STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47852 Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure an accurate assessment for one (1) of 27 sampled residents, Resident (R) 74. The facility assessed R74, on a Quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 07/17/2024, to have received 51% or more of proportion of total calories the resident received through parenteral or tube feeding. However, there was no evidence the facility completed a calorie count to determine the amount of nutrition the resident received from either tube feeding or intake by mouth. The findings include: Review of the RAI manual, dated 10/2024, revealed the steps for assessment of proportion of total calories the resident received through parenteral or tube feeding included review of intake records within the last 7 days to determine actual intake through parenteral or tube feeding routes and calculate the proportion of total calories received through these routes; if the resident had more substantial oral intake than sips of fluids, consult with the dietician who totaled their calories per day. The MDS was coded for a proportion of total calories the resident received through parenteral or tube feeding. Observation, on 10/08/2024 at 3:05 PM, revealed R74 up in his wheelchair, with tube feeding disconnected. Observation, on 10/09/2024 at 3:52 PM, revealed R74 out of his room with tube feeding disconnected and pump, tubing and bottle of formula hanging to bedside. Observation, on 10/09/2024 at 5:20 PM, revealed R74 up in his wheelchair, with tube feeding disconnected. Observation, on 10/10/2024 at 1:38 PM, revealed R74 out of his room with tube feeding disconnected and pump, tubing and bottle of formula hanging to bedside. Review of R74's Admission Face Sheet revealed the facility admitted the resident on 09/19/2023 with diagnoses which included esophageal obstruction, gastro-esophageal reflux disease with esophagitis, and acute kidney failure. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R74's Physician's Orders, dated 06/26/2024, revealed an order for water per gastrostomy tube (GT) at 53 ml/hour for 22 hours per day. Review of R74's Physician's Orders, dated 08/09/2024, revealed an order for pureed diet with nectar thick liquids comfort foods and thin water and ice chips. Review of R74's Physician's Orders, dated 08/26/2024, revealed an order for formula per tube at 75 ml/hour for 22 hours a day. Review of R74's Quarterly MDS, with an ARD of 07/17/2024, revealed the Swallowing/Nutritional Status section of the MDS was marked as 51% or more of proportion of total calories the resident received through parenteral or tube feeding. In an interview with Licensed Practical Nurse (LPN) 8, on 10/09/2024 at 5:15 PM, she stated R74's tube feeding was bolus and he unhooked himself from the feeding often. She further stated she was unfamiliar with R74 and didn't realize he had a physician order for continuous tube feedings and not bolus feedings. In an interview with the Dietician, on 10/11/2024 at 2:35 PM, she stated she started as the facility Dietician in August 2024. She further stated she was unaware of the facility completing any calorie counts and she relied on nursing services to provide any reports such as calorie counts. She continued to state the reports she ran for the weekly weight meetings were triggered by significant weight changes. Additionally, she stated she had not completed R74's previous MDS since she was new to the facility, and she was unaware of who completed the calorie counts. She stated she was responsible for completing the Swallowing/Nutritional Status section of the MDS. She further stated she monitored residents for significant weight changes and R74 had been stable with weight. In an interview with the Director of Nursing (DON), on 10/11/2024 at 3:28 PM, she stated the facility did not complete calorie counts and used resident weights to determine resident's nutritional status. In an interview with the LPN MDS Nurse, on 10/11/2024 at 4:08 PM, she stated it was the policy of the facility to complete the MDS per the RAI manual. She further stated she did not complete the Swallowing/Nutritional Status section of the MDS, and it was completed by the Dietician or the Dietary Manager. In an interview with the Account Manager of Healthcare Services Group, on 10/11/2024 at 4:38 PM, she stated she did not complete any calorie counts and the Dietician was responsible for gathering calorie counts for the MDS. In an interview with the District Manager of Healthcare Services Group, on 10/11/2024 at 4:40 PM, he stated it was the Dietician's responsibility to obtain calorie counts and complete that portion of the MDS.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51156 44974 The facility failed to have an effective system to ensure that all resident care plans were updated and revised to include individualized interventions for four of 27 sampled residents (Resident #36, Resident #64, Resident #79, and Resident #84). Review of Comprehensive Care Plans Standard of Practice dated 10/2020 revealed that each resident's comprehensive care plan is designed to identify problem areas, incorporate risk factors associated with identified problems, build on the resident's strengths, reflect the resident's expressed wishes regarding care and treatment goals, reflect treatment goals, timetables, and objectives in measurable outcomes. 