASARR information for R94 due to his psychiatric hospitalization , however, she failed to do so. She further stated, It was not on my radar. In an interview with the Administrator on 05/03/2024 at 5:24 PM, he stated it was his expectation that the facility would resubmit PASARR information when the resident had an increase in behaviors that resulted in an inpatient psychiatric stay and new diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46710 Based on observation, interview, record review, and review of the facility's documents and policies, the facility failed to develop and implement a comprehensive, person-centered care plan to meet a resident's medical, nursing, and psychosocial needs for 3 of 30 sampled residents (Residents (R) 11, 23, and 100). R100 had a care plan intervention for staff to follow physician's orders when providing care to the gastric tube insertion site. R100 developed an infection at the gastric tube insertion site; however, staff failed to implement the care plan intervention and follow the physician's orders for R100's gastric tube insertion site care. R23's care plan had interventions for the resident to wear a skin protective device and to keep fingernails trimmed; however, staff did not implement these interventions. R11 needed podiatry services; however, R11's care plan was not developed to include this intervention. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 2023, revealed the facility developed and implemented resident-centered care plans starting by assessing each resident's strengths and needs, including services provided or arranged by the facility. Further review revealed the comprehensive care plan was developed by an interdisciplinary team to include the physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, the resident or their representative, and other team members as applicable. Continued review revealed the facility would notify qualified staff responsible for implementing the care plan when interventions were initially added to the care plan or when changes were made. Review of the facility's policy titled, Podiatry Services, no date, revealed residents requiring foot care who had complicating disease processes would be referred to qualified professionals including a Podiatrist. Continued review revealed foot disorders included nail disorders. 1. Review of R100's Admission Record revealed the facility admitted the resident on 07/29/2023 with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke), dysphagia (impaired swallowing), and dysarthria (impaired speech). Review of R100's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2024, revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS). Facility staff assessed R100's mental status as severely impaired. Further review revealed R100 received greater than 51 percent of her caloric intake via her feeding tube. Review of R100's Care Plan, dated 05/19/2023, revealed R100 was totally dependent on tube feedings. Per review, the facility included interventions for staff to provide care to the gastric tube site per physician's orders and to monitor for signs and symptoms of infection. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's document Order Summary Report for R100 revealed, on 10/31/2023, the physician ordered Wash g-tube site with soap and water daily. Allow to air dry. Apply betadine and split gauze every day and night shift for infection control. Further review revealed the physician ordered Muciprocin (an antibiotic ointment) external ointment 2%, applied topically to g-tube site every day and night shift for infection control. Continued review revealed the physician ordered amoxicillin-pot clavulanate tablet 875-175 milligrams (mg) to be administered via g-tube for g-tube site infection two times per day for seven days, beginning 04/29/2024. Review of the facility's document Health Status Note, dated 04/25/2024, revealed nursing staff identified R100's gastric tube site had thick purulent (full of pus) drainage and a foul odor. Further review revealed nursing staff collected a sample of the drainage for testing (results were a heavy bacterial growth). Observation on 05/02/2024 at 9:16 AM, revealed R100's tube feeding site was reddened and there was a small amount of tan drainage from the site. In further observation, Licensed Practical Nurse (LPN) 5 performed gastric tube site care for R100 by cleaning the site with tap water and soap. Per observation, LPN5 then rinsed the site with sterile water and dried with a clean gauze. In continued observation, LPN5 placed a spilt gauze around the site and pulled the resident's shirt down over the site to discourage the resident from picking at the site. Per observation, LPN5 failed to apply betadine and antibiotic ointment as ordered. In an immediate interview with LPN5, she stated the technique she had demonstrated was how she performed site care for all residents with gastric tubes. She further stated she would have used different materials and applied an antibiotic ointment if the physician ordered it; however, she was unaware of specific orders for R100. In an interview on 05/02/2024 at 1:01 PM, LPN10 stated when she cared for R100, she used normal saline to clean the area and dried the site with a clean gauze before applying a split gauze to the site. In further interview, LPN10 stated she would check orders and the care plan to see if a resident required specific items or technique for their gastric tube site care. LPN10 stated that following the care plan was important because care plans described the specific care needed to provide the best possible care for each individual resident. In an interview on 05/03/2024 at 3:59 PM, the Director of Nursing (DON) stated she expected staff to follow the care plan and physician's orders when performing gastric tube site care. She further stated following the plan of care was important to provide appropriate, resident-specific care. In an interview on 05/03/2024 at 5:24 PM, the Administrator stated he expected staff to follow the care plan and physician's orders when providing gastric tube site care. 2. Review of R23's Admission Record revealed the facility admitted the resident on 04/10/2019. Further review revealed R23's current diagnoses as of 05/01/2024 included peripheral vascular disease, type 2 diabetes, and psychotic disorder with delusions. Review of R23's quarterly MDS, with an ARD of 02/08/2024, revealed the facility assessed R23 as severely cognitively impaired and unable to complete a BIMS. Further review revealed the facility assessed the resident as free from skin tears during the look-back period. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R23's Care Plan, revised 02/05/2024, revealed the facility assessed R23 had impaired skin integrity to his left upper extremity related to itching. Further review revealed the facility included interventions such as keeping the resident's fingernails short and keeping Geri-sleeves (soft, flexible sleeves used to protect skin on the limbs from friction and shear) on R23's arms. Observation of R23 on 04/30/2024 at 2:18 PM, revealed the resident sitting in bed, picking at a spot on his collarbone with long fingernails. Further observation revealed a brownish red substance with the appearance of old blood under the resident's fingernails. Per observation, the spot on R23's collarbone was bleeding and there were multiple scabbed-over skin tears on R23's forearms. Continued observation revealed the resident was wearing a short-sleeved shirt with no protective sleeves on his arms. Additional observations on 05/02/2024 at 2:38 PM, 05/03/2024 at 9:03 AM, 1:15 PM, 1:53 PM, and 2:14 PM revealed R23's nails remained long and with bloody-appearing material under them; the resident's arms were also bare during those observations. In an interview on 05/02/2024 at 2:38 PM, Nurse Aide-State Registered ([NAME]) 9 stated R23's care plan included the intervention for the resident to wear Geri-sleeves. She further stated the resident frequently removed the sleeves, and staff reapplied them on routine care rounds, approximately every two hours. In continued interview, NASR9 stated the care plan also described the need for R23's fingernails to be kept clean and trimmed, which was done when staff gave the resident a shower. In an interview on 05/03/2024 at 2:00 PM, LPN6 stated R23's care plan included interventions to protect his skin, such as application of Geri-sleeves and keeping his fingernails trimmed. She further stated following the care plan was important to give the resident the individualized care they needed. In an interview on 05/03/2024 at 3:59 PM, the DON stated she expected staff to implement care planned interventions. She further stated following the plan of care was important to provide appropriate, resident-specific care. In an interview on 05/03/2024 at 5:24 PM, the Administrator stated he was not familiar with R23's skin picking behavior. He further stated he expected staff to implement care planned interventions. Per interview, the Administrator stated if care planned interventions were not effective, he expected staff to let their manager know, so the interdisciplinary team (IDT) could develop new interventions. 