STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185275	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Hartford Rehab & Wellness	114 McMurtry Hartford, KY 42347

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure that each resident was free from chemical restraints imposed for purposes of discipline or convenience and that were not required to treat the resident's medical symptoms. Additionally, the facility failed to ensure that residents who use psychotropic drugs have behavior monitoring, non-pharmacological, and behavioral interventions for one of three sampled residents, Resident (R) 83.The findings include: Review of the facility's policy titled, Psychotropic Medications Policy, dated 05/07/2024, revealed psychotropic medications would be used appropriately for residents with mental illness and or related disorders. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotics, antidepressants, antianxiety, and hypnotics. Continued review revealed the facility would make every effort to comply with state and federal regulations related to the use of psychotropic medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects, risk, and/or benefits. Each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practical mental, physical and psychosocial well-being. As part of the residents' medication management, it is important for the interdisciplinary team to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility supports the goal of determining the underlying cause of residents having difficulty sleeping, so the appropriate treatment of environmental or medical interventions can be utilized prior to psychotropic medication use. Review of R83's Resident Face Sheet revealed the facility admitted the resident on 05/27/2025 with diagnoses that included multiple sclerosis, unspecified dementia, mild, with other behavioral disturbance, insomnia, and psychoactive substance abuse, uncomplicated.Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/29/2025, revealed a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating R83 was cognitively intact. Continued review of the MDS assessment revealed R83 had not exhibited any behaviors and active diagnosis included, non-Alzheimer's Dementia, and no psychiatric or mood disorders were documented on the admission MDS. Additional review of the MDS assessment revealed R83 received antipsychotic medication with an indication noted. Further review revealed that question N2001, drug regimen review, was not answered and was left blank.Review of the Hospital Discharge summary dated [DATE] revealed R83 discharge diagnoses included self-care deficit, multiple sclerosis, decubitus ulcer of sacrum stage 3, mild dementia with mood disturbance, history of drug abuse and chronic pain.Review of Event Report, Pharmacy Recommendation, dated 05/29/2025, revealed the pharmacy consultant completed a medication regimen review but gave no recommendations related to psychotropic medications and or diagnosis.Review of Event Report, Pharmacy Recommendations dated 06/16/2025, revealed the Medication Regimen Review (MRR) was completed and no recommendations were made.Review of physician order dated 05/27/2025, revealed R83 admitted to the facility with an order Seroquel (an antipsychotic) 100 milligrams (mg) daily at bedtime. The indication (diagnosis) for the medication was insomnia and dementia with mood disorder.Review of physician order dated 05/30/2025, revealed an order that read, 'Target Behavior: restlessness, inability to concentrate, impulsiveness, and lack of interest. Documentation directions read, at the end of each shift mark frequency-how often behavior occurred and intensity-how resident responded to redirection. Intensity code: 0=did not occur, 1=easily altered; 2= difficult to redirect.In an interview with the Pharmacy Consultant on 07/03/2025 at 10:36 AM, she stated she does medication reviews on admission and monthly. She stated insomnia was not an adequate diagnosis for the use of Seroquel. She stated R83 had a history of drug abuse which can cause mental and psychological issues. She stated Seroquel was a mood stabilizer and could be beneficial. She stated when reading the admission note that the NP provided, she saw a diagnosis of neurocognitive disorder and did not address the insomnia diagnosis listed as the indication for use. She further stated she does not typically ask for a dose reduction on psychotropic medications until the residents have settled in at the facility.In an interview with the interim Nurse Practitioner on 07/03/2025 at 11:03 AM, she stated she was just filling in and was not the routine provider for the facility. The NP stated using Seroquel for a diagnosis of insomnia would be dependent on the resident. She stated she gave no new diagnosis to R83, and she read he had a diagnosis of neurocognitive disorder in the hospital records. She stated she would expect behavior monitoring and care plan to be in