1.Review of (Resident (R)79's) Admission Face Sheet revealed the facility admitted the resident on 05/10/2024 with the diagnoses including cerebral infarction due to embolism of unspecified precerebral artery, mood disorder due to known physiological condition, secondary hypertension, and weakness. Review of R79's Minimum Data Set with an Assessment Reference Date (ARD) of 05/15/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS documented that it was very important for the resident to choose between baths and showers, and that the resident needed partial/moderate assistance from staff for bathing. Review of R79's Comprehensive Care Plan (CCP) revealed that R79 has a goal to have his ADL needs met through the next review on 11/19/2024. Review of R79's CCP interventions further revealed to adjust R79's daily routine as needed to promote independence, encourage resident to participate to his ability, incontinent care as needed, resident may have personal items at bedside, to notify the MD, family/responsible party of changes as needed, PT and OT as needed, and resident may use upright walker for assistance. There is no evidence that the facility created a person-centered care plan that addressed the resident's shower time preference, assistance needed by staff, or that the resident prefers a female staff member to bath him. Observation of R79 on 10/07/2024 at 3:21 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. An interview with R79 during this observation revealed that showers were not routinely offered twice a week per shower schedule, or during the shift he prefers. R79 stated staff frequently wake him after midnight for his shower and that made him very upset. R79 further stated that he did not want to get out of his warm bed during the night for a shower. Observation of R79 on 10/08/2024 at 09:15 AM revealed the resident had a noticeable body odor. During an interview with R79 during this observation he stated he had refused showers in the past due to the sex of the CNA performing the shower. R79 added that on admission he requested to only have females assist with his bathing. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of R79 on 10/09/2024 at 5:05 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. During an interview with R79 during observation he stated that he felt nasty when he didn't get a shower and liked to be clean every day. R79 added that he thought the facility should at least offer him a bed bath if they couldn't assist him with a shower. R79 further stated he had missed activities before because he felt too nasty to attend. 2. Review of R36's Admission Face Sheet revealed the facility admitted the resident n 07/06/2023 with diagnoses including multiple sclerosis, quadriplegia, contracture to the left elbow, muscle weakness, major depressive disorder, pressure ulcer to the left hip and sacral area, anxiety disorder, psychophysiologic insomnia, and a neuromuscular dysfunction of the bladder. Review of R36's Minimum Data Set with an Assessment Reference Date (ARD) of 09/15/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS documented that it was somewhat important for the resident to choose between baths and showers, and that the resident was dependent on staff for bathing. Review of the resident's care plan revealed an intervention for resident to use the shower bed for all baths with a 4/30/2024 start date. Review of R36's Nurse Progress Note dated 10/01/2024 at 4:05 AM revealed resident refused bed bath and said, I don't like a bed bath, I'm not taking a bed bath until all my antibiotics are done then I will start taking my showers again. Observation of R36 on 10/07/2024 at 1:15 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. Observation of R36 on 10/08/2024 at 3:50 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. During an interview with R36 during this observation he stated that I have to make them shower me. R36 further stated that the staff only wants to give him a bed bath because it takes two people to shower me, and they don't always have enough staff to do it. Review of R36's Comprehensive Care Plan (CCP) revealed that R36 has a goal to remain free from any unidentified ADL changes through the next review on 12/22/2024. Review of R36's CCP interventions further revealed to provide incontinent care as needed, to notify the MD, family/responsible party of changes as needed, PT and OT as needed, and for resident to use shower bed for all baths. There is no evidence that the facility created a person-centered care plan that addressed the resident's shower time preference, assistance needed by staff for transferring to shower bed, or the assistance needed for bathing. 