| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185246 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Rockcastle Health & Rehabilitation Center | 371 West Main Street<br>Brodhead, KY 40409 |

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) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview, record review, and facility policy review, the facility failed to immediately report (within no more than two hours) allegations of abuse to the state survey agency (SSA) for three residents (R) (R)3, R64 and R72) of three sampled residents reviewed for abuse. The facility failed to inform the SSA of an allegation of sexual abuse in which one resident (R72) was alleged to have masturbated in front of another resident (R64) without R64's consent, which meets the definition at S483.5 of non-consensual sexual contact of any type with a resident. The facility also failed to report an allegation of verbal abuse, when R3 initially reported that a nurse yelled at him. The facility made the determination to not report allegations to the SSA based on the findings of their investigations, rather than immediately as required by regulation.The findings included: Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, last revised on 09/15/2023, revealed, It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property. The policy also revealed, The organization's policy is that the Facility Administrator, or his or her designee, will conduct a reasonable investigation of each such alleged violation unless he or she has a conflict of interest or is implicated in the alleged violation. The Facility Administrator is responsible for reporting all investigations' results to applicable State agencies as required by Federal and State law. The policy defined Allegation of Abuse as, This means a report, complaint, grievance, statement, incident, or other facts that a reasonable person would understand to mean that abuse, as defined in this policy, is occurring, has occurred, or plausibly might have occurred. The policy revealed, All alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made. 1. Review of the Resident Face Sheet revealed the facility admitted R64 on 05/02/2024. Further review revealed the resident had a medical history that included diagnoses of depression and anxiety disorder. Per review the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2025, R64 had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident had intact cognition. Review of the Resident Face Sheet revealed the facility admitted R72 on 02/29/2024. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of Parkinson's disease without dyskinesia, cognitive communication deficit, schizophrenia, generalized anxiety disorder, and other Alzheimer's disease. Per a significant change in status MDS, with an ARD of 08/05/2025, R72 had a BIMS score of 2/15, which indicated the resident had severe cognitive impairment. During an interview with the Resident Council on 08/26/2025 at 2:02 PM, R64 stated he was tired of seeing his roommate (R72) naked in the room and that the roommate would play with himself. R64 stated he voiced his concerns to the Administrator, and the Administrator offered to move him to a different room. R64 stated he did not understand why he needed to move rooms when it was his roommate (R72) who was the problem, and he should not have to live with a roommate like that. During an interview on 08/26/2025 at 5:21 PM, R64 stated he moved into the current room with R72 a couple of weeks prior, and It's been a mess since [R72]'s been here. R64 stated he woke up two mornings prior, on 08/24/2025, and observed R72 naked at the foot of his (R64's) bed, masturbating near the shared closet in the room. R64 stated<br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | he informed the SSD of the concern that day and also informed a Certified Nursing Assistant (CNA) but was unable to state the specific CNA he told. R64 stated he was offended by R72's behavior, and it was embarrassing to witness. During a telephone interview on 08/28/2025 at 4:05 PM, the SSD stated R72 had behaviors specific to toileting and personal hygiene, such as removing all his clothing before going to the bathroom and washing his genitals in the room sink. The SSD stated that on 08/25/2025, R64 reported to her that on 08/24/2025, he witnessed R72 masturbating in the room, but then he stated the resident was not completely sure if R72 was masturbating or not. The SSD stated the behavior was not reported to her by any other staff members. The SSD stated the Interdisciplinary Team (IDT) met to discuss moving R72, but the SSD did not mention if an allegation of sexual abuse was reported. Review of SSA's (State Survey Agency's) records revealed no evidence that the allegation, which the facility was aware of on 08/25/2026, was reported to the State Agency. Review of the form used for reporting allegations to the SSA revealed that an Alleged violation is a situation or occurrence that is observed or reported by staff, resident.but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to.abuse. Per the reporting form, In response to allegations of abuse.the facility must: (1) Ensure that all alleged violations involving abuse.are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.to the administrator of the facility and to other officials (including to the State Survey Agency).in accordance with State law through established procedures. During an interview on 08/26/2025 at 4:34 PM, the Administrator stated the facility had not reported any allegations of abuse to the SSA since before August 2024. The Administrator stated he was aware of R64's concerns related to R72's sexual behaviors. In response, the facility's Social Services Director (SSD) spoke to R64, who reported he did not feel like he was abused by R72's behavior, and he simply did not want to see R64 naked in the room anymore. During an additional interview on 08/29/2025 at 1:31 PM, the Administrator stated the allegation involving R72 and R64 was not reported to the SSA. He stated he did not feel the allegation met the definition of sexual abuse because he did not think R64 was masturbating in front of R72. The Administrator added he did not report the allegation based on R72's recollection of the event. 2. Review of a Resident Face Sheet revealed the facility admitted R3 on 09/24/2018. An annual MDS, with an ARD of 07/31/2025, revealed the facility assessed R3 with a BIMS' score of 15/15, which indicated the resident had intact cognition. An interview was held with R3 on 08/25/2025 at 11:30 AM. During the interview, the resident stated the past weekend, she called the front office to contact the nurse's station so the staff would answer her call light. R3 stated a nurse (identified as Registered Nurse (RN) 5) yelled at her and told her to Quit calling everyone to get me and quit aggravating others. On 08/25/2025 at 11:40 AM, the allegation of verbal abuse was reported to the Administrator. The Administrator was interviewed on 08/26/2025 at 11:00 AM and stated that he, the Director of Nursing (DON), and SSD spoke to R3 regarding the allegation that RN5 yelled at her. The Administrator stated R3 was not upset about the incident and stated the incident was not an allegation of abuse, so he did not report the incident that alleged RN5 yelled at R3 to the state agency. Review of SSA's records confirmed that the facility failed to report the allegation of verbal abuse within two hours after initially becoming made of it on 08/25/2025. During additional interview on 08/29/2025 at 1:30 PM, the Administrator presented an investigation for the allegation involving R3 and RN5. The summary of the investigation indicated the resident had an issue with the nurse after an incident on 08/22/2025 when the nurse allegedly told the resident to stop calling the front office and ring the call bell. The Administrator stated he had not reported the incident to the state agency because after he spoke with the resident and the nurse, he did not feel the resident's interviews supported verbal abuse, and he thought it was more of a customer service issue. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure 1 of 1 sampled resident reviewed for self-administration of medications was assessed to determine if this practice was clinically appropriate and safe related to self-administration of potassium chloride, Resident (R)35.The findings include: Review of the facility's policy titled, Medication Administration Self-Administration by Resident, dated 01/2023, revealed, Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, and the medications are appropriate and safe for self-administration. The policy also revealed, If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. Review of the facility's policy titled, Resident Rights, revised on 01/21/2025, revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: Self-administer medication, if the interdisciplinary care planning team determines it is safe. Review of R35's Resident Face Sheet, located in the medical record, revealed the facility re-admitted the resident on 07/10/2025. The resident's diagnoses included pneumonia, chronic kidney disease, emphysema, and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/23/2025, revealed the facility assessed R35 as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This score indicated R35 cognition was intact. Review of R35's Care Plan revealed no information regarding the resident's ability to self-administer any of her medications. Review of R35's Physician Order Report for the timeframe from 07/29/2025 through 08/29/2025 revealed an order dated 07/10/2025 for potassium chloride extended release 20 milliequivalents (mEq) once a day. The order did not indicate the resident was approved to self-administer this medication. During a concurrent observation and interview on 08/26/2025 at 10:29 AM, a large, white pill was observed in a medication cup located on R35's bedside table. R35 identified the medication as potassium and stated the nurses left it on her bedside table for her to take at lunch time with her meal, per her request. R35 stated she thought she was approved to keep and administer some of her medications, but she was not sure about the potassium. R35 stated Licensed Practical Nurse (LPN)10 was the nurse that left the potassium with her today (08/26/2025). During an interview on 08/27/2025 at 12:36 PM, LPN10 stated she was the nurse that left the potassium pill on R35's bedside table on Tuesday (08/26/2025). LPN10 stated she left it per the resident's request, because the resident stated she needed to wait until lunch to take the medication with food. LPN10 stated she was not familiar with or aware of the process for conducting an assessment before a medication could be left at the bedside. Review of R35's Observation Detail List Report for Self-Administration of Medications, dated 08/19/2025, revealed the facility assessed the resident for self-administration of two inhalers. However, the assessment did not address the resident's ability to self- administer potassium chloride. During an interview on 08/29/2025 at 5:23 PM, the Director of Nursing (DON) stated medications should not be left at the bedside without completing a self-administration assessment. During a follow-up interview on 08/29/2025 at 5:49 PM, the DON stated she expected staff to follow the facility's policy for assessing residents for self-administration of medications. During an interview on 08/29/2025 at 5:53 PM, the Administrator stated he expected staff to follow the facility's policy for self-administration of medications. He stated this included the completion of a self-administration assessment and ensuring there was an order for self- administration of medications in place. |

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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.<br><br>Based on interview, record review, and facility policy review, the facility failed to provide written notification of a room change, including the reason for the change for 1 of 40 residents (Resident #3) sampled for room change, prior to relocating the resident to another room in the facility. The findings include: Review of the facility's policy titled, Room/Roommate Change Notification Policy, revised 01/31/2025, revealed a POLICY STATEMENT noting the facility would provide notice to the resident prior to changing the resident's room or roommate. Per policy review, the interdisciplinary team (IDT) was to participate in making all resident room relocation decisions. The policy specified, 2. Notice of intra-facility transfers will be made before the relocation except when: a. The safety of the resident or others in the facility is at risk; b. The health of the resident or others in the facility is at risk; or c. An immediate transfer is required by the resident's urgent medical needs. Further review revealed the intra-facility notice was to contain: a. Reasons for transfer. b. Effective date of the transfer. c. Location to which the resident is transferred. 4. The notice will be provided to: a. The resident and/or the resident's representative; and b. Documented in the electronic medical record. 1). Review of R3's Resident Face Sheet revealed the facility admitted the resident on 09/24/2018, and most recently readmitted the resident on 03/15/2024. Per review of the Resident Face Sheet, R3's diagnoses included: hemiparesis and hemiplegia following a cerebral infarction (stroke) affecting the left non-dominant side; type two diabetes mellitus; anxiety disorder; major depressive disorder, and post-traumatic stress disorder (PTSD). Review of a census sheet revealed Resident #3 was relocated to a new room on 08/19/2025. Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/31/2025, revealed the facility assessed R35 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Further review of the MDS Assessment revealed the facility assessed R3 to have exhibited no behaviors during the seven-day assessment look-back period. Review of R3's comprehensive Care Plan revealed a problem area, initiated on 04/05/2024 and revised on 08/07/2025, that noted the resident demonstrated non-compliance with physician's orders and/or the plan of care. Per review, R3's non-compliance was evidenced by not adhering to the ordered diet and refusing to shower/bathe at times. Continued review revealed an approach (intervention) started on 04/05/2024, instructing the nursing department and the social services department (SSD) to encourage R3 to participate in decision-making. Additional review of R3's Care Plan revealed it also included a problem area, started on 01/31/2023 and revised on 08/07/2025, that noted the resident needed to participate in decisions regarding tasks of daily life. Per review of that care plan, the long-term goal noted R3 was to be fully informed in advance about her care and treatment and also informed of any changes in that care or treatment. Review of R3's Social Services (SS) Progress Notes for the timeframe of 07/01/2025 through 08/28/2025, revealed no documented evidence of R3's room change on 08/19/2025. Continued review revealed no documented evidence R3 was provided notification regarding the room change as required. Review of R3's Resident Progress Notes for the timeframe of 07/28/2025 through 08/25/2025, revealed no documented evidence of R3's room change on 08/19/2025. Additionally, review revealed no documented evidence R3 was provided notification regarding the room change as required. In interview on 08/27/2025 at 1:05 PM, R3 stated she had been put out of her room about a week or so prior. She stated that before her room was changed, she shared a room with R40. R3 stated R40 (her former roommate) bought her (R3) some of her (R40) drinks on own free will. She stated she had not asked R40 to buy her anything, but the Social Services Director (SSD) moved her to another room due to R40 buying her drinks. 2). Review of the Quarterly MDS Assessment, with an ARD of 07/30/2025, revealed the facility assessed R40 to have a BIMS score of 14 out of 15. This score indicated the resident had intact cognition. In interview on 08/27/2025 at 1:10 PM, R40 stated R3 had previously been her roommate but R3 had recently been moved to another room. During the<br>(continued on next page) |

