STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185265	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grant Healthcare and Rehabilitation	201 Kimberly Lane Williamstown, KY 41097

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51155 Based on interview, record review, and review of the facility's policy, the facility failed to keep residents free from abuse for 1 of 25 sampled residents (Resident (R) 341). On [DATE], R341 was physically restrained by Certified Nursing Assistant (CNA) 6 and Licensed Practical Nurse (LPN) 6 while they were providing care which resulted in bruising of both of the resident's forearms. The findings include: Review of the facility's policy titled, Abuse, Neglect, and Exploitation, revised date [DATE], revealed, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. The policy also stated, 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations; and C. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriaton of resident property, reporting procedures, and dementia management and resident abuse prevention; and d. Establish coordination with the QAPI program. Review of R341's Facesheet revealed the facility admitted the resident on [DATE] with diagnoses of Alzheimer's disease, dementia, mood disturbance, and cerebral infarction without residual deficits. Further review revealed R341 expired on [DATE]. Review of R341's quarterly Minimum Data Set (MDS) assessment with an Assesment Reference Date (ARD) of [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating the resident had severe cognitive impairment. Further review revealed R341 was dependent for toileting hygiene. Review of R341's Care Plan revealed R341 was care planned for behavioral symptoms related to a history of resisting/refusing the care regime with the intervention/approach of to respect the resident's right to make decisions, dated [DATE]; provide a calm environment and demeanor, and if the resident resisted care, try to do the task later without forcing her, dated [DATE]; and if the resident refused care, try at a later time, possibly with a different staff member, dated [DATE]. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R341's ,d+[DATE] Medication Administration Record (MAR) revealed she had an order for aspirin 81 milligrams (mg) daily. Review of CNA6's Witness Statement, dated [DATE], revealed during rounds on [DATE], CNA6 entered R341's room and told her CNA6 was going to change her. R341 refused, pulled the covers up, and would not allow CNA6 to change her. Per the statement, CNA6 left the room and reported to LPN6 that R341 was refusing to be changed. Per the statement, CNA6 stated LPN6 told her she would help her change R341 when she was finished with her medication administration. Per the statement, CNA6 stated once LPN6 was finished, they both went into R341's room to change her, and the resident still refused to be changed. Per the statement, CNA6 stated LPN6 had to hold R341's hands against R341's chest because she was trying to hit them. Per the statement, once CNA6 changed the resident, they were rolling her back over, and CNA6 reported she was then holding R341's hands, and R341 was squeezing CNA6's hands. Per the statement, CNA6 was asked if at any point did R341 state they were hurting her. CNA6 stated yes. Review of R341's Wound Management Note, dated [DATE] at 6:34 PM, revealed the left lower arm bruise measured 12 centimeters (cm) long by 6.5 cm wide, and the color was black. The right lower arm bruise measured 18 cm (length) X 9.5 cm (width) and was black in color. Review of R341's Progress Notes on [DATE] at 9:05 PM revealed the resident was noted with discolorations to her bilateral upper extremities (BUE); the resident took aspirin daily; the Medical Director was aware of the bruising; a message was left for R341's representative to call the facility; and new orders were received to observe the resident every shift. Review of R341's Progress Notes on [DATE] at 1:23 AM revealed there was no change in the bruising on her arms; sleeves were in place; the resident denied pain or distress; and no open areas or infection were noted. Further review revealed on [DATE] at 2:17 PM geri-sleeves (placed on the arms to prevent skin injury) were in place. Review of R341's Progress Notes on [DATE] at 2:28 AM revealed the resident continued to have bruising to her BUE but denied pain and geri-sleeves were in place. The note stated on [DATE] at 10:04 AM the BUE bruising remained, and the resident would be followed by the Wound Nurse Practitioner (NP) on rounds. Per the note, R341's representative was now aware. Further review revealed on [DATE] at 2:43 PM the resident continued with bruising to her BUE, and geri-sleeves were in place. Review of R341's Progress Notes on [DATE] at 2:17 AM revealed the resident continued with bruising to her BUE but denied pain, and geri-sleeves were in place. Further review on [DATE] at 8:53 PM revealed both arms were looking better, and the bruising was getting lighter. Review of R341's Progress Notes on [DATE] at 6:53 AM and 10:03 AM revealed the bruises remained on her BUE, and the geri-sleeves were in place. Review of R341's Progress Notes on [DATE] at 2:45 AM revealed the resident denied pain; at 2:45 AM and 11:56 