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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185279	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mills Nursing & Rehabilitation	500 Beck Lane Mayfield, KY 42066

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 0656

Level of Harm - Immediate jeopardy to resident health or safety

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 37031

Based on interview, record review, and review of the facility's policies, it was determined the facility failed to implement a comprehensive person-centered care plan for each resident to meet the resident's medical, nursing, mental and psychosocial needs for one (1) of 29 sampled residents, Resident #1 (R1).

On [DATE], Nurse Assistant (NA) #3 (Non Certified) failed to implement R1's Comprehensive Care Plan related to ensuring there were leg rests on the wheelchair and that the resident was positioned correctly in the wheelchair in regards to the pommel cushion. (A pommel cushion is designed to promote proper positioning by preventing residents from sliding forward in the wheelchair and features a raised center section that helps keep legs supported). As NA #3 propelled R1 in the wheelchair, the resident fell face first onto the floor. The facility transferred R1 to the local hospital emergency room (ER). R1's diagnoses included traumatic subarachnoid hemorrhage of the brain, fracture of the first cervical vertebrae (neck), anterior displaced type II odontoid (neck) fracture, fracture of right eye socket on right side, and fracture of right maxillary sinus (cheek). R1 expired on [DATE]. (Refer to F689)

The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on [DATE], alleging removal of the Immediate Jeopardy (IJ) on [DATE]. The SSA validated the facility's IJ Removal Plan, on [DATE], and determined the deficient practice was corrected as alleged on [DATE], prior to the initiation of the investigation. Therefore, the IJ was determined to be Past Immediate Jeopardy.

The findings include:

Review of the facility's policy titled Comprehensive Care Plan, dated [DATE] and revised ,d+[DATE] revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, to meet a resident's medical, physical, mental, and psychosocial needs. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services are to be provided or arranged by the facility, as outlined by the comprehensive care plan.