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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interview R40 acknowledged buying drinks for R3. R40 stated she had done that because she had always been taught to share, and liked doing that. She stated R3 had never asked her (R40) to buy her (R3) anything. In interview on 08/28/2025 at 12:03 PM, Registered Nurse (RN) 5 stated she had been told by another nurse or a certified nursing assistant (CNA) that R3 had been moved to another room because the resident took drinks from R40. She further stated she had also been told R40 bought other things for R3. In a telephone interview on 08/28/2025 at 4:30 PM, the SSD stated she tried to document everything about residents' room changes; however, sometimes she forgot to document. She stated she usually called family members and spoke with the resident about any room changes. The SSD stated the facility's policy required her to document conversations about room changes in the resident's electronic medical record (EMR). She explained she had not been involved in R3's recent room change, and she did not know why the resident's room change occurred. The SSD further stated she was unaware she was to be giving residents written notices about any room changes. In interview on 08/29/2025 at 8:57 AM, Licensed Practical Nurse (LPN) 12 stated she was the unit manager on the unit where R3 and R40 resided. She stated previously R3 had expressed an interest in a room change due to R40 keeping her awake at night, but there was no documentation regarding that conversation. LPN 12 stated she was the one who asked R3 to change rooms, and the resident was given a choice. She explained R3's room change had nothing to do with R40 sharing drinks with R3. During the interview, LPN 12 reviewed the facility's census information and confirmed R3's room was changed on 08/19/2025. LPN 12 stated she was unaware of the facility's policy to provide a notice to the resident that included details such as when the move would occur, why the move was needed, and where the resident would be moved. She stated the SSD should have documented in the SS progress notes about R3's room change. The LPN stated the room change was discussed during the IDT meetings; however, she was not sure if the SSD was present for the IDT meetings in which that had been discussed as the facility did not maintain notes or attendance records of the meetings. In interview on 08/29/2025 at 2:25 PM, the Director of Nursing (DON) stated she was unsure why the room transfer for R3 had been initiated. The DON stated she remembered the transfer was discussed during a morning meeting, and she thought the transfer had to do with roommate incompatibility. She stated the SSD managed residents' room moves and was the one that completed documentation of the transfers in the residents' EMR prior to the transfer. The DON further stated the SSD was a part of the discussions about R3's room transfer, and the SSD should have completed the required documentation regarding the transfer. In interview on 08/29/2025 at 3:02 PM, the Administrator stated he remembered the IDT reviewing the room change for R3. However, he stated he was unable to recall the reason for the room change. The Administrator stated he expected there to be documentation in the resident's chart to support the room change. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to provide needed services to maintain good grooming for one (Resident (R9) of four sampled residents reviewed for activities of daily living (ADLs). The facility failed to ensure that R9, who was dependent on staff for assistance with personal hygiene, received the care needed to keep the resident's fingernails trimmed and clean. The findings included: A facility policy titled, Activities of Daily Living (ADLs), reviewed 01/31/2025, indicated, For those residents who are unable to perform their own activities of daily living, the facility will provide the needed assistance for completion of cares. Review of a Resident Face Sheet revealed the facility admitted R9 on 12/27/2024. According to the Resident Face Sheet, R9 had a medical history that included diagnoses of type 2 diabetes mellitus, muscle weakness, osteoarthritis, and cancer. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/18/2025, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 9/15, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident had moderate difficulty hearing, moderately impaired vision with the use of corrective lenses, and did not reject care during the assessment's lookback period. Per the MDS, R9 required substantial to maximal assistance from staff for completion of personal hygiene tasks. R9's Care Plan, included a problem statement edited 07/24/2025, that indicated the resident had concerns with ADL functional/rehabilitation potential. Interventions directed staff to assist the resident with ADL care as needed (created 12/30/2024). During an observation on 08/25/2025 at 9:51 AM, R9's fingernails extended at least 1/4 inch beyond the tip of his fingers. During an observation on 08/26/2025 at 2:55 PM, R9 was lying in bed. The resident's nails remained long. Two visitors whom R9 identified as family members were in the room. Interview with the family members revealed the resident's nails could stand trimming and the edges of his fingernails were jagged. The family stated that sometimes they trimmed R9's nails but thought it was the responsibility of the facility to trim the resident's nails. The family added that this time, they were waiting to see if the facility trimmed the resident's nails. During an observation on 08/27/2025 at 1:30 PM, R9's fingernails were still uncut and extended past the tip of his fingers, about 1/4 to 1/2 inch. Certified Nursing Assistant (CNA) 4 was interviewed on 08/27/2025 at 4:32 PM. She stated the CNAs were responsible for clipping and cleaning fingernails on shower days and as needed. CNA4 added that, if the resident had a diagnosis of diabetes, then the CNA told the nurse, and fingernail care was the responsibility of the nurse. Registered Nurse (RN) 5 was interviewed on 08/28/2025 at 11:49 AM. RN5 stated that the CNAs were supposed to look at the residents' nails on shower days and, if needed, trim the nails, unless the resident had diabetes. Per the interview, if the resident had diabetes, the CNAs were to report the need for nail trimming to the nurse, who was then responsible for performing this care as needed. During an observation on 08/29/2025 at 12:55 PM, R9 was lying in bed eating lunch. The resident's nails remained long and needed to be cleaned and trimmed. During a concurrent interview, R9 commented that the staff had not cleaned or trimmed his nails yet.CNA7 was interviewed on 08/29/2025 at 12:58 PM. CNA7, who stated she was not the resident's assigned CNA, observed R9's fingernails and confirmed that they needed to be trimmed and cleaned.Interview on 08/29/2025 at 12:59 PM with CNA9 revealed she was assigned to care for R9. CNA9 stated fingernails were to be cleaned and clipped either during showers or when the nails were noted to be long and dirty. CNA9 stated she had not given R9 a bath since there had been a shower aide on duty. After checking the schedule, she noted that day was not the resident's shower day. CNA9 stated that while she had assisted the resident with incontinence care and oral care, she had not noticed the resident's fingernails, which she indicated needed to be cleaned and clipped.The Director of Nursing (DON) was interviewed on 08/29/2025 at 5:44 PM. The DON stated she expected the staff to keep resident's nails clean and trimmed as the resident allowed. The Administrator was interviewed on 08/29/2025 at 5:53 PM. The Administrator stated he expected residents to be kept neat and tidy as the resident allowed staff to assist. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure services were provided so as to prevent complications of a gastrostomy tube (GT) for one of two sampled residents ((R) 49) who were observed for medication administration through a GT. Staff failed to check placement prior to administering medication, via the GT, to the resident.Findings included: Review of a facility policy titled, Medication Administration Enteral Tubes, dated 01/2025, revealed staff should, Verify tube placement per facility protocol. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100 ml [milliliters]. Review of a Resident Face Sheet revealed the facility admitted R49 on 08/14/2025. Further review revealed the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) following a stroke and gastroparesis (delayed stomach emptying). Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/21/2025, revealed the facility assessed R49 to have a Brief Interview for Mental Status (BIMS) score of 5/15, which indicated the resident had severe cognitive impairment. The MDS revealed R49 was dependent on staff for eating and had complaints of difficulty or pain with swallowing. Per the MDS, R49 received 51% or more of her nutrition and 501 cc (cubic centimeters) or more of water daily through tube feeding. Review of R49's Care Plan, included a problem statement with a start date of 08/20/2025, that indicated the resident was underweight and had an enteral nutrition order (feeding by GT). Interventions directed staff to give meals as ordered. Record review revealed an Order History for R49 that included active physician orders from 07/29/2025 through 08/29/2025 that indicated the resident received no food or medication by mouth. Further review of the Order History revealed there was no order to check the GT placement prior to medication administration. An observation was made on 08/27/2025 at 8:16 AM of Registered Nurse (RN) 11 preparing medication to administer to R49. RN11 crushed the medication, mixed the medication with water to dissolve, and then flushed the resident's GT with 30 ml of water. RN11 next gave the ordered medication to the resident and then flushed her GT with 30 ml of water. RN11 did not check placement of the resident's GT prior to flushing the GT with water or administration of the medication. During an interview on 08/27/2025 at 8:17 AM, RN11 stated she had been taught before giving medication by GT to check placement by listening for air to make sure the GT was in the right spot. RN11 stated she had been nervous and forgot to check the placement of R49's GT. The Director of Nursing (DON) was interviewed on 08/27/2025 at 3:49 PM. The DON stated she would have to read and verify the facility's policy for checking GT placement prior to medication administration. She stated the best practice was to check placement of the GT before giving medication to ensure the medication was administered into the correct location. The Administrator was interviewed on 08/29/2025 at 5:59 PM. The Administrator stated he expected the nurse to follow the facility's policy and physician's orders before giving medication via GT. |

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| | 185246 | A. Building<br>B. Wing | 08/29/2025 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a resident who needs respiratory care, is provided oxygen per the physician's directions for 1 of 1 sampled resident reviewed related to oxygen therapy, Resident (R)9.The findings include: Review of the facility policy titled, Medication Administration General Guidelines, dated 09/2018, revealed, Medications are administered in accordance with written orders of the prescriber. Review of R9's Resident Face Sheet revealed the facility admitted the resident on 12/27/2024 and re-admitted the resident on 05/23/2025 with diagnoses including chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, muscle weakness, osteoarthritis, and cancer. Review of R9's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/18/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 9 out of 15, revealing moderate cognitive impairment. Further review revealed the resident was assessed as dependent on staff for all mobility. Review of R9's Care Plan included a problem area with a revision date of 07/24/2025, stating the resident had the potential for complications related to emphysema/COPD. The Approach instructed staff to administer oxygen as ordered and observe oxygen precautions, initiated 06/10/2025. Review of R9's Medication Administration Record (MAR), dated 08/2025, revealed on 05/23/2025 the physician ordered oxygen therapy to be administered at two liters per minute (LPM) via nasal cannula (NC) as needed. The entry gave a space for the assigned nurse to sign each shift noting the oxygen had been given during the designated shift. The entry had been signed each shift from 08/25/2025 through the day shift on 08/29/2025. Observation on 08/25/2025 at 9:54 AM, revealed R9 was lying in bed receiving oxygen at 1.5 LPM via nasal cannula. Observation on 08/28/2025 at 11:30 AM, revealed R9 was lying in bed receiving oxygen per NC. The oxygen concentrator was set on 3 LPM. During interview with Registered Nurse (RN)5, on 08/28/2025 at 11:49 AM, she stated staff was to follow Physician's orders related to LPM of oxygen to be administered to a resident. She further stated it was possible the LPM set on the concentrator was changed by R9. During interview with Licensed Practical Nurse (LPN)8, on 08/29/2025 at 1:03 PM, she stated the nurses were to set the oxygen concentrator on the LPM as ordered by the Provider. LPN8 further stated the resident's oxygen concentrator was checked each shift to ensure it was set on the correct amount of oxygen to be delivered. LPN8 stated R9 was unable to adjust the oxygen concentrator independently. During further interview with LPN8, on 08/29/2025 at 1:03 PM, she stated R9 had current physician's orders to receive 2 LPM of oxygen through the NC. LPN8 then observed R9's oxygen concentrator and stated the LPM was set at 2.5 LPM. LPN8 stated she had been sure the resident's oxygen concentrator was set at 2 LPM today, until she bent down to check the oxygen concentrator. During interview on 08/29/2025 at 5:54 PM, the Director of Nursing (DON) stated it was her expectation for oxygen to be delivered at the rate ordered by the physician. The DON was questioned about the potential negative effects of a resident receiving too much oxygen; however, she declined to answer. The DON agreed the oxygen rate of administration should be validated before signing the MAR. During interview on 08/29/2025 at 5:56 PM, with the Administrator, he stated it was his expectation oxygen be delivered as ordered and as per the facility policy. He stated he expected nurses to verify the rate of oxygen administration prior to signing the MAR, noting the rate was correct. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>Based on interview, record review, and facility policy review, the facility failed to provide behavioral health services for one (Resident (R) 72) of six residents sampled for behavioral monitoring. The facility failed to monitor/document multiple behaviors displayed by R72. Staff were not consistently informed of and/or aware of significant behaviors which had the potential to affect others. The failure to monitor, be aware of, and/or take prompt actions to address all R72's behaviors affected at least three of his roommates (R64, R5, and R4).Findings included: A facility policy titled, Behavioral Health, last revised 09/15/2023, revealed, It is the organization's intent to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The policy also revealed, Stakeholders will be alert to the effectiveness of interventions and the care plan will be reviewed and revised as necessary. A Resident Face Sheet revealed the facility admitted R72 on 02/29/2024. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of Parkinson's disease with fluctuations and without dyskinesia, cognitive communication deficit, schizophrenia, generalized anxiety disorder, and other Alzheimer's disease. A Progress Note, dated 10/22/2024 at 8:53 AM, revealed the interdisciplinary team (IDT) met to review R72's recorded behavior of self-directed sexual acts in a public area. The note revealed R72 was observed engaging in self-directed sexual acts in the hall of the facility, outside of his room door, and staff redirected the resident to his room for privacy. Per the note, R72's understanding of the need for privacy was limited due to cognitive impairment, but the plan was for the Social Services Director (SSD) to follow up with the resident to review privacy. The note stated the care plan was updated to include this behavior, and a nurse practitioner (NP) and psychiatric provider were provided with a report of the new behavior. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/05/2025, revealed R72 had a Brief Interview for Mental Status (BIMS) score of 2/15, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had fluctuating behaviors of disorganized thinking and inattention. Per the MDS, R72 had physical and other behavioral symptoms 1-3 days during the assessment period. The MDS documented that the behaviors put R72 at significant risk for physical illness or injury, significantly interfered with the resident's care, significantly interfered with the resident's participation in activities or social interactions, put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. R72's Care Plan, included a problem statement edited on 08/22/2025, that indicated the resident demonstrated behaviors including yelling/screaming, combativeness at staff during care provisions, engaged in ritual behaviors including undressing to toilet and completing hygiene at the sink, and urinating in inappropriate places, such as the floor. Interventions directed staff to provide a quieted environment and reapproach the resident later if agitation was present, assist the resident away from other residents as needed, observe for triggers of inappropriate behaviors and alter the environment as needed, encourage participation in activities as appropriate, and observe for unmet needs such as for toileting, rest, food, fluids, and companionship. The Care Plan also included a problem statement, edited 08/19/2025, that indicated the resident exhibited inappropriate social and sexual behaviors. Interventions directed staff to allow the resident extended time to perform repetitive ritual tasks for completion to decrease the risk of socially inappropriate behaviors, provide diversional activities as needed, provide education on personal hygiene as needed, provide privacy for the resident as needed/or requested, and remind the resident to pull the curtain, and shut the door, as needed. R72's Physician Order Report for the timeframe from 07/28/2025 through 08/28/2025, contained an order, dated 03/10/2024, for monitoring of target behaviors by marking the frequency and intensity of the behaviors at the end of each shift. Target behaviors which were to be monitored/documented each<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | shift included agitation, anxiousness, restlessness, hallucinations/delusions, sadness, tearfulness, and self-isolation. The Physician Order Report revealed no orders related to monitoring the additional identified behaviors of inappropriate social and sexual behavior, ritual behaviors including undressing to toilet and completing hygiene at the sink, or urinating in inappropriate places, such as the floor. R72's Treatment Administration History, for the timeframe from 08/01/2025 through 08/28/2025, revealed no documentation related to monitoring behaviors of ritual behaviors including undressing to toilet and completing hygiene at the sink; urinating in inappropriate places, such as the floor; or inappropriate social and sexual behaviors. Review of R72's Progress Note, entries for the timeframe from 02/29/2024 to 08/20/2025 revealed no further documentation related to R72's sexual behaviors or ritualistic behavior of removing clothing. On 08/20/2025 at 4:05 PM, a Progress Note documented that R72 was observed to have impulses to complete ritual behaviors. The note revealed the resident was observed to take off his clothing when toileting and stand at the sink area to clean his genitals several times with water and paper towels prior to dressing again. Per the note, R72 was observed to complete the ritual each time he toileted. During an interview with the Resident Council on 08/26/2025 at 2:02 PM, R64 stated he was tired of seeing his roommate (R72) naked in the room and that R72 would play with himself. R64 stated he voiced his concerns to the Administrator, who offered to move him to a different room. R64 stated he did not understand why he needed to move rooms when his roommate, R72, was the problem, and he should not have to live with a roommate like that. Review of a quarterly MDS, with an ARD of 08/07/2025, revealed R64 had a BIMS score of 15/15, which indicated the resident had intact cognition. During an additional interview on 08/26/2025 at 5:21 PM, R64 stated he moved into his current room with R72 a couple of weeks prior, and It's been a mess since [R72]'s been here. R64 stated he woke up two mornings prior, on 08/24/2025, and observed R72 naked at the foot of R64's bed, masturbating near the shared closet in their room, which was in front of R64's bed. R64 stated he informed the SSD of the concern that day and also told a Certified Nursing Assistant (CNA), whom he could not identify, of R72's behavior. R64 stated R72 was naked in the room the previous night, 08/25/2025, and he again notified a CNA, who then assisted the resident with getting dressed. R64 added that when he informed the SSD of R72's behavior of removing his clothing on 08/22/2025, the SSD started making excuses for [R72]. R64 stated he was offended by R72's behavior, and it was embarrassing to witness. During an interview on 08/27/2025 at 10:53 AM, R5 stated that when he was R72's former roommate, the resident would walk around the room naked, just about every other day. R5 added that R72 would come out of the bathroom naked or come out wearing no pants. A quarterly MDS, with an ARD of 08/01/2025, revealed R5 had a BIMS score of 9/15, which indicated the resident had moderate cognitive impairment. During an interview on 08/27/2025 at 2:07 PM, R4 he was R72's roommate for about two days. R4 also stated R72 would walk around the room naked and urinated in the sink and on the floor all the time. R4 stated he felt offended by R72's behavior, adding I don't like stuff like that. A quarterly MDS, with an ARD of 05/27/2025, revealed R4 had a BIMS score of 14/15, which indicated the resident had intact cognition. During an interview on 08/26/2025 at 4:34 PM, the Administrator confirmed he was aware of R64's concerns related to R72's sexual behaviors. The Administrator added that R72 had ritualistic behaviors and tendencies, such as removing his clothing, and was seen by psychiatric services on a regular basis. During this interview, the Administrator stated that in response to R64's concerns, R72 was supposed to be moved into a different room on 08/25/2025, and he was not sure why the resident was not moved as planned. During an additional interview on 08/28/2025 at 8:39 AM, the Administrator stated R72 had behaviors described as ritualistic, mostly relating to cleanliness and personal hygiene, such as performing personal hygiene at the sink with paper towels. The Administrator added that when he spoke to R64, the resident's main concern was related to R72's personal hygiene habits and the resident's tendency to remove his clothing. The Administrator also stated R64 explained to him that he witnessed R72 grabbing his genitals, and R64 told the Administrator that, [R72] was masturbating in his presence. The Administrator said that when he (continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | asked R64 why he thought R72 was masturbating, R64 replied, Why else would you have your hand down there? Further interview with the Administrator revealed he had no documentation of this conversation with R64. During an interview on 08/28/2025 at 9:13 AM, the Advanced Practitioner Registered