AM the note stated the resident continued with bruising to her BUE, and the geri-sleeves were in place. Review of R341's Progress Notes on [DATE] at 2:03 AM and [DATE] at 2:57 AM revealed the resident continued with bruising to her BUE, and the geri-sleeves were in place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R341's Progress Notes on [DATE] at 11:13 AM revealed the resident refused a skin assessment and a shower and/or bed bath at this time. Per the note, the resident had no complaints of pain/discomfort. Review of R341's Progress Notes on [DATE] at 6:40 PM revealed the resident was seen by the Wound NP on rounds and documented the discoloration to the resident's BUE were healed, and the Medical Director was aware. Unsuccessful attempts were made to contact R341's representative on [DATE] at 4:04 PM. Immediately after this, a text message was sent, with no response received. During an interview with CNA6 on [DATE] at 6:00 PM, she stated she was familiar with R341 because she had just returned to work from maternity leave when the incident happened. She stated R341 had fragile skin and needed to be cleaned frequently. She stated when she entered R341's room to clean her up, R341 was not acting like she normally did, and the resident was being mean and combative. She stated she went out of room to get assistance from another staff member to help her. She stated she asked LPN6 for help, and LPN told her the LPN would help after she administered medications. CNA6 stated when she and LPN6 entered the room to clean R341, LPN6 was holding R341's arms to keep her from hitting. She stated, once they turned R341 over to get the dirty things out from under her, LPN6 instructed her to hold the resident's arms. She stated she followed instructions and held the resident's hands, but she did not feel like she held them tightly enough to cause bruising. She stated the whole time the resident was yelling that they were hurting her. She stated she did not know the bruises were there until the next day when she overheard staff talking about it. She stated when she entered R341's room the resident pointed CNA6 out, held up her arms, and said, You did this to me. CNA6 stated she was on her way to talk to the Director of Nursing (DON), when she was called into the office and suspended. She stated she was suspended for one week, and then the facility called her and terminated her over the phone. During an interview with Registered Nurse (RN) 3 on [DATE] at 9:20 AM, she stated she had no concerns related to care provided by CNA6 and did not recall the agency nurse involved. During an interview with LPN1 on [DATE] at 9:49 AM, she stated she was working the day the bruises were discovered on R341. LPN1 stated R341 complained that someone grabbed her arm. LPN1 stated she never had any issues/concerns with the care provided to residents by CNA6. She stated she did not remember LPN6. During an interview with the Activities Director (AD) on [DATE] at 12:30 PM, she stated she was a CNA at the time of the incident. She stated she entered the resident's room after coming on shift on [DATE]. She stated R341raised her arms and said, Look what they did to me. The AD stated R341 had bruises on both forearms that covered most of the surface area. The AD stated she had worked the previous day, and the bruises were not there. She stated she never had any concerns regarding care provided by CNA6 prior to this event. However, she stated CNA6 had no reaction when the resident showed her the bruises, and CNA6 never apologized to the resident. She stated CNA6 reported to her that she had to get a little aggressive and hold the resident's arms so she could perform care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN6 on [DATE] at 1:05 PM, she stated she was an agency nurse at the time of the incident. She stated she worked at the facility via the agency for six to eight months. She stated she remembered the resident and the incident. She stated the incident was why she quit picking up shifts at the facility. She stated the resident was confused on the day of the incident and did not want to be cleaned. However, she stated the resident had a pressure ulcer to her bottom and needed to be cleaned. LPN6 stated she had always been able to redirect R341, and she was able this day as well. However, she stated midway through cleaning R341, the resident became angry, combative, and began to throw her arms around. She stated the resident hit her and CNA6, who was helping. LPN6 stated she had to protect herself and had to hold the resident's hands. However, LPN6 stated she did not feel she held the resident tight enough to cause bruising. She also stated, if CNA6 felt like she was causing harm to the resident, she would have expected the CNA to tell her. During an interview with the DON on [DATE] at 8:52 AM, she stated she never had any concerns with CNA6 providing care to residents. She stated she expected any abuse to be reported immediately. She also stated residents had the right to refuse care. During an interview with the Administrator on [DATE] at 9:38 AM, he stated he was also the abuse coordinator. He stated he attempted to reached out to both perpetrators and was unsuccessful with reaching LPN6 but was