(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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NAME OF PROVIDER OR SUPPLIER Mills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Beck Lane Mayfield, KY 42066	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The comprehensive care plan will be prepared by an interdisciplinary team and will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Review of R1's closed medical record Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses to include Alzheimer's Disease, anxiety disorder, open wound left foot, abnormal posture, unspecified dementia, cognitive communication deficit, and depression. Review of R1's Comprehensive Care Plan (CCP), dated [DATE], revealed a category problem of Activities of Daily Living (ADL) self-care performance deficit related to Alzheimer's Disease. The goal revealed the resident would maintain current level of care of ADLs with a target date of [DATE]. The interventions included: Locomotion, assist x one (1) in standard wheelchair; position with pommel cushion for parallel thigh alignment; and bilateral elevating leg rests dated [DATE]. An additional intervention was added for Pommel cushion to wheelchair dated [DATE]. Further review of R1's Comprehensive Care Plan (CCP), dated [DATE], revealed a category problem of being at risk for alteration in skin integrity due to blindness, dementia, incontinence, generalized weakness, and arterial ulcers to the right and left heels. The goal revealed the resident would not experience any unidentified alteration in skin integrity with a target date of [DATE]. Interventions included wheelchair legs to be padded for protection twice a day at 6:30 AM and 6:30 PM with a start date of [DATE]. Review of R1's Resident Profile Care Plan (Kardex -a care plan for nurse aides), undated, revealed interventions including assist x one (1) in standard wheelchair; position with pommel cushion for parallel thigh alignment and bilateral elevating leg rests with start date of [DATE]. In an interview with the Staff Development Coordinator on [DATE] at 2:10 PM, she stated this was the document viewed by the Nurse Aides and SRNAs in providing care for the residents. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of zero (0) out of 15. This score indicated the resident was severely cognitively impaired. Review of R1's Progress Notes, dated [DATE] at 5:45 AM, entered by Licensed Practical Nurse (LPN) #7, revealed the resident was up in the wheelchair, and slid to the floor in prone (chest down) position. An order was obtained from the Medical Doctor to send the resident to the emergency room (ER) and treat. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's hospital x-ray report, dated [DATE], revealed, Brain: acute hemorrhage in the right frontal region consistent with contusions and subarachnoid hemorrhage. Skull and facial bones: minimally displaced fracture of the right orbital roof. Suspect fracture of anterior wall of the right maxillary sinus. Orbits: external hemorrhage along the right orbital roof process. Fracture of the anterior arch of C1 (first cervical vertebra). Displaced fracture of the left posterior arch of C1 near the junction with the lateral mass in the region of the vertebral artery groove. Continued review of the hospital records, dated [DATE] and [DATE], revealed after consulting with the family, requests were made for comfort measures only. Continued review revealed the resident expired on [DATE] from injuries sustained from a fall at the Nursing Facility. Review of the facility's Incident Report titled, Incident Fall with Major Injury, dated [DATE], revealed on [DATE] at 5:45 AM, NA was pushing resident out of room after morning care. Resident noted to slide from wheelchair onto floor. Audit and interview with staff to ensure all interventions were in place at time of incident according to care plan. On the ADL care plan, the resident should be placed in a standard wheelchair with a pommel cushion for parallel thigh alignment and bilateral leg rest. Per the Incident Report, the leg rests were not used at the time of the fall. This Incident Report was completed by the Director of Nursing (DON) and Administrator. During interview on [DATE] at 9:09 AM, with State Registered Nurse Assistant (SRNA3/NA3) she stated at the time of R1's fall on [DATE], she was a NA (uncertified nurse aide) and since had become a SRNA. Per interview, she stated she had transferred R1 into the wheelchair and noticed the resident was leaning forward in the wheelchair. Further, she stated the pommel cushion was in the wheelchair to help the resident to sit in proper alignment. However, she stated R1 was not in correct alignment because her right leg was on top of the raised center portion of the pommel cushion and she did not want to hurt R1 by pushing her leg down as the resident was very rigid. SRNA #3 stated when she rolled the resident over the threshold of the door, there was a little bump at the threshold and the resident fell out of the wheelchair and went straight to the floor and did not slide out of the chair. In continued interview on [DATE] at 9:09 AM, SRNA #3 stated the leg rests were not on the wheelchair prior to the fall. During further interview related to why she did not put the leg rests on the wheelchair, she stated she had helped to take care of the resident during the last year and she did not think the resident needed the leg rests. SRNA #3 stated after the accident