Nurse (APRN) stated that when facility staff reported resident behaviors to her, it depended on the extent of those behaviors to determine the course of action they would take to address them. The APRN stated residents were referred to psychiatric services, and medications would be monitored and adjusted as needed. The APRN stated she was familiar with R72, and she was not aware of the resident displaying any sexual behaviors or being naked in public places. The APRN described R72 as very fixated on cleanliness and would stand at the sink in the room to perform cleaning rituals, such as repeated handwashing. The APRN stated she was aware R72 had several room changes and believed it was due to the roommates not being able to tolerate R72's behaviors. The APRN related that interventions were in place to offer the resident assistance with dressing himself, but she was not sure what other interventions were in place related to the resident's behaviors. During an interview on 08/28/2025 at 9:25 AM, Licensed Practical Nurse (LPN) 15 stated any reports of resident behavior toward another resident or involving another resident were to be reported to the SSD, and resident behaviors were to be documented every shift. LPN15 noted she was familiar with R72 and had observed the resident in the hallway with no shirt on a time or two. LPN15 indicated that to her knowledge, no residents had reported sexual behaviors involving R72. During a telephone interview on 08/28/2025 at 3:08 PM, the Psychiatric-Mental Health Nurse Practitioner (PMHNP) revealed she was informed by the facility on 08/26/2025 (the day of surveyor intervention), that R72 was displaying inappropriate sexual behaviors, but she had never witnessed the behaviors herself. The PMHNP stated R72 had ritualistic behaviors, such as taking off all his clothing to go to the bathroom, using a certain amount of paper towels when performing personal hygiene, or washing his hands a certain number of times, and if he was not allowed to do that, he got frustrated. The PMHNP stated she would expect facility staff to report and document any resident behaviors. During a telephone interview on 08/28/2025 at 4:05 PM, the SSD stated she participated in the facility's behavior management program, and resident behaviors were reviewed as part of the IDT behavioral meetings. The SSD was familiar with R72, saying the resident displayed impulsive and ritualistic behaviors daily. The SSD stated R72 had behaviors specific to toileting and personal hygiene, such as removing all his clothing before going to the bathroom and washing his genitals in the room sink. The SSD confirmed that on 08/25/2025, R64 reported to her that the previous day (08/24/2025). the resident witnessed R64 masturbating in the room but added that the resident was not completely sure if R72 was masturbating or not. The SSD stated the behavior was not reported to her by any other staff members. The SSD also stated she was not aware that any other residents had concerns related to R72 being naked in their room. During an interview on 08/29/2025 at 8:01 AM, CNA22 stated she was familiar with R72 and that his former roommates had reported R72's had a behavior of washing his genitals in the room sink; however, she did not witness this behavior. Further interview with CNA22 revealed she was assigned to the resident on 08/25/2025. CNA22 stated she received a report from R64, explaining that R72 was undressing in the room in front of him, and R64 wanted R72 out of the room. CNA22 stated the incident was reported to LPN8. During an interview on 08/29/2025 at 2:58 PM, LPN8 stated she worked on R72's unit on 08/25/2025, and no behaviors were reported to her. LPN8 stated R72 had ritualistic behaviors related to personal hygiene and would sometimes remove his clothing to perform personal hygiene at the sink in the room; however, she was not aware of any resident complaints related to R72's behaviors. During an interview on 08/29/2025 at 4:46 PM, LPN6 stated residents would normally have orders in their electronic chart to monitor behaviors. LPN6 also stated she would expect nursing staff to document any increase in the resident's behaviors, or any new behaviors displayed. LPN6 stated she was familiar with R72, and related she was not aware of any behavior related to the resident removing his clothing. LPN6 indicated that to her knowledge, no residents reported sexual behavior involving R72 or behavior related to the resident removing his<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | clothing, as she stated staff had not reported any of these behaviors to her. During an interview on 08/29/2025 at 5:22 PM, the facility's Medical Director stated he was familiar with R72, adding that the resident liked to get naked, much to the chagrin of his roommates. Per the Medical Director, there had been mention of some masturbatory behaviors; however, nothing was documented to his knowledge. The Medical Director stated that ideally, R72 would have a private single room, and he would expect facility staff to redirect the resident if he was displaying behaviors. The MD also stated he would expect facility staff to document any masturbatory behaviors. During an interview on 08/29/2025 at 6:02 PM, the Director of Nursing (DON) stated resident behaviors should be monitored in accordance with the facility policy. The DON then stated the facility did not have a policy related to monitoring of resident behaviors. The DON stated she would expect nursing staff to document resident behaviors and any escalation in those behaviors as needed. The DON described the purpose of monitoring was to know what changed in the behavior, what new behaviors were present, and what behaviors were worsening. The DON stated that with that data, they could make sure the resident's physician was aware, and care plan interventions could be addressed by the IDT. During an additional interview on 08/29/2025 at 6:06 PM, the Administrator stated resident behaviors would be evaluated in the IDT meeting, and facility staff could chart and communicate any increase in resident behaviors. The Administrator stated that on 08/28/2025, an additional privacy curtain was installed around the sink in R72's room in case he decided to remove his clothing at the sink. Further interview with the Administrator revealed he could not state why this intervention was not put into place prior to 08/28/2025 (after surveyor intervention). |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>Based on interview, record review, and facility document review, the facility failed to assist with/provide medically related social services for one (Resident (R) 23) of one sampled resident reviewed for appointments and referrals. The facility failed to ensure follow-up appointments and referrals were made and/or kept as needed for R23. Findings included: Review of a Central Supply Staff job description revealed the duties included, Assist with Nursing Department activities to include administrative support; assist residents, families, and visitors, and running errands to include travel to supply sources, as well as other special projects and duties, as assigned. Review of a Resident Face Sheet revealed the facility admitted R23 on 09/10/2024. According to the Resident Face Sheet. the resident had a medical history that included diagnoses of difficulty in walking, unsteadiness on feet, and muscle weakness. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/06/2025, revealed the facility assessed R23 to have a Brief Interview for Mental Status (BIMS) score of 15/15. This score indicated the resident had intact cognition Review of R23's Care Plan revealed a problem statement, edited 08/20/2025, that indicated that the resident, relative, or representative expressed their wish for the resident to remain in the facility for long term care. Interventions directed staff to provide services according to the plan of care in an effort to enhance optimum wellbeing and prevent hospitalizations. a. Review of R23's Progress Notes, dated 03/12/2025, revealed new orders were received to schedule an orthopedic referral. Additional review of Progress Notes, dated 04/08/2025, revealed the resident returned from an orthopedic appointment and had a follow-up appointment scheduled for May. b. Review of R23's Progress Notes, dated 04/23/2025, revealed the resident went out to a nephrology appointment and returned with referrals for cardiology and hematology. Additional Progress Notes, dated 07/12/2025, also noted the resident had an order for a hematology referral. Review of the resident's record revealed no evidence that the resident was seen by a physician for the follow up appointment or that the referrals were acted upon. During an interview on 08/25/2025 at 11:08 AM, R23 stated that they were told that until they were released by orthopedic, they would not receive therapy services at the facility. R23 stated there was an insurance issue, and the facility was supposed to reschedule the orthopedic appointment but that was months ago. During an interview on 08/28/2025 at 12:51 PM, the Central Supply/Transporter (CS) stated she thought R23 went back to the orthopedic appointment in 05/2025; however, she was not sure if the resident was seen by the doctor. She stated that she knew there was an insurance issue, and she failed to follow up with the resident to see if they had new insurance or try to find a doctor that would accept the resident's insurance. The CS confirmed that she had not followed up and rescheduled the orthopedic appointment for the resident. Further interview with the CS revealed she did not know about the referrals for hematology or cardiology. She stated normally she would have the resident's face sheet and referrals in a binder when she sent in the request for appointments, but she had no documentation for R23 to be referred to orthopedic, cardiology, or hematology in the binder. The CS stated that once appointments were made, they were then placed in the appointment binder at the nurses' stations. The CS stated she had no documented evidence to prove she had attempted to make R23's appointments. During an interview on 08/29/2025 at 12:18 PM, Registered Nurse (RN) 5 stated that if a resident needed to be referred for an appointment, they filled out a paper and put it in the binder. She stated the CS was then notified, and the nurses made a note in the resident's chart. During an interview on 08/29/2025 at 12:51 PM, Licensed Practical Nurse (LPN) 12 stated that appointments were placed in the appointment book. She stated the CS then gathered the information. During an interview on 08/29/2025 at 5:43 PM, the Director of Nursing (DON) stated she expected her staff to make appointments immediately once referred and if there were any issues to let her know. She stated that she expected the CS to follow up if there was an issue to ensure the residents were going to their appointments. She also expected<br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that, if needed, the CS would try to find another doctor that accepted the resident's insurance. Further interview with the DON revealed that the facility did not have a policy on making appointments. During an interview on 08/29/2025 at 5:53 PM, the Administrator stated he expected the staff to schedule appointments in a timely manner. He stated he also expected staff to document the appointments. |

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| | 185246 | A. Building<br>B. Wing | 08/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rockcastle Health & Rehabilitation Center | 371 West Main Street<br>Brodhead, KY 40409 |

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

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, record review, and review of facility policy, the facility failed to maintain a medication error rate of less than 5% (percent). There were 4 errors in 32 opportunities, for a medication error rate of 12.5%. This affected 4 out of 5 residents observed for medication pass, Residents (R)68, R69, R87, and R95. The findings include: Review of the facility policy titled, Medication Administration General Guidelines, dated 09/2018, revealed, 1. Medications are administered in accordance with written orders of the prescriber. 5b. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. 1. Review of R69's Resident Face Sheet, located in the medical record, revealed the facility re-admitted the resident on 04/08/2025 with diagnoses including Alzheimer's disease. Review of R69's Medication Administration Record (MAR) for the timeframe from 08/01/2025 to 08/26/2025, revealed a physician's order was included for delayed release/enteric coated aspirin, 81 milligrams (mg), 1 tablet to be given once a day. Observation on 08/26/2025 beginning at 8:23 AM, revealed Licensed Practical Nurse (LPN)18 was preparing medication for R69. LPN18 crushed all the resident's medications, including the enteric coated aspirin, and committed to giving the crushed aspirin by placing all the crushed medications into a cup together. LPN18 stated the enteric coated aspirin did not have a warning label stating not to crush, and she had no access to a list of medications that should not be crushed. After crushing all the medications together, LPN18 reviewed the card for the enteric coated aspirin and commented, It says not to crush. At this point, LPN18 threw all the medications away and then started over. She stated R69 was able to take medications whole but would only take a few at a time. This was medication error #1. 2. Review of R95's Resident Face Sheet, located in the medical record, revealed the facility readmitted the resident on 08/13/2025 with diagnoses including type 2 diabetes mellitus. An instruction pamphlet for the Novolog FlexPen, revised 02/2023, revealed an air shot should be given before each injection. The pamphlet revealed this was to avoid injecting air into the resident and to ensure proper dosing. Instructions for completing the air shot included, Turn the dose selector to 2 units. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A dose of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. Observation on 08/26/2025 beginning at 10:53 AM, revealed LPN10 completed a fingerstick blood sugar test on R95 with results of 293 milligrams per deciliter (mg/dL). The nurse then removed a Novolog FlexPen with 100 units/ml and turned the dial on the Flexpen to 12 units. LPN10 attached the needle to the end of the pen and administered the insulin to R95's upper right arm. The insulin pen was not primed before administration of the insulin. This was medication error #2. During interview with LPN10 on 08/26/2025 at 11:03 AM, she stated she had not been taught to prime the insulin pen before administering insulin. LPN10 stated she had completed nursing school recently and had not been taught to prime the pen during that time either. LPN10 stated she was unaware the insulin pen needed to be primed before administering the insulin. During interview with the Director of Nursing (DON) on 08/27/2025 at 3:54 PM, she stated she taught nurses to prime insulin pens before administering insulin to ensure the resident received the ordered dose of insulin. The Administrator was interviewed on 08/29/2025 at 6:03 PM, and stated he expected nursing staff to follow manufacturer's guidelines for the insulin pen. 3. Review of R68's Resident Face Sheet, located in the medical record, revealed the facility admitted the resident on 08/12/2025 with diagnoses including chronic obstructive pulmonary disease and hypertension. Review of R68's MAR, with active orders for 08/2025, revealed an order for diltiazem extended-release capsules, 240 milligrams (mg), administer two capsules once a day. An observation was made on 08/27/2025 beginning at 7:49 AM, of LPN17 preparing medication to be administered to R68. LPN17 placed one capsule of diltiazem into the medication cup and then<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | picked up another medication card and placed that medication into the cup. After the nurse had committed to giving the diltiazem, she was asked what dosage the resident was to receive. LPN68 read the label again and acknowledged R68 should receive two tablets of the diltiazem. This was medication error #3. Interview was conducted with LPN17 on 08/27/2025 at 7:58 AM. She stated she should have double checked the dosage of diltiazem that R68 was ordered to receive. 