3. Review of R64's Admission Face Sheet revealed the facility admitted the resident on 11/02/2022 with diagnoses including listerial sepsis, nicotine dependence, alcohol abuse, type 2 diabetes mellitus, depression, congestive heart failure, chronic atrial fibrillation, and chronic obstructive pulmonary disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of 64's Minimum Data Set with an Assessment Reference Date (ARD) of 09/04/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS documented that it was somewhat important for the resident to choose between baths and showers, and that the resident required partial/moderate assistance from staff for bathing. Review of the facility's undated Shower Schedule CDE Unit provided by the Senior Administrator on 10/07/2024, revealed R64 was supposed to receive a shower twice a week (during night shift on Tuesdays/Fridays). Per the shower sheet in the Electronic Medical Record (EMR), staff were to document each day that either a bath was given, a shower was given, the activity did not occur, or the resident refused care. During an interview with R64 on 10/09/2024 at 8:40 AM he stated he had gone four weeks without a shower in the past due to staff waking him up after midnight to shower. R64 further stated that he does not like to take late showers. During an interview 10/07/2024 at 11:40 AM with the Senior Administrator she stated that the residents plan of care should reflect the resident's shower schedule, time preferences, assistance needed for bathing and transferring to the shower bed or chair, and if the resident has a male or female preference. 4. Review of Resident(R) 84's Admission Face Sheet revealed R84 was admitted on [DATE] with diagnoses of Hemiplegia and hemiparesis following intracerebral hemorrhage affecting left side, Atherosclerotic heart disease, and central pain syndrome. Review of R84's Admission Minimum Data Set (MDS) assessment with a Assessment Reference Date (ARD) of 09/10/2024 revealed a Brief Interview for Mental Status (BIMS) score of fifteen of fifteen, which indicated R84 was cognitively intact. Further review of the MDS section GG-Functional Abilities and Goals, revealed R84 was dependent with shower/bathing self, and toileting hygiene. Review of section GG-further revealed R84 was dependent with transferring from bed to chair, and required assist of 2. Review of R84's Comprehensive Care Plan (CCP) dated 09/16/2024 revealed a self-care deficit as evidenced by the need for total assist with bathing, dressing lower body, mobility, related to left hemiplegia and additional risk for decline, and additionally R84 preferred no male caregivers. Interventions included grooming/dressing, and oral care, and incontinent care as needed. Goals were that R84 would be washed, dressed and free from symptoms of pain times ninety days. However, there was no documented evidence of resident centered goals for shower/bath or frequency. Further review of R84's care plan revealed there was no documented evidence that resident required assist of 2 persons and a hoyer lift for transfers. Further review of the CCP dated 09/16/2024 revealed a behavior as related to declination of showers and refusal of therapy with interventions of allowing resident time to verbalize feelings, social worker to visit and encourage resident to follow physician orders. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/08/2024 at 4:49 PM with R84, he stated he is supposed to get a shower or bed bath at least twice weekly, but only gets one when he really needs a bath. He further stated the staff have come into his room late at night, not sure of time and asked if he wanted a shower and he told staff it was too late. He stated if he refused a shower or bath, he had to sign a paper saying he refused. R84 further stated I don't refuse a shower or bath unless its late at night. During an interview on 10/11/2024 at 6:45 PM with the Interim Administrator stated the Care Plans should be person centered. She further stated Care plans could be updated by any nurse or administrative discipline. In September department managers started asking residents their preferences. As far as showers being specific on the Care Plan the facility had not addressed that area yet. During an interview on 10/11/2024 at 7:12 PM with the Medical Director he stated he expected the resident care plans be resident centered with their preferences to give the resident as much control possible with their choices.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51156 44974 47852 Based on observation, interview, and record review, it was determined the facility failed to ensure the residents were given the appropriate treatment and services to maintain personal hygiene-bathing for five of 27 sampled residents, Resident (R) 36, Resident 55, Resident 64, Resident 79, Resident 84. Review of a facility policy, titled Activities of Daily Living (ADLs), dated 10/2020, revealed the facility would provide care and services for the following ADLs: hygiene (bathing, dressing, grooming, oral care). According to the policy, any resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal/oral hygiene. The policy failed to include specifics related to the provision of these services. Review of an undated Shower List revealed each resident was scheduled to receive two showers per week. Further review of the schedule revealed that the determination of the schedule was based on the resident's room number. 1.Review of (Resident (R)79's) Admission Face Sheet revealed the facility admitted the resident on 05/10/2024 with the diagnoses including cerebral infarction due to embolism of unspecified precerebral artery, mood disorder due to known physiological condition, secondary hypertension, and weakness. Review of R79's Minimum Data Set with an Assessment Reference Date (ARD) of 05/15/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS documented that it was very important for the resident to choose between baths and showers, and that the resident needed partial/moderate assistance from staff for bathing. Review of the resident's care plan revealed a goal with a target date of 11/19/2024 for the resident to be clean, dry and odor free through the next review. The care plan further documented that hygiene care would be provided daily and as needed with a 5/28/2024 start date. Review of the facility's undated Shower Schedule AB Unit provided by the Senior Administrator on 10/07/2024, revealed R79 was supposed to receive a shower twice a week (during day shift on Mondays/Thursdays). Review of the shower sheet in the Electronic Medical Record (EMR) revealed staff were to document each day that either a bath was given, a shower was given, the activity did not occur, or the resident refused care. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R79's shower sheets from 09/01/2024 through 10/08/2024 revealed no evidence of showers or baths between 09/01/2024 - 09/18/2024, or 09/30/2024 - 10/08/2024. Review of the shower sheets revealed that R79 had refused a shower on 09/02/2024 and 10/03/2024. During an interview with R79 on 10/07/2024 at 3:21 PM, R79 stated he refused his shower after staff woke him up at midnight to shower. R79 further stated that staff marked his shower as a refusal and did not offer to reschedule it the next day. Observation of R79 on 10/07/2024 at 3:21 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. An interview with R79 during this observation revealed that showers were not routinely offered twice a week per shower schedule, or during the scheduled shift of 7AM -7PM. R79 stated staff frequently wake him after midnight for his shower and that made him very upset. R79 further stated that he did not want family or friends to visit him when he couldn't get a shower because he knew how bad he smelled. R79 added that he is not a nasty person and liked to be clean. Observation of R79 on 10/08/2024 at 09:15 AM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. During an interview with R79 during this observation he stated he still had not had a shower since 09/30/2024 and I can smell myself. Observation of R79 on 10/09/2024 at 5:05 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. During an interview with R79 during observation he stated that he felt nasty when he didn't get a shower and liked to be clean every day. R79 added that he thought the facility should at least offer him a bed bath if they couldn't assist him with a shower. R79 further stated he had missed activities before because he felt too nasty to attend. 2. Review of R36's Admission Face Sheet revealed the facility admitted the resident on 07/06/2023 with diagnoses including multiple sclerosis, quadriplegia, contracture to the left elbow, muscle weakness, major depressive disorder, pressure ulcer to the left hip and sacral area, anxiety disorder, psychophysiologic insomnia, and a neuromuscular dysfunction of the bladder. Review of R36's Minimum Data Set with an Assessment Reference Date (ARD) of 09/15/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS documented that it was somewhat important for the resident to choose between baths and showers, and that the resident was dependent on staff for bathing. Review of the resident's care plan revealed an intervention for resident to use the shower bed for all baths with a 4/30/2024 start date. Review of the facility's undated Shower Schedule CDE Unit provided by the Senior Administrator on 10/07/2024, revealed R36 was supposed to receive a shower twice a week (during day shift on Tuesdays/Fridays). Review of the shower sheet in the Electronic Medical Record (EMR) revealed staff were to document each day that either a bath was given, a shower was given, the activity did not occur, or the resident refused care. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R36's shower sheets from 09/01/2024 through 10/08/2024 revealed no evidence of showers or baths between 09/10/2024-09/15/2024, and 09/24/2024-10/09/2024. Review of these shower sheets revealed that for each day when no shower/bath was provided, staff documented that the activity did not occur. Review of R36's Nurse Progress Note dated 10/01/2024 at 4:05 AM revealed resident refused bed bath and said, I don't like a bed bath, I'm not taking a bed bath until all my antibiotics are done then I will start taking my showers again. Observation of R36 on 10/07/2024 at 1:15 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. Observation of R36 on 10/08/2024 at 3:50 PM revealed the resident had a noticeable body odor. The resident's hair was flattened to the back of his head and appeared to be oily. During an interview with R36 during this observation he stated that I have to make them shower me. R36 further stated that the staff only wants to give him a bed bath because it takes two people to shower me, and they don't always have enough staff to do it. During an interview with R36 on 10/09/2024 he stated that the staff had been refusing to shower him because he was in isolation due to a urinary tract infection. R36 further stated that staff told him he could not go to the shower room until he completed his antibiotics. R36 added that he had felt gross and dirty this week. R36 also stated that he did not feel clean after taking a bed bath and that is why he preferred a shower. 