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policies, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident, to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for two of 22 sampled Resident (R) 83 and R59. The findings include: 1.Review of facility policy, Comprehensive Care Plans', reviewed on 01/31/2025, revealed the facility would develop and implement a comprehensive person- centered care plan for each resident that included measurable objectives, the time frames to meet a residents’ medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. Continued review revealed the licensed nurse and or the interdisciplinary team (IDT) would develop and maintain a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain. Each resident's comprehensive care plan was designed to incorporate identified problem areas and incorporate risk factors associated with identified problems. The comprehensive care plan would be person-centered for each resident. Review of facility policy Psychotropic Medications Policy, dated 05/07/2024, revealed psychotropic medications would be used appropriately for residents with mental illness and or related disorders. Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions unless clinically contraindicated in an effort to discontinue these drugs. It was important for the interdisciplinary team (IDT) to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility supported the goal of determining the underlying cause of residents having difficulty sleeping, so the appropriate treatment of environmental or medical interventions can be utilized prior to psychotropic medication use. Review of Resident Face Sheet revealed the facility admitted Resident 83 (R83) to the facility on [DATE] with diagnoses that included multiple sclerosis, unspecified dementia, mild, with other behavioral disturbance, insomnia, and psychoactive substance abuse, uncomplicated. Review of the admission Minimum Data Set with an assessment reference date (ARD) of 05/29/2025, revealed a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating R83 was cognitively intact. Review of MDS, section E, Behavior, revealed R83 had not exhibited any behaviors. Review of physician order dated 05/27/2025, revealed R83 admitted to the facility with an order Seroquel (an antipsychotic) 100 milligrams (mg) daily at bedtime. The indication (diagnosis) for the medication was insomnia and dementia with mood disorder. Review of physician order dated 05/30/2025, revealed an order that read, 'Target Behavior: 'restlessness, inability to concentrate, impulsiveness, and lack of interest. Documentation directions read, at the end of each shift, mark frequency-how often behavior occurred, and intensity-how resident responded to redirection. Intensity code: 0=did not occur, 1=easily altered; 2=difficult to redirect. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R83's Comprehensive Care Plan (CCP), dated 05/27/2025, revealed the care plan did not include a focus problem for any type of behavior monitoring as indicated by the physician's order. Additionally, there was no evidence that a care plan had been developed for R83's diagnosis of insomnia. Review of CCP focus problem, Health Related Complications, dated 05/27/2025, revealed Patient was at risk for substance abuse due to substance use disorder. Interventions dated 05/27/2025 included offer behavioral health services as indicated for substance use disorder, be alert for bizarre behaviors with visiting friends and family members. Review of Psych Services Consent to Treat, not signed by R83 or his representative, revealed, R83 declined services on 07/03/2025. During an interview with the Minimum Data Set (MDS) nurse and the Regional Clinical Reimbursement Specialist (CRS) on 07/03/2025 at 3:31 PM, the MDS nurse stated she had been the MDS nurse since February and was still in training. The MDS nurse stated, the purpose of the care plan was to plan care for the resident to guide staff. She stated it was important for the care plan to be accurate so that staff know what care a resident needed. The MDS nurse stated R83 did not have a behavior care plan because he did not have behaviors. She stated that the Seroquel was for insomnia. During an interview with the Assistant Director of Nursing (ADON) on 07/03/2025 at 3:58 PM, she stated R83 really doesn't have any behaviors. She stated he had a diagnosis of insomnia, dementia with mood disorder, and substance abuse. She stated she would not expect R83 to have a behavior care plan if he did not have behaviors. During an interview with the Director of Nursing on 07/03/2025 at 4:07 PM, she stated she expected care plans to reflect the needs of the residents. She stated R83 should have had a care plan for insomnia. The DON stated that if behavior monitoring was being done on a resident, then the resident should have a behavior care plan. The DON stated that nonpharmacological interventions vary and should be specific