45990 3. Review of R11's Admission Record revealed the facility admitted the resident on 05/07/2021 with diagnoses to include type 2 diabetes, essential hypertension (high blood pressure), and atherosclerosis (buildup of plaque in arteries causing obstruction in blood flow). Review of R11's annual MDS, with an ARD of 04/15/2024, revealed the facility assessed the resident to have a score of 10 out of 15 on the BIMS, indicating intact cognition. Review of R11's active orders as of 05/02/2024 revealed no order or referral for podiatry services. Review of R11's Care Plan, last review date 04/18/2024, revealed no focus or interventions for foot health or podiatry services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/30/2024 at 3:50 PM, revealed R11 lying in bed with feet uncovered. Continued observation revealed R11's toenails were long, untrimmed, and thick. In an interview on 05/02/2024 at 2:30 PM, R11 stated at times pain occurred when his toes touched the footboard of the bed. R11 stated his nails probably needed to be worked on, and he could not recall the last time anyone looked at his toenails. In an interview with the child of R11 on 05/02/2024 at 2:20 PM, she stated she asked staff at the nurse's station about one month ago for podiatry to see R11. In an interview with R11's Primary Care Provider (PCP) on 05/03/2024 at 9:18 AM, he stated foot health was important to residents especially if they had a diagnosis of diabetes since that condition could make an infection more complicated. The PCP stated a podiatrist would need to evaluate any nail deformities such as long, crooked, or nails growing at an angle. In an interview with the DON on 05/03/2024 at 4:45 PM, she stated she could not locate a podiatry referral for R11. She stated, due to R11's diagnosis of diabetes, not just anyone could trim R11's toenails. She stated complications could occur if his nails were not trimmed by a professional such as podiatry, and infection would be a concern. During interview with the Administrator on 05/03/2024 at 2:45 PM, he stated his tasks included to oversee operation of the facility including daily operation of all departments, staffing, and maintenance of the facility to assure the needs of the residents were met.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46710 Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide quality care according to the resident's plan of care for 1 of 3 residents sampled for skin care, Resident (R) 23. The findings include: Review of the facility's policy titled, Skin Integrity-Skin Tears, dated 2022, revealed the facility was responsible to intervene to protect residents from self-inflicted injury. Further review revealed facility staff members were responsible to modify the resident's plan of care for resident non-compliance. Review of R23's Admission Record revealed the facility admitted the resident on 04/10/2019. Further review revealed R23's current diagnoses as of 05/01/2024 included peripheral vascular disease, type 2 diabetes, and psychotic disorder with delusions. Review of R23's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/08/2024, revealed the facility assessed R23 as severely cognitively impaired and unable to complete a Brief Interview for Mental Status (BIMS). Further review revealed the facility assessed the resident as free from skin tears during the look-back period. Review of R23's Care Plan, revised 02/05/2024, revealed the facility assessed R23 as having impaired skin integrity to his left upper extremity related to itching. Further review revealed the care plan included interventions such as keeping the resident's fingernails short, and keeping Geri-sleeves (soft, flexible sleeves used to protect skin on the limbs from friction and shear) on R23's arms. Observation of R23 on 04/30/2024 at 2:18 PM, revealed the resident sitting in bed, picking at a spot on his collarbone with long fingernails. Further observation revealed a brownish red substance with the appearance of old blood under the resident's fingernails. Per observation, the spot on R23's collarbone was bleeding, and there were multiple scabbed-over skin tears on R23's forearms. Continued observation revealed the resident was wearing a short-sleeved shirt with no protective sleeves on his arms. Additional observation on 05/02/2024 at 2:38 PM; and on 05/03/2024 at 9:03 AM, 1:15 PM, 1:53 PM, and 2:14 PM revealed R23's nails remained long and with bloody-appearing material under them. R23's arms were also bare during those observations. In an interview on 05/02/2024 at 2:38 PM, Nurse Aide-State Registered ([NAME]) 9 stated R23 picked at his skin, and the facility care planned for the resident to wear Geri-sleeves. She further stated R23 frequently removed his Geri-sleeves, so staff reapplied them whenever they were in the room for routine care rounds. NASR9 stated R23's nails were long and appeared to have a bloody substance under them. Per interview, NASR9 stated residents' nails were cleaned and trimmed during their showers, so she would let the night shift aide know R23 needed nail care during his next shower, which [NAME] believed was due that night (05/02/2024). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/03/2024 at 2:00 PM, Licensed Practical Nurse (LPN) 6 stated she was aware of R23's skin picking behavior. She further stated she applied hydrocortisone cream and antibiotic ointment to the site on his collarbone and any smaller ones on his forearms as ordered. LPN6 stated NASRs should trim R23's fingernails on his shower days. Per interview, LPN6 stated she did not believe R23 had a history of refusing to have his fingernails trimmed. Additionally, LPN6 stated staff should reapply R23's Geri-sleeves when he took them off and attempt to distract and redirect him to prevent him from picking his skin. In an interview and observation of R23 on 05/03/2024 at 2:14 PM with NASR9 and LPN6, both staff members verbalized that R23's fingernails needed to be trimmed. NASR9 stated she failed to inform the on-coming [NAME] for night shift that R23's fingernails needed to be trimmed, but she checked the shower schedule, and R23's shower was actually due the night of 05/03/2024. In further observation, R23 was not wearing a Geri sleeve on his right arm. NASR9 and LPN6 searched for the sleeve in R23's bed but were unable to locate it and stated they would get another one. In an interview on 05/03/2024 at 2:24 PM, the Unit Manager (UM) stated she had not looked at R23's nails recently, but stated her expectation was for them to be kept short due to R23's skin picking behavior. She further stated her expectation was for NASRs to trim residents' nails on shower days. Per interview, the UM stated she reviewed shower documentation to monitor for resident refusals. However, she stated she did not know of R23 refusing showers or fingernail care. In an interview on 05/03/2024 at 3:59 PM, the Director of Nursing (DON) stated the facility's process for managing a resident who picked his/her skin was to treat the underlying cause if a rash or other medical condition was present. She further stated a common intervention was to use Geri-sleeves to protect the resident's skin, but she was not familiar with the details of R23's care plan, nor the cause of his skin-picking. The DON stated leaving a resident's nails long and dirty when the resident had a history of picking his/her skin was not acceptable practice. In an interview on 05/03/2024 at 5:24 PM, the Administrator stated he was not familiar with R23's skin picking behavior. He further stated he expected staff to implement care planned interventions. Per interview, the Administrator stated if care planned interventions were not effective, he expected staff to let their manager know, so the interdisciplinary team (IDT) could develop new interventions.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45990 Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide podiatry services for foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) for 1 of 5 sampled residents, Resident (R) 11. The findings include: Review of facility policy titled, Podiatry Services, undated, revealed residents received proper treatment and care within professional standards of practice to maintain mobility and good foot health. The policy stated residents requiring foot care who had complicating disease processes would be referred to qualified professionals including a Podiatrist. Continued review revealed foot disorders included nail disorders, and staff should refer any identified foot care needs to the Social Worker or designee. Further review revealed the Social Worker or designee would refer residents' services providing treatment in the facility or making and arranging transportation to obtain needed services. Review of R11's Admission Record revealed the facility admitted the resident on 05/07/2021 with diagnoses to include type 2 diabetes, essential hypertension, and atherosclerosis. Review of R11's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/15/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. Review of R11's active Physician's Orders, as of 05/02/2024 revealed no order or referral to podiatry services. Review of R11's Care Plan, last review date 04/18/2024, revealed no focus or interventions for foot health or podiatry services. Observation on 04/30/2024 at 3:50 PM, revealed R11 lying in bed with feet uncovered. Continued observation revealed R11's toenails were long, untrimmed, and thick. In an interview with R11 on 05/02/2024 at 2:30 PM, he stated at times pain occurred when his toes touched the footboard of the bed. He stated his nails probably needed to be worked on, but he could not recall the last time anyone looked at his toenails. In an interview with R11's daughter on 05/02/2024 at 2:20 PM, she stated she asked about one month ago for podiatry to see R11, adding she could not recall who she spoke to, just someone at the nurse's station. She stated she had just received a phone call from someone at facility, and that person told her R11 was now on the schedule for podiatry. She stated she was unsure if podiatry had seen R11 since admission. In an interview with Nurse Aide-State Registered ([NAME]) 7 on 05/03/2024 at 9:50 AM, she stated R11 did have some redness to one of his left toenail areas a while ago, but it had improved. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Social Worker on 05/02/2024 at 3:15 PM, she stated she was unable to locate a referral to for podiatry services since the facility admitted R11 on 05/07/2021. During an interview with R11's Primary Care Provider (PCP) on 05/03/2024 at 9:18 AM, he stated he was not familiar with R11's care or diagnoses without looking at records. He stated foot health was important to residents, especially if they had a diagnosis of diabetes. He stated diabetes could make an infection more complicated. The PCP stated a podiatrist would need to evaluate any nail deformities such as long, crooked, or growing at an angle. During an interview with the Director of Nursing (DON) on 05/03/2024 at 4:45 PM, she stated she could not locate a podiatry referral for R11. She also stated with R11's diagnosis of diabetes, not just anyone could trim R11's toenails. She stated complications could occur if his toenails were not trimmed by a professional such as podiatry, and infection would be a concern. During an interview with the Administrator on 05/03/2024 at 2:45 PM, he stated his tasks included to oversee operation of the facility including daily operation of all departments, staffing, and maintenance of the facility to assure the needs of the residents were met. He stated there was an auxiliary service company to meet needs of residents at the facility, which included podiatry services. He stated if a resident had any issues concerning care needs, the Social Worker would get a referral; then, she would go through the facility process to set up any appointments the resident might need.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44486 Based on observation, interview, record review, and review of the facility's documents and policy, the facility failed to ensure residents with limited range of motion (ROM) received appropriate treatment and services to increase ROM for 3 of 3 residents sampled for ROM (Resident (R) 1, 37 and 79). Multiple staff interviews revealed the facility currently had no restorative nursing program (RNP). The findings include: Review of the facility's policy titled, Restorative Nursing Programs, undated, revealed it [was] the policy of [the] facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. The RNP [referred] to nursing interventions that [promoted] the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively [focused] on achieving and maintaining optimal physical, mental, and psychosocial functioning. Nursing personnel [were] trained on basic, or maintenance nursing care that [did] not require the use of a qualified therapist or licensed nurse oversight. This training may [have] included, but [was] not limited to: a. maintaining proper positioning and body alignment, b. encouraging and assisting residents, as needed, in turning and position changes, c. encouraging residents to remain active and assisting with any exercises according to the plan of care, d. promoting independence in activities of daily living (ADLs), performing tasks for residents only as needed to ensure completion of tasks, e. assisting residents in adjustment to their disabilities and use of any assistive devices, f. assisting residents with range of motion [ROM] exercises, performing passive ROM for residents who lack active ROM ability, and g. promoting continence with various toileting and/or bowel and bladder training activities. Further review of the facility's policy titled, Restorative Nursing Programs, undated, revealed all residents [would] receive maintenance nursing services as described above, as needed, by certified nursing assistants. The Restorative Nurse and restorative aides (RA) [would] receive additional training on restorative nursing program activities upon hire and as needed. The Restorative Nurse [was] responsible for maintaining a current list of residents who [required] restorative nursing services, and for ensuring that all elements of each resident's program [were] implemented. A resident's Restorative Nursing plan [would] include: a. the problem, need, or strength the restorative tasks are to addressed, b. the type of activities to be performed, c. frequency of activities, d. duration of activities, and e. measurable goal[s] and target date. The discharging therapist, Restorative Nurse, or designated licensed nurse [would] communicate to the appropriate RA, the provisions of the resident's restorative nursing plan, providing any necessary training to carry out the plan. RAs [would] implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Aide Documentation Form. The Restorative Nurse, or designated licensed nurse, [would] provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's document Daily Staffing, dated 05/03/2024, revealed the facility staffed its' four residential units with 13 nurses, and 22 nurse aides ([NAME]) and certified medication aides (KMA). Additionally, the Daily Staffing document indicated two places for Restorative staff names to be added, indicating they were working that day in the facility. However, no names were written on the two blank lines for two Restorative staff members' names. 1. Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2024, revealed the facility assessed R1 to have functional limitation in ROM impairment on both sides of her upper extremities (shoulders, elbows, wrists, hands). Observation on 05/02/2024 at 8:35 AM, revealed R1 was in her bed in her room at the facility. R1's room was dark. Nurse Aide-State Registered ([NAME]) 13 knocked on R1's door, entered the room, and said good morning to R1. During an interview with the Director of Rehabilitation (DOR) on 05/02/2024 at 9:27 AM, she stated R1 was not currently in therapy and was at baseline, with no therapy goals to achieve. 2. Review of R37's quarterly MDS, with an ARD of 02/06/2024, indicated R37 had functional limitation in ROM impairment on one side of her lower extremity (hip, knee, ankle, foot). Observation on 05/02/2024 at 9:31 AM, revealed R37 was in her bed in her room at the facility eating breakfast. During an interview with R37 on 05/01/2024 at 9:57 AM, she stated she did not know what staff was doing to help her with her limited ROM. During continued interview with the DOR on 05/02/2024 at 9:27 AM, she stated R37 was not in therapy, and R37 was last on the therapy caseload in February 2024. The DOR stated therapy worked with R37 on getting out of bed, changing from sitting to standing, lower body dressing, and wheelchair propulsion. The DOR stated when residents were discharged from therapy, nursing was notified. 3. Review of R79's quarterly MDS, with an ARD of 04/16/2024, revealed the facility assessed R79 to have functional limitation in ROM impairment on both sides of her upper extremities (shoulders, elbows, wrists, hands) and in her hips, knees, ankles, and feet. Observation on 05/03/2024 at 9:05 AM, revealed R79 lying on her back in bed in her room at the facility. R79's head was tilted toward her left side. During an interview with NASR11 on 05/02/2024 at 10:32 AM, she stated, We do ROM with ADLs. [The residents] get ROM when we dress them. NASR11 stated, It hurts [R79] to sit up for a long time, and she wants to go back to bed. During an interview with NASR13 on 05/02/2024 at 4:20 PM, she stated she repositioned R79's leg that was contracted with a pillow. NASR13 stated she had tried to use a neck pillow for R79, but when she did, R79 let her know the neck pillow was uncomfortable. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During continued interview with the DOR on 05/02/2024 at 9:27 AM, she stated R79 was not in therapy. The DOR stated she had tried multiple times to get R79's insurance to cover therapy, but they kept denying her coverage because she was at baseline. During an interview with NASR9 on 05/03/2024 at 9:55 AM, she stated she did ROM with residents every time she changed [their brief]. NASR9 stated she would like to have some direction, and it would be helpful to have some guidance on what specific ROM activities to do for each resident. During an interview with NASR3 on 05/03/2024 at 10:30 AM, she stated she recalled at one time the facility had restorative aides (RAs), and those RAs had a list of residents the physical therapy department had referred [to the RNP]. She stated the RAs would do ROM activities and put residents' braces on them. NASR3 stated, We had one aide who would do restorative all the time, and I missed them. NASR3 stated she did not know what had happened to the RA, and the program kind of disappeared. NASR3 stated the facility did not really tell us we had to do restorative, but [the residents] need it, so we do it. NASR3 stated she had not received any specific training on restorative, but I just know [how to do restorative care with residents], and we do what we think we need to do for certain residents. NASR3 stated if she were new to the facility, she would not know how to do restorative care for each resident and she would like to have pictures or diagrams that showed what we should be doing for each resident. During an interview with the Assistant Director of Nursing on 05/02/2024 at 3:24 PM, she stated, At this time restorative is only done with ADLs, and we are hoping to get our restorative program back. During an interview with the Regional Nurse Consultant on 05/02/2024 at 10:45 AM, she stated the facility, since COVID, had not been able to start the RNP again, and ROM was done with donning (putting on) and doffing (taking off) of residents' clothing and other ADLs. During an interview with the Director of Nursing (DON) on 05/03/2024 at 5:45 PM, she stated the facility had a RNP at the facility before she became DON, and she RNP being at the facility was dependent on whether they could get the needed staff. The DON stated the RNP was important to prevent residents from getting contractures and to prevent a decline in residents' ROM abilities. During an interview with the Administrator on 05/03/2024 at 2:14 PM, he stated they have the FTE [full-time equivalent] for a restorative aide. He stated a wage increase had been put through, but the facility currently did not have the staff for an RNP.