3. Review of R64's Admission Face Sheet revealed the facility admitted the resident on 11/02/2022 with diagnoses including listerial sepsis, nicotine dependence, alcohol abuse, type 2 diabetes mellitus, depression, congestive heart failure, chronic atrial fibrillation, and chronic obstructive pulmonary disease. Review of 64's Minimum Data Set with an Assessment Reference Date (ARD) of 09/04/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. The MDS documented that it was somewhat important for the resident to choose between baths and showers, and that the resident required partial/moderate assistance from staff for bathing. Review of the facility's undated Shower Schedule CDE Unit provided by the Senior Administrator on 10/07/2024, revealed R64 was supposed to receive a shower twice a week (during night shift on Tuesdays/Fridays). Per the shower sheet in the Electronic Medical Record (EMR), staff were to document each day that either a bath was given, a shower was given, the activity did not occur, or the resident refused care. Review of R64's shower sheets from 09/01/2024 through 10/04/2024 revealed no evidence of showers or baths between 09/06/2024 - 09/23/2024. Review of the shower sheets revealed that R64 had a partial bath on 09/07/2024, and 09/13/2024. During an interview with R64 on 10/09/2024 at 8:40 AM he stated he had gone four weeks without a shower in the past due to staff waking him up after midnight to shower. R64 further stated that staff marked his shower as a refusal and did not offer to reschedule it the next day. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of R64 on 10/08/2024 at 8:56 AM and 10/09/2024 at 8:40 AM revealed a strong body odor scent. R64 stated during the observation that neither him nor his roommate had not been offered a shower in days. During an interview with R64 on 10/09/2024 at 5:18 PM R64 stated that he did not like being dirty or smelling bad. R64 further stated that this embarrassed him when he was around other residents. During an interview with Certified Nursing Aide (CNA) 8 on 10/10/2024 at 10:13 AM a partial bath was marked when staff cleaned the resident's face, arm pits, and peri area of the body. Review of the facility's undated Partial Bed Bath (assisting resident with bath) form it revealed that a partial bath was the cleaning of the entire body except the resident's hair, applying deodorant and lotion, and providing the resident with clean clothes. During an interview with CNA 12 on 10/11/2024 at 12:50 AM she stated that the facility does not always have enough staff to do all the scheduled showers. CNA 12 further stated that the facility had to have at least six CNAs on night shift to complete all their task and showers. 4. Review of R 84's Admission Face Sheet revealed R84 was admitted on [DATE] with diagnoses of Hemiplegia and hemiparesis following intracerebral hemorrhage affecting the left side, Atherosclerotic heart disease, and central pain syndrome. Review of R84's Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 09/10/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R84 was cognitively intact. Further review of the MDS section GG-Functional Abilities and Goals, revealed R84 was dependent with shower/bathing self, and toileting hygiene. Review of R84's Comprehensive Care Plan (CCP) dated 09/16/2024 revealed a self-care deficit as evidenced by the need for total assist with bathing, dressing lower body, mobility, related to left hemiplegia and additional risk for decline, and additionally R84 preferred no male caregivers. Interventions included grooming/dressing, and oral care, and incontinent care as needed. Goals were that R84 would be washed, dressed and free from symptoms of pain times 90 days. There was no documentation of resident centered goals for shower/bath or frequency. Further review of the CCP, dated 09/16/2024, revealed a behavior related to declination of showers and refusal of therapy with interventions of allowing the resident time to verbalize feelings, social worker to visit and encourage resident to follow physician orders. During an interview, on 10/08/2024 at 4:49 PM with R84, he stated he was supposed to get a shower or bed bath at least twice weekly, but only got one when he really needed a bath. R84 further stated the staff have come into his room late at night, not sure of time, asked if he wanted a shower, and he told staff it was too late. R84 stated if he refused a shower or bath, he had to sign a paper saying he refused. R84 further stated I don't refuse a shower or bath unless its late at night. During an interview, on 10/09/2024 at 8:52 AM with R84, he stated when staff came into the room, they would not listen to him when he requested assistance. R84 further stated when the Certified Nursing Assistant (CNA) (unknown) brought his breakfast tray in, just minutes before State Surveyor Agent (SSA) entered the room, R84 had told CNA he was soiled and needed his brief changed. R84 stated she just said OKAY and left the room. R84 pressed his call light for assistance at 8:53 AM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Madison Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 131 Meadowlark Drive Richmond, KY 40475	