to the residents. During an interview 07/03/2025 with R83 at 4:56 PM, he stated he was offered psych services today, just a few minutes ago. He stated he had not been provided with psych services previously. R83 stated he had seen a therapist in another county last year, and when he requested something to help him sleep, Seroquel was prescribed. He stated he had been taking the medication for about a year. During an interview with the Administrator on 07/03/2025 at 5:01 PM, he stated he expected the Pharmacy Consult to follow guidelines and policies when doing the monthly medication reviews. He stated if the Nurse Practitioner referred a resident for a psychiatric consult, that information would be communicated to the Social Services Director, who would reach out to the provider. He stated he was not sure if R 83 had been offered or refused psych services since admission to the facility. 2. Review of the facility's policy titled, Falls, last revised on 01/31/2025, revealed care plan goals and interventions would be revised as applicable, and a comprehensive care plan would be implemented with interventions specific to each resident to attempt to reduce the risk of avoidable falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R59' Face Sheet revealed the facility admitted the resident on 05/26/2022 with diagnoses that included unspecified displaced fracture of surgical neck of left humerus, subsequent encounter for fracture with routine healing, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/02/202 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R59 is cognitively intact. Review of a Progress Note dated 06/04/2025 at 8:38 AM revealed R59 experienced a fall during a self-transfer to the recliner when the recliner moved causing R59 to fall without injury. Review of the Fall Event report dated 06/04/2025 at 8:59 AM revealed the Interdisciplinary Team (IDT) discussed the root cause of the fall and determined placing dycem under the legs of the recliner would address the root cause of the recliner sliding when weight was applied during a transfer. Review of the care plan in the category Falls identified an intervention with an approach start date of 06/04/2025 that stated dycem to legs under recliner. Observation on 06/30/2025 at 12:36 PM, 06/30/2025 at 4:15 PM, and 07/03/2025 at 5:02 PM, revealed there was no dycem was present under the legs of the recliner. In an interview with Certified Nursing Assistant (CNA) 4 (CNA4) on 07/03/2025 at 5:01 PM, CNA4 stated she was assigned to R56 on 07/03/2025. CNA4 stated she used the CNA paper as a guide to care. Upon viewing the CNA paper care guide, it was dated 05/27/2025 with no update regarding dycem related to the fall intervention placed for R59 on 06/04/2025. In an interview with Housekeeper (HK) 13 (HK13) on 07/03/2025 at 5:07 PM, HK13 stated she cleaned R59's room today but didn't recall seeing the dycem under R59's recliner. She added that she cleans on several of the halls and can't recall if she has seen the dycem in R59's room or not but knows what dycem was. In an interview with the Staff Scheduler / Ambassador (SS/A) on 07/03/25 at 5:29 PM, the SS/A stated she has been the Ambassador for R59 since around November [2024]. She stated she knew what dycem was and it normally sets under the metal frame of the recliner. The SS/A stated she doesn't know why it wasn't there. In an interview with the Director of Nursing (DON) on 07/03/2025 at 5:19 PM, the DON stated when a fall occurs, staff create an event in the electronic medical record (EMR) then call her or the on-call staff to notify of the fall and the immediate intervention. The DON stated events were reviewed as part of their clinical meetings and following the meeting, one staff will go and ensure the intervention is in place. The DON added that Ambassador Rounds were done daily to ensure interventions stay in place. She stated the CNA Care guide was updated daily and printed a couple of times a week then taken to the respective nursing desk to be placed in the binder but, added that CNAs can also see the plan of care in the EMR. She stated the interventions were in place to ensure the safety of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 07/03/2025 at 5:12 PM, he stated that if the IDT reviews an event and determines an intervention based on the root cause and reviews the intervention in place and may add to or change the intervention to ensure the resident was safe. He stated an intervention should be put in place, given a fair amount of time to place the intervention. He stated that from 06/04/2025 to 07/03/2025 would be a fair amount of time to place dycem under the resident's recliner. The Administrator further stated the IDT keeps the CNA care guide up to date and no one person was responsible to change out the updated versions. He stated the CNA could utilize the EMR to view the residents one at a time but, the care guide allowed more than one resident's information for ease of access.