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46710 Based on observation, interview, record review, and review of the facility's policy, the facility failed to prevent complications of enteral feeding for 1 of 3 residents sampled for tube feeding care, Resident (R) 100. Observation on 05/02/2024 revealed the nurse failed to apply a bacterial ointment to R100's infected gastric tube insertion site as ordered by the physician. The findings include: Review of the facility's policy titled, Care and Treatment of Feeding Tubes, dated 2023, revealed the facility was to implement interventions to prevent complications of enteral feedings, including cleaning of the insertion site to prevent or resolve skin irritation and local infection. Review of R100's Admission Record revealed the facility admitted the resident on 07/29/2023 with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke), dysphagia (impaired swallowing), and dysarthria (impaired speech caused by weak muscles). Review of R100's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2024, revealed the resident was unable to complete a Brief Interview for Mental Status (BIMS). Facility staff assessed R100's mental status as severely impaired. Further review revealed R100 received greater than 51 percent of her caloric intake via her feeding tube. Review of R100's Care Plan, dated 05/19/2023, revealed R100 was totally dependent on tube feedings. Per review, the facility included interventions for staff to provide care to the gastric tube site per physician's orders and to monitor for signs and symptoms of infection. Review of the facility's document Order Summary Report for R100 revealed, on 10/31/2023, the physician ordered, Wash g-tube site with soap and water daily. Allow to air dry. Apply betadine and split gauze every day and night shift for infection control. Further review revealed the physician ordered Muciprocin (an antibiotic ointment) external ointment 2%, applied topically to g-tube site every day and night shift for infection control. Continued review revealed the physician ordered amoxicillin-pot clavulanate tablet 875-175 milligrams (mg) to be administered via g-tube for g-tube site infection two times per day for seven days, beginning 04/29/2024. Review of the facility's document Health Status Note, dated 04/25/2024, revealed nursing staff identified R100's gastric tube site had thick purulent (full of pus) drainage and a foul odor. Further review revealed nursing staff collected a sample of the drainage for testing. Review of the facility's document Health Status Note, dated 04/29/2024, revealed the testing results of the drainage from R100's gastric tube site revealed heavy bacterial growth. Further review revealed the physician ordered an oral antibiotic to treat the infection. In an attempted interview on 05/02/2024 at 9:07 AM, R100 was not interviewable. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/02/2024 at 9:16 AM, revealed R100's tube feeding site was reddened, and there was a small amount of tan drainage from the site. In further observation, Licensed Practical Nurse (LPN) 5 performed gastric tube site care for R100 by cleaning the site with tap water and soap. Per observation, LPN5 then rinsed the site with sterile water and dried with a clean gauze. In continued observation, LPN5 placed a spilt gauze around the site and pulled the resident's shirt down over the site to discourage the resident from picking at the site. Per observation, LPN5 failed to apply betadine and antibiotic ointment as ordered. In an immediate interview, LPN5 stated the technique she had demonstrated was how she performed site care for all residents with gastric tubes. She further stated she would have used different materials and applied an antibiotic ointment if the physician ordered it. However, she stated she was unaware of the specific orders for R100. In an interview on 05/03/2024 at 9:33 AM, R100's primary care physician (PCP) stated he expected staff to follow facility policy and physician's orders for gastric tube site care, to include application of an antibiotic ointment as indicated. He further stated he did not recall specifics about R100's gastric tube site. In an interview on 05/03/2024 at 2:24 PM, the Unit Manager (UM) stated her expectations were for staff to follow physician's orders when providing site care to a resident's gastric tube site. In further interview, the UM stated she was aware R100 had a gastric tube site infection, the facility had collected a bacterial culture, and staff was treating the infection with oral and topical antibiotics. In an interview on 05/03/2024 at 3:59 PM, the Director of Nursing (DON) stated her expectations were for staff to follow physician's orders when providing site care to a resident's gastric tube site. She further stated she had not conducted a root cause analysis (RCA) of R100's gastric tube site infection, nor had she observed staff performing site care. In an interview on 05/03/2024 at 5:24 PM, the Administrator stated his expectations were for staff to follow proper infection control practices and physician's orders when providing site care to a resident's gastric tube site. He further stated he expected the interdisciplinary team (IDT) to conduct an RCA into the cause of any gastric tube site infection, but he did not see evidence of an RCA in the IDT notes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, review of the Centers for Disease Control and Prevention's (CDC) document, review of medication package inserts, and review of the facility's policy, it was determined the facility failed to ensure drugs, biologicals, and vaccines were stored per currently accepted professional principles and failed to ensure appropriate environmental controls were used to preserve their integrity. This deficient practice was found in three of four medication storage rooms. Observations of the facility's treatment carts revealed improper storage of medications was found in three of four treatment carts affecting nine residents, Resident (R) 30, R31, R34, R37, R43, R46, R58, R68, and R94. Observation of the Lakeview and Sterling Units' medication refrigerators revealed one influenza vaccine was improperly stored in the door of the medication refrigerators. Observation of the Sterling Unit's medication refrigerator revealed the medication refrigerator's temperature was not maintained between 36 and 46 degrees Fahrenheit (F). The temperature of the refrigerator was at 50 degrees F. Observation of the Lakeview Unit's medication cart revealed multiple boxes of medication for R43 were remained in the cart after the resident was discharged . Observation of the Bluegrass Unit's medication storage room revealed the medication cart was unlocked and the room was unattended. Observation of the Lakeview Unit revealed nursing staff kept the keys to the Medication Room and the refrigerator, which held the controlled substance lock box, in a drawer at the nurse's station. The nursing station was unattended. Observation of the Sterling Unit's Verification of Controlled Substances Count sheets revealed the medication nurse did not sign the sheet at the beginning of the 7:00 AM shift. Observation of the Lakeview, Sterling, and Wisteria Units' treatment carts revealed staff failed to date, discard, and store medications and insulin according to professional standards and in a sanitary manner. The findings include: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Centers for Disease Control and Prevention's (CDC) document, Vaccine Storage and Handling, updated 09/29/2021, revealed vaccines exposed to storage temperatures outside the recommended ranges might have decreased efficacy (result), creating limited protection. Per the document, vaccine temperatures should be monitored and documented at least twice daily if the refrigerator did not have a temperature monitoring device, which read minimum and maximum temperatures. Further review revealed best practices for storage of vaccines was to ensure that vaccines were not stored on the top shelf, floor, or door of the refrigerator as the temperature in these areas might differ significantly from the temperature in the body of the unit. Review of the facility's policy titled, Storage of Medications, no date, revealed drugs and biologicals were stored safely, following manufacturer's recommendations. Further review revealed the medication supply was accessible only to licensed nursing personal and staff members lawfully authorized to administer medications. Medications requiring refrigeration would be stored in a refrigerator in the medication room. Per the policy, outdated, contaminated, or deteriorated (cracked, soiled, or without closers) medications were removed from stock. Furthermore, nursing staff was responsible for maintaining medication storage. In addition, the policy stated compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals were locked when not in use. Per the policy, medication storage conditions were monitored monthly. Review of the facility's policy titled, LTC Facility's Pharmacy Services and