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The SSA observed the Registered Nurse (RN) 1, on 10/09/2024 at 8:54 AM, step into R84's room, spoke with him briefly and turned off the call light. Continued observation, on 10/09/2024 at 8:57 AM, revealed the Infection Preventionist (IP) 1 (male), coming down hallway. The IP1 stated I thought a call light needed answered. LPN 4 stated No. I don't see a light on. RN1 did not say anything, and, as the IP started to walk away, the SSA informed him R84 needed assistance. The IP1 was then informed by RN1 that R84 needed assistance. The IP1 stated R84 would not let him provide care. Continued observation on 10/09/2024 at 9:01 AM revealed IP2 at R84's doorway. R84 informed IP2 he needed changed. IP2 went down hallway to get someone to assist R84. Continue observation on 10/09/2024 at 9:06 AM revealed CNA 7 came to R84's room, and IP2 also went into the room and closed the door to change R84. During an interview on 10/09/2024 at 9:25 AM, R84 stated he felt much better, and he didn't have to lay all day in a wet brief. R84 further stated sometimes it was 3-4 hours before someone came to change him. During an interview on 10/10/2024 at 3:54 PM, R84 stated he was informed his shower day was changed and he did not know what days he was supposed to have a shower. R84 stated the last shower he remembered was approximately 2 weeks ago when he was on another hallway. During an interview on 10/11/2024 at 6:30 AM, R84 stated he was not offered a shower yesterday or last night. R84 further stated CNA5 told him on 10/10/2024 that she was off on 10/11/2024, but would try to get him on the shower list for yesterday. During an interview on 10/11/2024 at 9:30 AM, R84 stated he was not offered a shower/bath last night and did not receive a bed bath. R84 further stated CNA11 had came in and changed his brief and cleaned him after he had a bowel movement. R84 further stated if they said I refused that is not true, I do not like being lied on, I did not refuse a shower. During an interview on 10/11/2024 at 2:54 PM, R84 stated his roommate had just been brought back from getting a shower. R84 stated he asked the CNA(unknown) if he was getting a shower next and she stated to him she wasn't sure that someone else had been added to the list. 5. Review of R55's Admission Face Sheet revealed the facility admitted the resident on 05/03/2024 with diagnoses which included right femur and spine fractures, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). Review of R55's Quarterly MDS assessment, dated 09/13/2024, revealed a BIMS score of 15 out of 15, which indicated R55 was cognitively intact. Further review of the MDS section GG-Functional Abilities and Goals revealed the facility assessed R55 to require substantial/maximal assistance with showering or bathing self and toileting hygiene. (continued on next page)

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Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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F 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of R55's CCP, dated 12/21/2021, revealed the facility assessed R55 to have a self care deficit as evidenced by diagnoses of respiratory failure, COPD and CHF. Interventions included for staff to provide assistance with the Activities of Daily Living (ADL) and oral mouth care every shift and as needed. Further review revealed no documentation of resident centered goals for shower/bath or frequency for R55. Review of the CCP dated 07/25/2022 revealed a behavior related to declination of showers with interventions to encourage the resident to follow physician orders and allow personal hygiene.

During an interview, on 10/11/2024 at 9:30 AM, R55 stated she did not receive her scheduled bath/shower on 10/10/2024 because staff came in about 10:00 PM to offer the shower, she had already gone to bed for the evening and I wasn't getting up once I went to bed. R55 further stated staff often try to bathe/shower her after she has gone to bed for the night and, if she refuses, staff do not offer to bathe/shower her at other times and she loses one (1) of her weekly showers.

During an interview on 10/11/2024 at 3:30 PM, the Director of Nursing (DON) stated she conducted random shower/bath audits. The DON stated her expectation was for showers/bathing to be provided to residents to maintain hygiene. The DON further stated a new shower sheet was provided to her on Monday from either the Wound Care nurse or the Unit Manager and the DON was told it was initiated by the Administrator. The DON stated she preferred the resident sign the shower sheets, so she knew they did refuse. The DON further stated the process they follow was, if a resident refused 1-2 times, a note was put in by the nurse on the floor. The note would be pulled by the DON and taken to the Interdisciplinary team meeting (IDT) every morning. The DON would then add the resident back to the list to see if maybe the time the bath was offered was wrong. The DON stated staff had not been documenting why a resident refused a shower until the past week or so. The DON further stated it was the responsibility of the IDT to talk to the Resident to see why a shower was refused. The DON stated she followed up to see why the shower was refused. According to the DON, shower sheets should have the reason why a shower was refused and the nurse should sign the document. The DON stated the process for refusal of the shower was the nurse was required to confirm the refusal with the resident, then document the findings in a progress note. The IDT then reviewed and added interventions to the care plan.

During an interview 10/07/2024 at 11:40 AM with the Senior Administrator she said showers were literally given all day. The Administrator further stated that the facility was in the process of adjusting shower schedule to avoid late hour showers.