able to reach CNA6. He stated he had a conversation and took a statement from CNA6. He stated LPN6 was an agency nurse who never returned his call. He stated he did not believe CNA6 intended to harm to resident, but she was ultimately terminated. He stated LPN6 was placed on a do not return list. He stated the incident was reported to the Ombudsmen, state agency, and Adult Protective Services (APS). He stated LPN6 was reported to her agency. He stated CNA6 was previously employed at an assisted living facility before she came to the facility. He stated, once here, she had some issues with services related to changing/cleaning residents that was addressed but did not exhibit behaviors related to any abuse toward residents. He stated LPN6 did not exhibit any behaviors prior to the incident. He stated his expectation was that no one in the facility was abused. He stated if staff saw abuse, he expected staff to stop it, keep residents safe, and report it immediately. The Administrator stated this was important because, I care about the resident, and they should not be in an environment where there is a possibility they could be abused.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51155 Based on observation, interview, review of the website https://www.fda.gov/media/74866/download, review of Medication Refrigerator Temperature Guidelines: What You Should Know, and review of the facility's policies, the facility failed to label and store drugs and biologicals in accordance with currently accepted professional principles for 1 of 2 medication refrigerators observed. A multi-use vial of Tuberculin Purified Protein Derivative (PPD) was found in a plastic bag in the door of the refrigerator and was opened and not dated in the Medication Room on Heritage Hall. The findings include: Review of the facility's policy titled, Medication Storage, revised 08/01/2024, revealed it was the policy of the facility to ensure all medications housed on the premises would be stored in accordance with the manufacturer's recommendations to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Review of the facility's policy titled, Medication Administration, revised 02/20/2024, revealed the nurse must identify the expiration date. Per the policy, if the medication was expired, the nurse manager should be notified. Review of website https://www.fda.gov/media/74866/download, under Storage for Tuberculin Purified Protein Derivative stated a vial of tubersol which has been entered and in use for 30 days should be discarded. It also stated PPD should be stored in a refrigerator at a temperature between 35 to 46 degrees Fahrenheit. Review of the American Biotech Supply document Medication Refrigerator Temperature Guidelines: What You Should Know, undated, revealed medications should be stored in the center of the refrigerator, away from the bottoms and sides. It stated to never store medications in door shelves or bins as these areas were prone to larger fluctuations in temperature. Observation on 10/22/2024 at 11:00 AM, revealed one opened and undated multiuse vial of PPD (used in a tuberculin skin test to diagnose tuberculosis) was found in door of the refrigerator on the Heritage Hall medication room. During an interview with an agency nurse, Licensed Practical Nurse (LPN) 7 on 10/24/2024 at 8:39 AM, she stated when opening a multi-use vial of medication, it was to be dated. LPN7 stated she was not aware of not storing medications in the door of the refrigerator. She stated she received all her education through her agency. During an interview with LPN5 on 10/24/2024 at 8:43 AM, she stated she knew to date multi-dose medications when opening for the first time. She stated she knew not to store medications in the refrigerator door. She stated all her education and competencies were done through the agency portal. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN) 3 on 10/24/2024 at 9:20 AM, she stated any medication should be dated when opened. She stated, if a medication was found opened and undated, it should be discarded and replaced with a new one. She stated no medication should be kept in the door of the refrigerator due to not being stored at the proper temperature. During an interview with LPN1 on 10/24/2024 at 9:49 AM, she stated any medication should be dated when opened. She stated, if opened and not dated, the medication should be discarded and replaced with a new one. She stated this was done because if the medication was outdated, it might not work the same. LPN1 stated no medication should ever be placed in the door of the refrigerator. During an interview with the Director of Nursing (DON) on 10/24/2024 at 8:52 AM, she stated she expected nurses to date medications when they opened them. She stated no medications should be stored in the door of the refrigerator. During an interview with the Administrator on 10/25/2024 at 9:38 AM, he stated it was his expectation for staff to follow policies and procedures that were in place related to medication storage and administration. He stated staff had to date the medication when opened for the first time so staff knew when the medication should be discarded. He stated it was important to ensure the residents were not receiving expired medications.