Procedures Manual, revised 01/01/2022, revealed the facility should maintain separate individual controlled substance records on all Schedule II medications and any medication with the potential for abuse or diversion. The policy stated the full form of declining inventory, using the controlled substance declining inventory record, should include the resident name, prescription number, medication name, strength, dosage form, dosage with total quantity received, the date and time of administration, the quantity remaining, and the name/signature of the person administering the medication. Per the policy, the facility should ensure the incoming and outgoing nurses counted all Schedule II controlled substances and any other medications with the risk of abuse or diversion at the change of each shift or at least once daily. The policy stated, after the count, the nurses should document the results on the controlled substance account verification sheet. Review of Drugs.com product insert (https://www.drugs.com/) for insulin glargine and insulin lispro, revealed opened (in-use) vials and injection pens, stored at room temperature, should be discarded after 28 days. Review of Drugs.com product insert (https://www.drugs.com/) for Levemir revealed opened (in-use) vials and injection pens, stored at room temperature, should be discarded after 42 days. 1. a. Observation of the Lakeview Unit's medication refrigerator on 04/30/2024 at 9:48 AM, revealed one vial of unopened influenza vaccine was stored improperly in the door of the medication refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Kentucky Medication Aide (KMA) 1 on 04/30/2024 at 9:48 AM, she stated she was unaware staff should not store medications and vaccines in the refrigerator door. She stated the facility provided education on medication storage upon hire, which included checking for expiration dates, dating medications when opened, and discarding any expired medication. She stated the nurse or KMA on the medication cart was responsible to check for expired medications and discard. She stated nursing staff should check the refrigerator to ensure medications were stored properly. KMA1 stated it was important to store medication according to the insert to ensure they remained effective and for the safety of the resident. b. Observation of the Sterling Unit's medication refrigerator on 05/02/2024 at 8:20 AM and 05/02/2024 at 3:15 PM, revealed one vial of unopened influenza vaccine was stored improperly in the door of the medication refrigerator. During an interview with Licensed Practical Nurse (LPN) 5 on 05/02/2024 at 8:25 AM, she stated she was unaware staff should not store medications and vaccines in the refrigerator door. She stated the facility provided education on medication storage upon hire, which included checking for expiration dates, dating medications when opened, and discarding any expired medication. LPN5 stated, if medications were not stored properly, they might not work. 2. Observation of the Sterling Unit's medication refrigerator on 05/02/2024 at 3:15 PM, revealed the temperature inside the refrigerator was 50 degrees F. During an interview with LPN2 on 04/30/2024 at 3:30 PM, she stated the freezer compartment had accumulated ice, and she had turned the temperature up to a higher degree to defrost the freezer. She stated she did not think to move the medications to another refrigerator. LPN2 stated the night shift maintained the temperature log for the refrigerator. She stated that temperatures needed to be checked once daily and should be around 40 degrees F. LPN2 stated the nurse or KMA assigned to the medication carts was responsible for maintaining the cart and the refrigerator. She stated she was not aware of routine medication cart or refrigerator audits. She stated monitoring refrigerators was important to ensure residents' safety. During an interview with LPN1 on 04/30/2024 at 9:38 AM, she stated there was no set time for checking the refrigerator temperatures, but it needed to be done every day on night shift. She stated the temperature should be around 40 degrees F. During continued interview with KMA1 on 04/30/2024 at 9:48 AM, she stated medication refrigerators were checked once daily on night shift. She stated she was unsure of the appropriate temperature range for medication and vaccine storage. She stated it was important to store medications and vaccines at the correct temperature range to maintain their effectiveness. During continued interview with LPN5 on 05/02/2024 at 8:25 AM, she revealed medication refrigerator temperatures were monitored twice daily by the nurse or KMA responsible for the medication cart. LPN5 stated medications must be stored at the proper temperature to ensure their effectiveness. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observation of the Lakeview Unit's medication cart on 04/30/2024 at 8:20 AM, revealed multiple boxes of medication for R43 remained in the cart after the resident had been discharged . The discontinued medications included one box of Vitamin C 500 milligrams (mg), one box of Vitamin D 5000 units (u), one box of loratadine (an antihistamine) 10 mg, one box of omeprazole (a proton pump inhibitor given for heartburn) 40 mg, one box of magnesium 400 mg, one box of potassium 10 milliequivalents, one box of baclofen (a muscle relaxant) 5 mg, one box of Jardiance (a hypoglycemic) 10 mg, and one box of senna (a laxative) 8.6 mg. During an interview with KMA1 on 04/30/2024 at 8:20 AM, she stated R43 was discharged from the hospital on 04/26/2024 and returned to the facility on [DATE] with new medication orders. She stated the facility's policy stated medication for a resident discharged to a hospital should be held for 48 hours. KMA1 stated according to the facility policy, R43's medication should have been taken from the medication cart on 04/29/2024 and sent back to the pharmacy when R43 did not return to the facility within 48 hours. 4. a. Observation of the Bluegrass Unit's medication storage room on 04/30/2024 at 9:40 AM, revealed the medication cart was unlocked, and the room was unattended. During an interview with LPN1 on 04/30/2024 at 9:40 AM, she stated she forgot to lock the cart when she left the medication storage room. She stated medication carts were to be locked when not attended. b. Observation of the Lakeview Unit's medication storage room on 05/02/2024 at 2:30 PM, revealed when KMA4 was searching for the key to the medication refrigerator, which stored the refrigerated narcotic lock box, KMA4 found the keys stored in the top drawer of the desk at the nurse's station. The nurse's station was unattended at the time. Further observation revealed the key to the medication storage room and the key to the refrigerator were on the keychain, allowing anyone possessing the keys to enter the medication storage room, unlock the refrigerator, and access the narcotic box. During an interview with KMA4 on 05/02/2024 at 2:30 PM, she stated the medication cart should be locked inside the medication room, and the nurse or KMA in charge of the medication cart should have access to the keys. She stated this was important to prevent unauthorized staff in the medication rooms. During an interview with LPN5 on 05/02/2024 at 8:20 AM, she stated the medication cart should be locked inside the medication room, and the nurse or KMA in charge of the medication cart should be responsible for the keys to prevent access to medication storage. During an interview with LPN10 on 05/03/2024 at 1:15 PM, she stated the nurse in charge of the medication cart should lock it when it was unattended or while it was stored inside the medication room. She further stated the nurse or KMA in charge of the medication cart should be responsible for the keys to prevent unauthorized access to medication storage. 5. Observation of the narcotic count sheets for both Sterling Unit's medication carts on 05/03/2024 at 9:45 AM, revealed the medication day shift nurse did not sign the Verification of Controlled Substances Count sheet at the beginning of the 7:00 AM shift. Further review revealed there was no verification of the number of controlled substance cards on either cart. Observation of the narcotic count revealed the count was correct. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with LPN11 on 05/03/2024 at 9:45 AM, she stated that it was the facility's policy to sign the controlled drug count record at every shift change to verify that all controlled drugs had been counted and reconciled with the quantity on hand. She stated she did the count with the night shift nurse at shift change but failed to document it on the control sheets. She emphasized the importance of following the facility's policy to ensure the proper reconciliation of controlled narcotics. 