Additional interview with the Senior Administrator and Administrator on 10/10/2024 at 4:05 PM revealed that the Senior Administrator had worked on a new shower schedule yesterday and instructed staff to start it today. She stated that currently the new shower schedule was based off the room number but would be tweaked in the upcoming days to reflect the resident's shower preference. Both Administrators stated that it was not their expectation for residents to be woke up for showers after 11 PM or marked as a refusal if this occurred.

During an interview on 10/11/2024 at 6:45 PM, the Interim Administrator stated her expectation was for residents to receive hygiene/showers as scheduled and should be clean and neat without odor. The Interim Administrator stated any refusals should be addressed as a team to discern a reason for the refusals. The Interim Administrator further stated R84 had been offered a schedule change in September, and the facility did a Performance Improvement Plan (PIP) for the shower process. The Interim Administrator stated several residents did not want a shower at night.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/2024 at 7:12 PM, the Medical Director stated his expectation was that residents receive regular showers/baths and be kept clean. The Medical Director further stated if a resident was refusing care, then there should be documented evidence and follow up to find reason for refusal of personal care and the resident should be accommodated as much as possible.

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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. 47852 Based on observation, interview, and record review, the facility failed to ensure all residents with gastrostomy tubes had their nutritional needs met and the administration of enteral nutrition was consistent with and followed the practitioner's orders for one (1) of 27 sampled residents, Resident (R) 74. Review of the facility's policy, Nutrition/Hydration Status Maintenance, dated 10/2020, revealed the facility would ensure, based on a resident's comprehensive assessment, a resident who demonstrated sufficient intake alone or with assistance was not fed by enteral methods unless the resident's clinical condition demonstrated enteral feeding was clinically indicated. Review of the facility's policy, Weight Process Standard of Practice, dated 07/2020, revealed the facility would provide nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment. The findings include: Observation, on 10/08/2024 at 3:05 PM, revealed R74 up in his wheelchair, with tube feeding disconnected. Further observation revealed a 1000 milliliter (ml) bottle of formula, dated 10/07/2024 at 10:00 PM, with 480 ml remaining in the bottle. Observation, on 10/09/2024 at 3:52 PM, revealed R74 out of his room with tube feeding disconnected and pump, tubing and bottle of formula hanging to bedside. Observation, on 10/09/2024 at 5:20 PM, revealed R74 up in his wheelchair, with tube feeding disconnected. Further observation revealed a 1000 milliliter (ml) bottle of formula, dated 10/09/2024 at 6:00 AM, with 500 ml remaining in the bottle. Observation, on 10/10/2024 at 1:38 PM, revealed R74 out of his room with tube feeding disconnected and pump, tubing and bottle of formula hanging to bedside. Review of R74's Admission Face Sheet revealed the facility admitted the resident on 09/19/2023 with diagnoses which included esophageal obstruction, gastro-esophageal reflux disease with esophagitis, and acute kidney failure. Review of R74's Physician's Orders, dated 06/26/2024, revealed an order for water per gastrostomy tube (GT) at 53 ml/hour for 22 hours per day. Review of R74's Physician's Orders, dated 08/09/2024, revealed an order for pureed diet with nectar thick liquids comfort foods and thin water and ice chips. Review of R74's Physician's Orders, dated 08/26/2024, revealed an order for formula per tube at 75 ml/hour for 22 hours a day. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with R74, on 10/08/2024 at 3:05 PM, he stated when staff assisted him from his bed to his wheelchair in the morning, they disconnected his tube feeding and it was typically not reconnected until bedtime when he went back to bed. He further stated some days he went without his tube feeding connected from 7:00 AM to 9:00 PM or 10:00 PM. He continued to state he wasn't sure how much of his nutritional needs were being met, and he did eat food by mouth some days, but not every day. In an interview with Licensed Practical Nurse (LPN) 8, on 10/09/2024 at 5:15 PM, she stated she did not normally work on that hall and believed R74's tube feeding was bolus and he unhooked himself from the feeding often. She further stated she was responsible for R74's care during that shift, but she did not work on his unit often. She continued to state she was unaware R74 had a physician's order for a continuous G-tube feeding instead of a bolus. In an interview with the Dietician, on 10/11/2024 at 2:35 PM, she stated she started as the facility Dietician in August 2024. She further stated she ran reports for the weekly weight meetings which triggered for significant weight changes but did not keep a calorie count on R74. She continued to state she was unsure how many calories R74 received each day and based her recommendation for formula of 75 ml/hour for 22 hours a day on the resident's nutritional needs. Additionally, she stated she was not sure how much of the feeding the resident received and she was aware he unhooked himself from the feeding periodically. She stated she had not completed any calorie counts for residents