4. Review of R87's Face Sheet, located in the medical record, revealed the facility re-admitted the resident on 11/09/2023 with diagnoses including chronic obstructive pulmonary disease and an adjustment disorder with mixed anxiety and depressed mood. Review of R87's Medication Administration Record (MAR) with physician's orders active for 08/2025, revealed an order for buspirone (a medication to treat anxiety) 5 milligrams (mgs), give 10 mgs three times a day orally (started 06/13/2025). An observation was made on 08/27/2025 beginning at 8:30 AM of Registered Nurse (RN)11 preparing medications for R87. RN11 removed a medication card from the medication cart that read buspirone 5 mg and placed one tablet into the medication cup and placed the card back into the medication drawer, therefore committed to giving the resident one tablet (5 mg) of the buspirone. After the medication card was returned to the medication cart, RN11 was stopped, and a request was made that she read the medication label again. After reading the label, the nurse placed another tablet of the buspirone into the medication cup and stated she would have reviewed the medications again and would have caught her error. This was medication error #4. Interview was conducted with the Director of Nursing (DON) on 08/27/2025 at 1:39 PM, and on 08/27/2025 at 3:44 PM. The DON stated medication pass observations were not completed yearly on each nurse and were only completed when there was a need. She stated when preparing medications, she expected the nurses to follow the five rights of medication administration, which included giving the right dosage of medication. The DON further stated she expected the nurse to check the MAR against the medication label. The Administrator was interviewed on 08/29/2025 at 6:03 PM and stated he expected nurses to administer medication based on facility policy and best practice. The Administrator further stated he also expected the nurses to follow the pharmacy recommendations. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on observation, interview, facility document review, and facility policy review, the facility failed to accommodate food preference for one (Resident (R) 97) of five sampled residents reviewed for food preferences. The facility repeatedly served R97 food which did not honor the resident's identified preferences.The findings included: Review of the facility's policy titled, Resident Food Preferences, last revised on 01/31/2025, revealed, Nutritional assessments will include an evaluation of individual food preferences. The policy also noted that, 4. The resident's clinical record will have documented preferences. Review of a Face Sheet revealed the facility admitted R97 on 05/18/2024. According to the Face Sheet, the resident had a medical history that included a diagnosis of moderate protein-calorie malnutrition. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/23/2025, revealed the facility assessed R97 to have a Brief Interview for Mental Status (BIMS) score of 14/15. This score indicated the resident was cognitively intact. Review of the Monthly Grievance Log for 06/2025 revealed an entry, dated 06/05/2025. Further review revealed R97 had a grievance concern related to food preferences. Review of the Complaint/Grievance Report, dated 06/05/2025, revealed R97 verbally communicated to the facility's Social Services Director (SSD) concerns related to receiving food she did not prefer. The investigation was then assigned to the Dietary Manager (DM) on 06/05/2025. The report noted the findings of the investigation included that, when speaking with the resident, they addressed concerns with food items not liked. The report stated the expected results of actions taken included the resident was to receive items she preferred. Further review of the Monthly Grievance Log for 06/2025 revealed the resolution to R97's grievance included updating the resident's food preferences. Further review revealed the resident was notified of the resolution on 06/09/2025. Review of R97's Physician Order Report, for the timeframe from 07/28/2025 through 08/28/2025, revealed a diet order, dated 06/03/2025. The order was for a regular diet with special instructions to send fortified foods with all meals. Review of R97's current Food Preference Assessment, revealed R97 had food dislikes, which included Oatmeal Cereal. This dislike was added on 12/11/2024. During an interview on 08/25/2025 at 11:34 AM, R97 stated she was served oatmeal for breakfast on a regular basis; however, the resident stated, she could not eat oatmeal because it made her sick. R97 stated she told someone in the cafeteria about it, but could not recall the date when the facility was notified or the name of the person she notified. During observation on 08/26/2025 at 7:43 AM, R97 was in her room during breakfast. R97's meal included a bowl of oatmeal, as well as a plate of scrambled eggs with cheese, biscuit with jelly, and a bowl of dry cereal. R97 stated she did not want the oatmeal on her tray. During an interview on 08/28/2025 at 8:14 AM, R97 stated she again received a bowl of oatmeal on her breakfast meal tray that morning. During a telephone interview on 08/28/2025 at 3:57 PM, the SSD stated any facility staff could file a grievance for a resident, but some residents would request to speak with her specifically regarding their concerns. Further interview revealed that complaints about food preferences would then be assigned to the dietary department. The SSD stated she remembered speaking to R97, who voiced concerns related to receiving food items she did not like. The SSD related that the grievance about food preferences was assigned to the dietary department, and R97's food preferences were updated. The SSD stated she was not aware of any further concerns related to R97's food preferences. During an interview on 08/29/2025 at 10:36 AM, the DM stated residents had a choice of food they could receive on their meal trays, and the choices were documented on the resident's meal preferences sheet. The DM added that R97 received fortified oats in the morning because the resident ate them when she was first admitted to the facility. The DM stated she was not aware R97 did not like oatmeal, and the resident received fortified oats because she had an order for fortified foods. Further interview with the DM revealed that fortified oats were not the only option the facility had to offer, and R97 could receive other fortified items, including milk,<br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | grits, or cream of wheat, instead of oatmeal. During an interview on 08/29/2025 at 3:19 PM, Certified Nursing Assistant (CNA) 19 stated that if a meal tray was served to a resident and the resident had a concern with the meal, staff were to offer the resident an alternative meal choice and let the dietary staff know so the resident's meal preferences could be updated. CNA19 confirmed R97 was served oatmeal during breakfast, and she would let the kitchen know the resident did not like oatmeal, adding that she could not remember the last time the resident voiced this concern to her. During an interview on 08/29/2025 at 6:18 PM, the Director of Nursing (DON) stated if a resident expressed concern about food preferences, she would expect the staff to offer the resident an alternative option and communicate the concern to the dietary staff if the resident continually received an item they did not want. During an interview on 08/29/2025 at 6:21 PM, the Administrator stated he would expect a grievance form to be filled out if a resident communicated a concern related to food, which would then go to the DM. The Administrator also stated if a resident received food items they did not like, he would expect the resident's food preferences to be updated. |