6. a. Observation of the Lakeview Unit's treatment cart on 05/03/2024 at 2:40 PM, revealed R43's insulin was not stored in the original packaging received from the pharmacy or in a manner to prevent cross contamination from contact with other pens, medications, or supplies. Furthermore, nursing staff failed to date opened insulin and discard according to product instructions. One vial of R43's Novolog 100 units/milliliter was observed with no opened date. The top of the original packaging was torn off exposing the insulin to light. During an interview with LPN2 on 05/03/2024 at 2:55 PM, she stated all medications should be dated when opened. She stated insulin should be placed in its original packaging to protect the solution from light, and medication that had expired should be discarded appropriately. She stated she was not sure when insulin pens should be discarded after opening. She stated medications should be stored in a manner to prevent cross contamination. b. Observations of the Wisteria Unit's treatment cart on 05/03/2024 at 3:05 PM, revealed multiple residents' insulin pens were not stored in the original packaging received from the pharmacy or in a manner to prevent cross contamination from contact with other pens, medications, or supplies. Furthermore, nursing staff failed to date insulin pens and discard according to product instructions. Observations included: 1) R34's Basaglar (insulin glargine) kwik pen was not stored in its original packaging and was undated; 2) two of R46's Humalog 100 unit insulin pens were not in their original packaging and had opened dates of 04/12 and 04/27 without the year; 3) R58's Humalog 100 unit insulin, dated 04/15, and insulin glargine, dated 04/12, were not in their original packaging; 4) R37's Levemir insulin 100 unit flex pen was not in its original packaging and not dated; 5) R30's Lispro insulin 100 unit pen was not in its original packaging; and 6) R68's Lispro insulin 100 unit pen was not in its original packaging. During an interview with LPN9 on 05/03/2024 at 3:05 PM, she stated all medication should be dated when opened. She stated insulin should be placed in its original packaging to protect the solution from light, and medication that had expired should be discarded appropriately. She stated she was not sure when insulin pens or vials should be discarded after opening but thought it was around 28 days. She stated medications should be stored in a manner to prevent cross contamination. LPN9 stated proper medication storage was important for the safety of the residents and staff. c. Observations of the Sterling Unit's treatment cart on 05/03/2024 at 3:45 PM, revealed: 1) one bag of albuterol inhaler was opened without a date. The remaining 10 vials were unprotected from light, and there was no resident's name on the packaging; 2) one opened bottle of hydrogen peroxide with no opened date; 3) one opened bottle of hydrogen peroxide with an opened date of 12/20; 4) R94's insulin Lispro 100 unit pen was not in the original packaging, and two vials of R94's insulin glargine were opened. One had an opened date of 03/20, and the other was dated 04/27. Both were outside their packaging, which protected them from light; and 5) one package of R31's ipratropium albuterol 3 milliliter vials was opened, with no date, exposing the vials to light. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Windsor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Sterling Way Mount Sterling, KY 40353	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with LPN5 on 05/03/2024 at 3:45 PM, she stated, per the facility's policy, medication should be stored in its original packaging, and all medication should be dated when opened. If the medication had expired or was past its opened date, she stated, it should be discarded. She stated she was not sure when insulin pens should be discarded after opening. She stated medications should be stored in a manner to prevent cross contamination. She stated following policy was important for the safety of the residents. During an interview with the facility's Pharmacist on 05/03/2024 at 4:53 PM, she stated controlled substances sheets were audited by the Pharmacy to ensure staff was reconciling controlled medication. She stated she had experienced no issues with the facility's audits. She further stated medication and vaccines should be stored according to manufacturer's instructions to protect the safety of the residents. She stated most insulin pens were good for 28 days after opening. She stated most pens and vials should be discarded 28 days after opening. During an interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 05/03/2024 at 11:00 AM, she stated vaccines were stored in one refrigerator in the Lakeview Unit's medication storage room. She stated she was unaware there was influenza vaccine in the refrigerator in the Sterling Unit's medication room. She stated all medication should be stored according to accepted standards, and expired medication should be discarded appropriately. The ADON/IP stated Unit Managers (UM) were responsible for auditing medication storage. She stated it was done routinely, but she did not have documentation of any audits. She stated it was important for the safety of the residents. During an interview with the Director of Nursing (DON) on 05/03/2024 at 11:25 AM, she stated she expected the nurses to discard expired medications. She stated nursing staff was educated on medication administration and storage during their orientation upon hire. She stated it was her expectation that medications and vaccines were stored according to currently accepted professional standards and under the appropriate environmental controls to protect the efficacy of the medication and vaccines for the safety of the residents. Furthermore, the DON stated it was her expectation the nursing staff and KMAs followed the facility's policy regarding documentation of controlled medication counts. She stated medication carts should be locked when unattended to prevent unauthorized access to medications. During an interview with the Administrator on 05/03/2024 at 2:22 PM, he stated everyone must follow the facility's policies. He stated it was important for the safety of residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32635 Based on observation, interview, and review of the facility's policy, the facility failed to store food under sanitary conditions for three of four nourishment unit refrigerators as determined by observations during survey of ice packs stored in two unit nourishment freezers, and one unit nourishment refrigerator with no thermometer, and no temperature log for April 2024. The findings include: Review of the facility's policy titled, Monitoring of Cooler/Freezer Temperature, dated 2024, revealed logs for recording temperatures for each refrigerator or freezer would be posted in a visible location outside the freezer or refrigerator unit. Further review revealed temperatures would be checked and logged at least twice per day by designated personnel, and thermometers shall be placed inside each cooler/freezer and calibrated at least once per week. Continued review revealed all refrigerator storage must be maintained at or below 41 degrees Fahrenheit (F), and all frozen storage must be maintained at or below -4 degrees F. Observation of the Sterling Unit nourishment refrigerator on 04/30/2024 at 11:46 AM, revealed six ice packs located in the freezer door. Observation of the Lakeview Unit nourishment refrigerator on 04/30/2024 at 11:56 AM, revealed no temperature log and no thermometer for the month of April 2024. Observation of the Bluegrass Unit nourishment refrigerator on 04/30/2024 at 12:56 PM, revealed five ice packs located in the freezer door. In an interview with Licensed Practical Nurse (LPN) 10 on 05/03/2024 at 1:13 PM, she stated it was important to check the refrigerator temperatures to know if the food was stored at an appropriate temperature. She further stated the ice packs stored in the freezer presented a potential for cross contamination, and the ice packs should be stored in the medication storage room. In an interview with LPN8 on 05/03/2024 at 1:37 PM, she stated the AM or PM nurse checked the nourishment refrigerator. She further stated the therapy department stored ice packs in the nourishment freezer to use with residents in rehabilitation. In an interview with the Director of Rehabilitation on 05/03/2024 at 1:44 PM, she stated nursing used ice packs for residents, and therapy had not used ice packs in about two years. She further stated there was potential for cross contamination when stored in the nourishment refrigerator. In an interview with the Director of Nursing (DON) on 05/03/2024 at 3:55 PM, she stated there should be a thermometer and a temperature log to record temperatures. She further stated the ice packs should not be stored in the nourishment freezer with food items due to cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Administrator on 05/03/2024 at 4:41 PM, he stated his expectation was for the nourishment refrigerators to be used to keep food cold. He further stated the ice packs should not be stored in the unit nourishment refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, review of the manufacturers' directions for use for the glucometer (blood glucose monitoring device) and disinfectant wipes, and review of the facility's policies, the facility failed to identify and correct problems related to infection prevention practices for 5 out of 57 sampled residents, Resident (R) 31, R37, R43, R49, and R318. Three additional observations of the Bluegrass Unit (BGU) revealed violations of infection control standards. 1. Observation of R37 and R43 revealed staff failed to clean the glucometer (shared equipment) before and after use according to the Environmental Protection Agency (EPA) registered disinfectant manufacturer's instructions. In addition, for both residents, appropriate hand hygiene was not performed. 2. Observation of R318 and R31 revealed staff failed to clean and disinfect a mechanical lift (shared equipment) after use on the residents. 3. Observation on R49 during medication administration revealed the resident was given a medication that had contact with the medication cart surface and the staff's bare hands. 4. Observation of the BGU's portable vital sign machine (shared equipment) revealed it was visibly dirty on the base and the screen. 5. Observation of the BGU's clean linen storage room revealed the facility did not properly store residents' briefs and supplies off the floor in a sanitary manner. 