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and review of facility policy, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug without an adequate indication for its use. This affected one of three of 22 sampled residents Resident (R) 83. Review of record revealed R 83 was receiving an antipsychotic medication (seroquel) for an indication of insomnia and dementia. Review of the facility's policy titled, Psychotropic Medications Policy, dated 05/07/2024, revealed psychotropic medications would be used appropriately for residents with 's mental illness and or related disorders. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Continued review revealed the facility would make every effort to comply with state and federal regulations related to the use of psychotropic medications in the long-term care facility, to include regular review for continued need, appropriate dosage, side effects, including psychosocial, and risk and or benefits. Residents who use psychotropic drugs received gradual dose reductions and behavioral interventions unless clinically contraindicated in an effort to discontinue these drugs. Each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practical mental, physical, and psychosocial well-being. As part of the resident's medication management, it was important for the interdisciplinary team (IDT) to implement non-pharmacological approaches designed to meet the individual needs of each resident. The facility supported the goal of determining the underlying cause of residents having difficulty sleeping, so the appropriate treatment of environmental or medical interventions can be utilized prior to psychotropic medication use. Review of R83's Resident Face Sheet revealed the facility admitted the resident on 05/27/2025 with diagnoses that included multiple sclerosis, unspecified dementia, mild, with other behavioral disturbance, insomnia, and psychoactive substance abuse, uncomplicated.Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/29/2025, revealed a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating R83 was cognitively intact. Review of MDS, section E, Behavior, revealed R83 had not exhibited any behaviors.Review of MDS assessment revealed R83 was coded as having non-Alzheimer's Dementia, and no psychiatric or mood disorders were documented on the MDS. Further review revealed R83 received an antipsychotic medication with an indication noted. Continued review revealed that question N2001, drug regimen review, was not answered and was left blank.Review of physician order dated 05/27/2025, revealed R83 admitted to the facility with an order Seroquel (an antipsychotic) 100 milligrams (mg) daily at bedtime. The indication (diagnosis) for the medication was insomnia and dementia with mood disorder.Review of physician order dated 05/30/2025, revealed an order that read, 'Target Behavior: restlessness, inability to concentrate, impulsiveness, and lack of interest. Documentation directions read, at the end of each shift, mark frequency-how often behavior occurred, and intensity-how the resident responded to redirection. Intensity code: 0=did not occur, 1=easily altered; 2=difficult to redirect.Review of Event Report, Pharmacy Recommendation', dated 05/29/2025, revealed the pharmacy consultant completed a medication regimen review but gave no recommendations related to psychotropic medications and or diagnosis.Review of Event Report, Pharmacy Recommendations dated 06/16/2025, revealed the MRR was completed, and no recommendations were made Interview with the Pharmacy Consultant on 07/03/2025 at 10:36 AM, she stated she does medication reviews on admission and monthly. She stated insomnia was not an adequate diagnosis for the use of Seroquel. She stated R83 had a history of drug abuse, which can cause mental and psychological issues. She stated Seroquel was a mood stabilizer and could be beneficial. She stated that when reading the admission note that the Nurse Practitioner (NP) provided, she saw a diagnosis of neurocognitive disorder and did not address the insomnia diagnosis listed as the indication for use. She further stated she does not typically ask for a dose reduction on psychotropic medications until the residents have settled in at the facility.Interview with the interim Nurse Practitioner on 07/03/2025 at 11:03 AM, she stated she was just filling in and was not the routine provider for the facility. The NP stated that using Seroquel for a diagnosis of insomnia would be dependent on the resident. She stated she gave no new diagnosis to R 83, and she read he had a diagnosis of neurocognitive disorder in the hospital records. She stated she would expect behavior monitoring and a care plan to be in place for a resident receiving psychotropic medications, specifically antipsychotic medications. Interview with the Minimum Data Set (MDS) nurse and the Regional Clinical Reimbursement Specialist (CRS) on