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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. 50442 Based on observation, interview, review of the facility's policies, review of the manufacturer's directions for use for the Assure Prism Multi-Blood Glucose Monitoring System, and review of the instructions for Clorox Healthcare Bleach Germicidal Wipes, the facility failed to follow standard infection procedures for cleaning and handling 1 of 8 glucometers. The findings include: Review of the facility's policy titled, Routine Cleaning and Disinfection, dated 01/02/2020, revealed the purpose of the policy was to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Review of the facility's policy titled, Blood Glucose Monitoring, dated 01/02/2020, revealed the purpose of the policy was for the facility to perform blood glucose monitoring to diabetic residents as per physician's orders. The policy outlined the procedure for obtaining a resident's blood glucose level. As part of the procedure for obtaining the blood glucose level, the policy stated the glucometer was to be cleaned and disinfected per manufacturer's instructions. Review of the Assure Prism Multi-Blood Glucose Monitoring System's User Instruction Manual revealed the glucometer should be cleaned and disinfected after use on each resident and might only be used for testing multiple residents when Standard Precautions and the manufacturer's disinfection procedures were followed. Further review revealed the only cleaning and disinfecting solution that had been validated for use with this glucometer was Clorox Healthcare Bleach Germicidal Wipes. Review of the cleaning and disinfecting instructions for Clorox Healthcare Bleach Germicidal Wipes container revealed for cleaning and disinfection the contact time was three (3) minutes. Observation on 10/23/2024 at 8:35 AM revealed Registered Nurse (RN) 1 placed the cleaned glucometer onto the surface of the medication cart labeled Cart 400-408, without a barrier underneath. Further observation revealed RN1 touched the glucometer without wearing gloves. In an interview with RN1 on 10/23/2024 at 8:35 AM, he stated he only placed cleaned glucometers on barriers when he set them on surfaces inside a resident's room. He also stated he did not wear gloves to touch the glucometer unless he was performing a blood glucose test, handling a used glucometer, or cleaning the glucometer. In an interview with Licensed Practical Nurse (LPN) 5 on 10/23/2024 at 8:58 AM, she stated glucometers were to be cleaned between residents. She stated they were to be cleaned/disinfected with Clorox Wipes. She stated after wiping the glucometer, she wrapped it in the Clorox wipe and placed it in a clean cup. LPN5 stated the time needed to kill microbes was three minutes. After the glucometer dried, she stated she placed it on a barrier (a paper towel) on top of her medicine cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 10/24/2024 at 4:24 PM, she stated her expectation was that nursing staff would clean the glucometer after use, in between each resident. The DON stated the procedure for cleaning and disinfecting the glucometers was the glucometer was cleaned by wiping it with the Clorox Healthcare Bleach Germicidal Wipes and then disinfected by wrapping it in the wipe to keep it wet for the three minutes needed to kill microbes. She stated the wrapped glucometer was placed in a clean plastic cup. She stated, once cleaned and disinfected, the glucometer should be placed on a barrier. In an interview with the Administrator on 10/25/2024 at 8:20 AM, he stated glucometers should be cleaned after use/between each resident. He stated he expected nursing staff to clean and disinfect the glucometers with the wipes provided by the facility. He stated, once the glucometer was cleaned/disinfected, it should be placed on a barrier.