6. Observation of the BGU's medication cart revealed staff did not dispose of disinfecting wipes when they expired. The findings include: Review of the CDC's Guidelines, provided by the facility, titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated [DATE], revealed that reusable or shared medical equipment should be cleaned and disinfected according to manufacturer's instructions or the facility's policies before use on another patient. The guidelines stated facilities were to adhere to the manufacturer's instructions for reprocessing. The guidelines stated facilities should maintain separation between clean and soiled equipment to prevent cross-contamination. Further review of the guidelines revealed staff should be trained in the correct steps for cleaning and disinfection of shared equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Routine Cleaning and Disinfection, dated 2023, revealed the purpose of the policy was to ensure routine cleaning and disinfection to provide a safe environment to prevent the development and transmission of infections. Per the policy, routine surface cleaning and disinfection according to manufacturer's recommendations would be conducted with a detailed focus on visibly soiled surfaces. Additionally, staff should adhere to standard precautions when cleaning any soiled material that had the potential to contain a contaminated substance, to include hand hygiene. Review of the facility's policy titled, Glucometer Disinfection, dated 2023, revealed the purpose of the procedure was to provide guidelines for the disinfection of blood glucose sampling devices to prevent transmission of bloodborne diseases to residents and employees. Per the policy, the facility would ensure blood glucometers would be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. The policy stated the glucometer would be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that was effective against HIV Hepatitis C and Hepatitis B virus. Review of the cleaning and disinfecting instructions for the Assure Prism Blood Glucose Monitoring System, no date, revealed to minimize the risk of transmitting bloodborne pathogens, the exterior of the glucometer should be cleaned of all dirt, blood, and bodily fluids before performing the disinfection procedure, which would prevent the transmission of bloodborne pathogens. Per the instructions, the exterior of the glucometer should remain wet for the appropriate contact time according to the disinfectant's instructions. Review of the cleaning and disinfecting instructions for the MicroDot Bleach Wipes, undated, revealed to preclean prior to disinfecting the surface. Further review revealed the user was to unfold a clean wipe to thoroughly wet the surface and allow the treated surface to remain wet for a full three minutes to ensure complete disinfection of all pathogens, and then allow the treated surface to air dry. Review of the cleaning and disinfecting instructions for the Sani-Cloth Germicidal Disposable Wipe, undated, revealed to clean and disinfect non-porous surfaces, the user would use one or more wipes as necessary to wet surfaces sufficiently and clean the surface. Further review revealed the user was to unfold a clean wipe to thoroughly wet the surface and allow the treated surface to remain wet for a full two minutes to ensure complete disinfection of all pathogens, and then allow the treated surface to air dry. Review of the cleaning and disinfecting instructions for the One Step Cleaner and Disinfecting Wipe, undated, revealed the item must stay wet for the required one minute dwell time and then air dry to achieve disinfection. (continued on next page)

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Windsor Care Center	125 Sterling Way Mount Sterling, KY 40353

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. a. Observation of Licensed Practical Nurse (LPN) 3 on [DATE] at 8:35 AM, revealed LPN3 performed blood glucose monitoring on R37. The glucometer was stored in a plastic container with other residents' glucose injector pens (not inside the original packaging from the pharmacy), lancets, and test strips. LPN3 did not disinfect the glucometer prior to use and placed it on the treatment cart without a barrier. She took her supplies into R37's room, placing the glucometer and supplies on the bedside table without a barrier. After performing the fingerstick, she put the contaminated glucometer back on the bedside table. LPN3 did not perform hand hygiene (HH) upon leaving the room. She then placed the contaminated glucometer on top of paperwork on the cart and without performing HH, she donned (put on) a new pair of gloves. Using a MicroDot bleach wipe, LPN3 wiped the glucometer, placed it again on the paperwork to dry. She did not wrap the glucometer to stay wet for the required 3 minute dwell time. During an interview with LPN3 on [DATE] at 8:55 AM, she stated she received infection control training upon hire to include hand hygiene (HH), use of personal protective equipment (PPE), and transmission-based precautions (TBP). She stated the facility educated staff regarding infection prevention and control practices (IPCP) annually and during frequent in-service trainings. LPN3 stated staff should use HH before and after resident care and after removing PPE, including gloves. She stated staff should wash hands with soap and water if they came in contact with bodily fluid. Furthermore, LPN3 stated staff should remind each other of IPCP if they saw another co-worker breach protocols or fail to perform hand hygiene. In continued interview with LPN3 on [DATE] at 8:55 AM, LPN3 stated she did not know the dwell time for the MicroDot Bleach Wipes. She stated she thought the dwell time was the same as the dry time. She stated she used two glucometers so that one could dry while the other glucometer was being used. She stated she cleaned the glucometer before and after each use using one wipe and allowed it to dry thoroughly. LPN3 stated all nurses who performed blood glucose monitoring (BGM) received training and had to pass a return demonstration competency given by the Assistant Director of Nursing/Infection Preventionist (ADON/IP). b. Observation of LPN5 on [DATE] at 4:15 PM, revealed LPN5 performed blood glucose monitoring on R43. LPN5 took R43's supplies into her room, placing the glucometer and supplies directly on top of R43's bedside table. After performing the fingerstick, LPN5 put the contaminated glucometer back on R43's bedside table. She doffed (took off) her gloves but did not perform HH upon leaving the room. She placed the contaminated glucometer on a tissue barrier on the treatment cart. She performed HH and donned gloves. Using a One Step Cleaner and Disinfecting Wipe, LPN5 wiped the glucometer and placed it on the same tissue to dry. During an interview with LPN5 on [DATE] at 4:28 PM, she stated the facility educated staff regarding IPCP upon hire and annually. LPN5 stated that staff should perform HH before and after resident care and after removing PPE. She stated HH should be performed after removing gloves. Continued interview revealed LPN5 stated the dwell time for One Step Cleaner and Disinfecting Wipes was round about two minutes. She stated she thought the dwell time was the time it took for the glucometer to dry. LPN5 stated she received blood glucose monitoring (BGM) training from the ADON/IP. 2. a. Observation of Nurse Aide-State Registered ([NAME]) 1 on [DATE] at 9:15 AM, revealed the [NAME] removed a mechanical lift out of R318's room. She took it down the hall and stored it in the Library at the end of the BGU. NASR1 did not clean and disinfect the lift after use on R318. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with NASR1 on [DATE] at 9:24 AM, she stated that the mechanical lift should be cleaned and disinfected after each use and before being stored. She stated the lift was cleaned prior to using it on R318. She stated she was going to clean the lift before using it on the next resident. However, she stated she should have cleaned it immediately before storing it in a public area. NASR1 stated it was important to clean and disinfect shared equipment to prevent the spread of disease. During an interview with NASR4 on [DATE] at 10:01 AM, she stated she received IPCP training upon hire and during monthly in-services. She stated all shared equipment was cleaned after each use. She stated staff cleaned mechanical lifts and portable vital sign equipment between residents to prevent cross-contamination. b. Observation on [DATE] at 4:30 PM revealed NASR9 failed to disinfect the mechanical lift after use with R31, placing the lift in the hallway and entering another resident's room. In an interview with NASR9 on [DATE] at 4:39 PM, she stated she should have disinfected the lift before beginning another resident's care task because another staff member could have used the lift, not realizing it was not clean. She further stated this would have created a risk for cross contamination. 