since she started as the Dietician. She further stated she was responsible for completing the Swallowing/Nutritional Status section of the resident's Minimum Data Set, which required a percentage of nutrition the resident received from tube feeding in relationship to overall nutrition. In an interview with the Director of Nursing (DON), on 10/11/2024 at 3:28 PM, she stated the facility did not complete calorie counts and used resident weights to determine resident's nutritional status. She continued to state residents who received tube feedings were discussed in the weekly weight meetings and R74's weight was stable. In an interview with the Administrator, on 10/11/2024 at 6:45 PM, she stated she expected staff to follow physician orders and to report to the physician if orders could not be followed so the physician could change the orders if needed. In an interview with the Medical Director, on 10/11/2024 at 7:12 PM, he stated it was his expectation for staff to follow all physician orders and notify him if they had trouble following the orders so treatment could be changed if necessary. He continued to state residents' health conditions could be negatively affected if physician orders were not followed, he treated residents based upon the current orders, and needed to be aware of any deviation from those orders to give the best care possible.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49360 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections. Review of the undated facility's policy, titled Hand Hygiene, revealed hand hygiene was described as cleaning your hands by using either handwashing, antiseptic hand wash, or antiseptic hand rub and was to be performed before and after glove use in the facility. Review of the facility's policy, titled Policies and Practices-Infection Control, revised October 2018, revealed the policy was intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Continued review of the policy revealed two of the objectives were to prevent, detect, investigate, and control infections in the facility and to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. 1. On 10/08/2024 at 8:15 AM, observation of LPN3 revealed she did not clean her hands before putting on gloves after touching a doorknob on the supply room door. During an interview with LPN3 on 10/08/2024 at 8:24 AM, LPN3 stated she knew she was supposed to clean her hands before putting on her gloves after touching the supply room doorknob but got nervous and forgot. LPN3 stated the risk for not performing good hand hygiene was spreading germs to residents and potentially giving herself an infection as she couldn't say who else had touched the doorknob. 2. On 10/11/2024 at 6:15 AM, during a tour of the facility, one pack of unopened briefs was observed lying on the floor in room [ROOM NUMBER]. During an interview with Certified Nursing Assistant (CNA) 12, on 10/11/2024 at 6:25 AM, CNA12 stated she was not sure who passed the briefs and they should have been put in the resident's closet, not lying in the floor. CNA12 further stated the briefs were contaminated and an infection control issue and should not be used on a resident. During an interview with Kentucky Medication Aide (KMA) 1, on 10/11/2024 at 6:25 AM, KMA1 stated the briefs were a fall risk for anyone entering or exiting room [ROOM NUMBER]. KMA1 further stated she was not sure who passed the briefs, but they should not be lying in the floor. During an interview with the Infection Preventionist (IP) on 10/11/2024 at 12:05 PM, the IP stated all staff should be using hand hygiene before and after putting on gloves as it was in the policy and all staff should follow the policies. The IP stated the risk for not using proper hand hygiene was the spread of infection, which could cause both residents and staff to get sick. The IP stated that briefs should never be left on the floor, whether they were opened or unopened, as it was not sanitary and could spread germs and bacteria throughout the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 10/11/2024 at 3:28 PM, the DON stated she expected her nursing staff to follow the facility policies, especially during direct care with the residents. The DON stated briefs should never be left on the floor even if unopened because of possible germs on the floor. The DON stated all of these infection control issues were discussed during the infection control training, which was just done on 09/23/2024. The DON stated the risk of anybody in the facility not utilizing good hand hygiene was the spread of infection, which could cause sickness to both staff and residents. The DON stated she made rounds daily on the hallways and if she saw an issue with infection control, then she educated either the staff or resident on good hand hygiene and the importance of washing hands. During an interview with the Administrator on 10/11/2024 at 6:45 PM, the Administrator stated she expected all staff to follow the policies and procedures of the facility. The Administrator stated if staff didn't use hand hygiene, then infection could spread and harm residents and staff. The Administrator stated she expected when briefs were passed to store them properly and not just put them on the floor as that went against the facility's infection control policy. The Administrator stated staff were educated on infection control during orientation and at least annually thereafter. The Administrator stated infection control had just been reviewed for all staff recently on 09/23/2024. The Administrator stated disciplinary action would occur if a staff member continued to be noncompliant with the policy.