3. a. Observation on the BGU of the Clean Linen storage room on [DATE] at 9:30 AM, revealed residents' supplies including shampoo, lotions, and two briefs, were on the floor and not stored on the shelves. There was also one large bottle of perineal-care wash and one large bottle of body wash stored directly on the floor with visible dust and dirt on it. b. Observation on the BGU on [DATE] at 9:40 AM, revealed the portable vital sign machine in the nurses' station had visible dust and dirt on the base. The screen was covered with multiple fingerprints. During an interview with LPN1 on [DATE] at 9:48 AM, she stated shared equipment should be cleaned between residents. She stated this included lifts and vital sign equipment. She stated she received infection control training upon hire to include HH and the use of PPE. She stated all staff was trained in IPCP upon hire and periodically throughout the year. LPN1 stated all supplies should be kept off the floor and placed on shelves to prevent cross contamination. During an interview with LPN10 on [DATE] at 11:25 AM, she stated shared equipment should be cleaned and disinfected after each use. She stated staff should store all supplies off the floor to prevent contamination. During an interview with the ADON/IP on [DATE] at 9:00 AM, she stated nursing staff ensured supplies and equipment were cleaned and stored correctly according to the facility's policy. The ADON/IP stated staff cleaned mechanical lifts and portable vital sign machines with disinfecting wipes between residents. She stated nursing leadership did daily rounds and looked for any infection control issues. She stated, if an issue was identified, it was brought to the attention of staff, and if necessary, in-service training was provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation of the BGU Medication Storage room on [DATE] at 9:38 AM, revealed a container of Jantex Disinfecting Alcohol Wipes (75%) on top of the medication cart, which had an expiration date of ,d+[DATE]. During an interview with LPN1 on [DATE] at 9:48 AM, she stated she used the wipes to clean the glucometers. She was unsure if the 75% alcohol solution was the appropriate product to use for cleaning and disinfecting of glucometers. She stated further that expired products should be discarded to ensure the effectiveness of the product. During an interview with the ADON/IP on [DATE] at 10:55 AM, she stated expired products should be discarded when expired. She stated nursing staff was responsible for checking the medication carts daily to ensure there were no expired supplies. She also stated it was important to check the expiration dates to ensure the product's efficacy to prevent the spread of infection and disease. 5. Observation of Kentucky Medication Aide (KMA) 2 on [DATE] at 11:35 AM, revealed she was preparing to give a medication to R49. The medication was Gabapentin (given for nerve pain) 100 milligrams oral, to be given whole with a glass of water. Per the observation, KMA2 placed the capsule in a medication cup, which turned the medication cup over, and the capsule landed on the surface of the medication cart. KMA2 picked up the capsule with bare hands and placed it back in the medication cup prior to administering it. During an interview with with KMA 2 on [DATE] at 11:40 AM, after medication administration, she stated she should not have touched the medication with bare hands, adding it could cause contamination, and she knew better. During an interview with the ADON/IP on [DATE] at 11:05 AM, she stated the facility followed CDC guidelines and recommendations related to infection control. She stated, in addition to having the role of IP, she was also the ADON. She stated while she did not keep documentation, she, and nursing leadership (Unit Managers (UM)) monitored staff nurses to ensure they were following the facility's policy and at a minimum, standard precautions. She stated alcohol wipes were not used to clean and disinfect glucometers. She stated nurses should use the MicroDot Bleach Wipes or Sani Wipes according to the manufacturer's instructions. She stated it was her expectation that all staff followed the facility's infection control policies and procedures. The IP/ADON stated it was important to prevent the spread of infection. During an interview with the Director of Nursing (DON) on [DATE] at 11:25 AM, she stated the facility followed IPCP guidelines as per the CDC. She stated she reviewed infection surveillance reports and assisted the ADON/IP and UMs in maintaining a safe environment for the staff and residents. Furthermore, the DON stated she expected all staff members to be responsible for infection control and follow the facility's infection control policies and procedures. She stated having an infection control and prevention program was essential to prevent the spread of infectious and communicable diseases. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on [DATE] at approximately 4:00 PM, he stated infection prevention and control education was provided upon hire for all staff, and it was based on job duties. He stated the facility followed the CDC's recommendations and guidelines related to IPCP, HH, and TBPs. The Administrator stated it was his expectation that all staff followed the CDC guidelines and facility policies. Additionally, the Administrator stated everyone was responsible for infection control and providing a safe environment for the residents and staff. During an interview with the Medical Director on [DATE] at 11:29 AM, she stated it was her expectation that the facility followed infection control guidelines and policies to prevent the spread of infection and to ensure the safety of residents and staff. 45990 46710

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44001 Based on interview, record review, review of the Centers for Medicaid and Medicare Services (CMS) document, and review of the facility's policy, the facility failed to maintain documentation of screening, education, offering, and current COVID-19 vaccination status for 2 of 3 sampled staff, Kentucky Medication Aide (KMA) 3, and Dietary Aide (DA) 1. This failure placed the residents and staff at increased risk for communicable diseases and healthcare-associated infections (HAI). The findings include: Review of the CMS's Center for Clinical Standards and Quality/Quality, Safety & Oversight Group's QSO-21-19-NH Memo, dated 05/01/2021, revealed Long-term Care facilities (LTC) must offer staff vaccination against COVID-19 when vaccine supplies were available to the facility. LTC's must screen staff prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine whether they were appropriate candidates for vaccination. Per the guidance, the vaccine might be offered and provided directly by the LTC facility or indirectly, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity. Review of the facility's policy titled, Covid-19 Vaccination, (COVID-19) - Vaccination of Staff, copyright 2023, revealed the facility would educate staff about the benefits, risks, and potential side effects of the COVID-19 vaccine and encourage staff to obtain the COVID-19 vaccination. The facility should retain education and vaccine status in the employee's medical file. 1. Review of DA1's employee file revealed no documented evidence noting the DA had received the COVID-19 vaccination or that it was offered to the employee. Additionally, there was no documentation that education regarding the benefits, risks, and potential side effects of the vaccine was provided to the employee. Review of the facility's New Hire Checklist, dated 04/05/2024 revealed a supervisor wrote refused all vaccinations for DA1 on the line for proof of a COVID-19 vaccination card. DA1 was unavailable for interview. 2. Review of KMA3's employee file revealed no documented evidence the facility had provided the KMA with education regarding the benefits, risks, and potential side effects of the vaccine. Per the file, KMA3 requested an exemption for the COVID-19 vaccination. During an interview with KMA3 on 04/30/2024 at 3:39 PM, she stated she was not provided education related to the COVID-19 vaccine and was not offered the vaccine by the facility. She stated she declined the COVID-19 vaccination and filed a Religious Exemption request with the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Windsor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Sterling Way Mount Sterling, KY 40353	

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Infection Preventionist (IP) on 05/03/2024 at 11:05 AM, she stated the facility followed the CDC's recommendation for all immunizations and vaccines. The IP stated she did not have complete vaccination records for all employees. However, she stated the facility provided vaccine education to staff on hire. She stated she did not know why the sampled files did not have the employee's COVID-19 vaccine education documentation. However, she stated it was important for the facility to educate staff about and offer the COVID-19 vaccine. The IP also stated the facility should keep documentation of their immunization or declination of the vaccine in their files. She stated it was important to follow the CDC's recommendations for infection prevention and control to prevent the spread of diseases and infections. During an interview with the Director of Nursing (DON) on 05/03/2024 at 11:25 AM, she stated the facility followed infection control guidelines as per the CDC to include recommendations for staff immunizations and vaccines. She stated knowing the vaccination status of residents and staff was essential for everyone's safety. She stated it was important for staff to be educated about and offered the COVID-19 vaccine. She stated the staff members' immunization or declination of the vaccine should be documented in their files, as part of a comprehensive infection control program. During an interview with the Administrator on 05/03/2024 at 2:22 PM, he stated it was important that the facility maintained the appropriate documentation to reflect that it provided the required COVID-19 vaccine education to employees to comply with CDC recommendations and adhere to the facility's infection control program. The Administrator stated the IP Nurse was responsible for infection control oversight, but everyone must follow policies. He stated it was important for the safety of residents and staff.