she was educated about the care plans, to look at them often, and if she was unsure about anything, ask a nurse. She stated she should have checked R1's care plan and followed it as it was written. SRNA3/NA3 stated she should have ensured she put the leg rests on the wheelchair and that the resident was positioned properly in the wheelchair with the pommel cushion. During interview with Licensed Practical Nurse (LPN) #7, on [DATE] at 7:41 AM, she stated she was the East Unit Charge Nurse on the night shift. She stated on [DATE] around 5:30 AM, NA #3 who was now a SRNA, came to notify her of R1's fall. LPN #7 stated she came down the hall and saw R1 was on the floor lying prone on the left side and was noted to have swelling with an abrasion to the forehead, and her nose was bleeding. She stated R1 was voicing complaints of hurting all over. LPN #7 stated NA #3 told her she was rolling the resident out to the hallway and the resident fell out of the wheelchair. The LPN stated she noticed the resident's leg rests were not on the wheelchair at the time of the fall. LPN #7 stated R1 was care planned to use the leg rests on the wheelchair and NA #3 should have followed the care plan. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with MDS Coordinator #1, on [DATE] at 12:30 PM, she stated she developed/revised Comprehensive Care Plans for all residents. However, there were many staff members who also wrote care plans including Nurses, Therapists, Social Services, and Administrative staff such as the Director of Nursing (DON). She further stated the Comprehensive Care Plans were used as a guide in caring for the residents and were to be followed as written. She further stated, all nursing staff had access to the residents' profiles and their Comprehensive Care Plans. During an interview with the Staff Development Coordinator (SDC), on [DATE] at 2:10 PM, she stated during general orientation, she used a PowerPoint presentation for staff education and all information was covered regarding the Comprehensive Care Plan and how to find it. She further stated the staff also used a computerized program for training on equipment usage, floor training, care plans, and documentation. The SDC verified that all SRNAs and Nurse Aides prior to becoming SRNAs, received this training. She stated the decision to utilize leg rests on wheelchairs could be made by therapy, nurses or physicians, but typically Physical Therapy would evaluate the residents for the need for leg rests on wheelchairs. She further stated, after R1 fell , she started education and ensured 100 % (percent) of clinical staff was educated related to finding the Comprehensive Care Plans and implementing them. During an interview with the Director of Nursing (DON), on [DATE] at 9:16 AM, he stated after he was notified of R1 sustaining a fall, he immediately started an investigation. The DON stated R1 was being pushed into the hall, and had to have taken a head first fall onto the floor. He stated R1 was being pushed in a wheelchair without the leg rests and was not sitting up in the wheelchair in proper alignment as per the Comprehensive Care Plan and Resident Profile Care Plan (Kardex). He further stated SRNA/NA #3 was educated related to following the CCP and Kardex after the incident. During a phone interview with the Medical Director, on [DATE] at 3:48 PM, he stated on [DATE] he was notified of R1's fall. Per interview, he stated he gave staff orders to send the resident to the Emergency Department for evaluation and treatment. The Medical Director stated the executive staff had a meeting on [DATE] regarding the facility's plan for corrective action. He stated after the incident, corrective action included further education for staff. He stated staff was to follow the Comprehensive Care Plans as written. During an interview with the Administrator on [DATE] at 4:10 PM, he stated he was notified of R1's fall the morning of the incident and the facility started working on the Root Cause. Per interview, he stated education was started on [DATE] for all nursing staff related to the importance of following the care plan. He further stated he expected all staff to follow the Comprehensive Care Plans as written.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37031 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (1) of 29 sampled residents (Resident (R1)). On [DATE], Nurse Assistant (NA) #3 (Non Certified) pushed R1 in her wheelchair from her room. However, NA #3 failed to place the leg rests on the wheelchair and failed to ensure the resident was positioned correctly in the wheelchair in regards to the cushion. R1 fell face first onto the floor. The facility transferred R1 to the emergency room (ER) for evaluation. R1 sustained injuries which included: traumatic subarachnoid hemorrhage of the brain, fracture of first cervical vertebrae (neck), anterior displaced type II odontoid (neck) fracture, fracture of right eye socket on right side, and fracture of the right maxillary sinus (cheek). R1 expired in the hospital on [DATE]. (Refer to F656) The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on [DATE], alleging removal of the Immediate Jeopardy (IJ) on [DATE], prior to the State Survey Agency's (SSA's) investigation. The SSA validated the facility's IJ Removal Plan, on [DATE], and determined the deficient practice was corrected as alleged on [DATE], prior to the initiation of the investigation. Therefore, the IJ was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy titled, Accidents and Supervision, dated [DATE] and revised [DATE], revealed the resident environment will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: (1) identifying hazards and risks; (2) evaluating and analyzing hazards and risks; (3) implementing interventions to reduce hazards and risks, and (4) monitoring for effectiveness and modifying interventions when necessary. Review of the facility's policy titled Falls, dated [DATE] and revised [DATE], revealed the facility strived to maintain a hazard free environment, mitigate fall risk factors, and implement preventative measures. Intensive efforts will be directed toward minimizing or preventing injury. Procedures include: any orders received from the physician should be noted and carried out; the resident's care plan should be updated to reflect any new interventions or change in interventions; discuss risks and interventions with resident and/or responsible party, and communicate interventions during shift report. Review of R1's Face Sheet (closed medical record) revealed the facility admitted the resident on [DATE] with diagnoses that included Alzheimer's Disease, anxiety disorder, open wound left foot, abnormal posture, unspecified dementia, cognitive communication deficit, and depression. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Comprehensive Care Plan (CCP), dated [DATE], revealed a problem of Activities of Daily Living (ADL) self-care performance deficit related to Alzheimer's Disease. The goal stated the resident would maintain the current level of care of ADLs with a target date of [DATE]. Approaches included: locomotion, assist x one (1) in standard wheelchair; position with pommel cushion (A cushion designed to promote proper positioning by preventing residents from sliding forward in the wheelchair. It features a raised center section that helps keep the legs supported) for parallel thigh alignment; and bilateral elevating leg rests dated [DATE]. Another approach was added for a Pommel cushion to the wheelchair dated [DATE]. Review of R1's Comprehensive Care Plan (CCP), dated [DATE], revealed a problem of being at risk for alteration in skin integrity. The goal stated the resident would not experience any unidentified alteration in skin integrity with a target date of [DATE]. Approaches included wheelchair legs to be padded for protection twice a day at 6:30 AM and 6:30 PM with a start date of [DATE]. Review of R1's Resident Profile Care Plan (Kardex) undated, revealed approaches included: assist x one (1) in standard wheelchair; position with pommel cushion for parallel thigh alignment and bilateral elevating leg rests with start date of [DATE]. During an interview with the Staff Development Coordinator on [DATE] at 2:10 PM, she stated the Kardex was viewed by the Nurse Aides and SRNAs in providing care for the residents. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0) out of 15 which indicated the resident was severely cognitively impaired. Review of R1's Occupational Therapist Evaluation, dated [DATE], revealed the reason for the referral by nursing was due to the residents' inability for holding her feet up during transport with nursing providing elevating leg rest. However, poor lower extremity placement with the knees flexed greater than 90 degrees caused the resident's feet to slightly go inward on the foot rest and increased bilateral lower extremity adduction (move toward the midline) impacting care as well as foot placement on the foot rest. The plan was to address positioning with devices that were appropriate and least restrictive. Further review revealed the resident was dependent in areas of eating, oral hygiene, personal hygiene, toileting, shower/bath, transfers, upper body dressing, lower body dressing and putting on or taking off footwear. Review of R1's Progress Notes, dated [DATE] at 5:45 AM, entered by Licensed Practical Nurse (LPN) #7, revealed the resident was up in the wheelchair, slid to the floor in prone (face down) position, and the Certified Nurse Aide (CNA) sent for the nurse. Upon nursing assessment, the resident had a bleeding nose, knot midline that was bleeding to the forehead, and her right eye was swollen shut. R1 had complaints of pain to the head and face. Resident alert to self and pain only, normal for resident. Left pupil three (3) millimeters (mm) and reactive, and unable to assess right due to swelling. Resident's normal is stiff and ridged and unable to assess Range of Motion (ROM). Order obtained from Medical Doctor to send the resident to the emergency room (ER) and treat. Employee to be educated. Power of attorney (POA) and Director of Nursing (DON) aware. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's hospital Admission Note, dated [DATE] through [DATE], revealed the resident arrived at the hospitalER on [DATE] at 6:27 AM and was transferred from a nursing home for contusion sustained from falling out of her wheelchair. Patient (resident) not very verbal. The hospital x-ray report, dated [DATE], revealed Brain: acute hemorrhage present in the right frontal region consistent with contusions and subarachnoid hemorrhage. Skull and facial bones: minimally displaced fracture of the right orbital roof. Suspect fracture of anterior wall of the right maxillary sinus. Sinuses: fluid in the right maxillary sinus which is mildly hyperdense. Mastoid air cells: small amount of right mastoid fluid without destructive changes. Orbits: external hemorrhage along the right orbital roof process. Fracture of the anterior arch of C1 (first cervical vertebra). Displaced fracture of the left posterior arch of C1 near the junction with the lateral mass in the region of the vertebral artery groove. Further review revealed the resident was admitted to the hospital and after consulting with family, requests for comfort measures only. Patient is a Do Not Resuscitate (DNR). Additional review revealed the resident expired on [DATE] from injuries sustained from a fall at nursing facility. Review of the facility's Incident Report titled Incident Fall with Major Injury, dated [DATE], revealed on [DATE] at 5:45 AM, NA was pushing the resident out of her room after morning care. The resident was noted to slide from the wheelchair onto the floor. Resident noted to be in prone position at the time. NA alerted nurse of event, nurse noted resident to be on floor with blood from nose, raised area to midline and laceration to forehead. Right eye noted to be swollen. Resident assessed for pain and voiced complaints of pain. Resident alert to self and pain, baseline for resident. Medical Director was in the facility for rounds and orders were given to send resident to the hospital ER to evaluate and treat and perform a Computed Tomography Scan (CT). Only history of falls was on [DATE] with no injury noted. Audit and interview with staff to ensure all interventions were in place at time of incident according to care plan. On the ADL care plan, resident should be placed in a standard wheelchair with pommel cushion for parallel thigh alignment and bilateral leg rest. Per the Incident Report, leg rests were not used at the time of locomotion. The Incident Report was completed by the Director of Nursing (DON) and Administrator. During an interview on [DATE] at 9:09 AM, with State Registered Nurse Assistant (SRNA) #3 (NA #3 at time of R1's fall), she stated she had worked at the facility approximately one (1) and a half months and worked the night shift. She stated she had been transferred to the facility from a sister facility. SRNA #3 stated on the morning of [DATE] she went to R1's room to perform morning care, brush R1's teeth, get her clothes on and brush her hair. In further interview, she stated she transferred the resident into the wheelchair by standing and pivoting the resident and sitting the resident down in the chair while the resident held onto her. During interview with SRNA #3, on [DATE] at 9:09 AM, she stated once R1 was in the wheelchair, she noticed she was leaning forward, but she thought the resident was just adjusting herself. SRNA #3 stated the pommel cushion was in the wheelchair, which was to help the resident to sit in proper alignment. However, she stated R1 was not in correct alignment because her right leg was on top of the raised center portion of the pommel cushion and she didn't want to hurt R1 by pushing her leg down as the resident was very rigid. She stated the resident did not respond much during conversation due to her dementia diagnosis. In further interview, SRNA #3 stated when she rolled the resident over the threshold of the door, there was a little bump at the threshold and the resident fell out of the wheelchair and went straight to the floor. She stated R1 did not slide out of the chair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview with SRNA #3, on [DATE] at 9:09 AM, she stated on [DATE], the R1's leg rests were leaning against the wall behind the wheelchair at the time she transferred the resident to the wheelchair. She stated the leg rests were not on the wheelchair prior to the fall. SRNA #3 state she did not put the leg rests on the wheelchair, she stated she did not think the resident needed the leg rests. She further stated she had helped to take care of the resident during the last year and had not used them. SRNA #3 stated she had not reviewed the resident's Comprehensive Care Plan or Kardex prior to the transfer. She stated she was unaware of the interventions related to the leg rests on the chair and making sure R1 was correctly positioned in the chair with the pommel cushion. She stated she had since been educated related to ensuring the Care Plan was followed. During an interview with Licensed Practical Nurse (LPN) #7, on [DATE] at 7:41 AM, she stated she was the East Unit Charge Nurse on night shift. She further stated on [DATE] around 5:30 AM NA #3, who was now a SRNA, came to get her. LPN #7 stated she came down the hall and saw R1 on the floor. She stated she told NA #3 to go find the charge nurse. LPN #7 stated R1 was lying prone on her left side on the floor. She further stated the resident had swelling with an abrasion to the forehead, and her nose was bleeding. LPN #7 stated there were no visual injuries to R1's arms or legs. She stated R1 was talking and voicing complaints she was hurting all over. LPN #7 stated NA #3 told her she was rolling the resident out to the hallway and the resident fell out of the wheelchair. The LPN stated the resident's leg rests were not on the wheelchair at the time of the fall. She further stated she had placed the leg rests in the seat of the resident's wheelchair earlier in the night prior to NA #3 assisting the resident to the wheelchair in the morning. In continued interview, LPN #7 stated R1 was care planned for locomotion to use the leg rests on the wheelchair prior to the fall. During a phone interview with SRNA #5, on [DATE] at 9:10 AM, she stated she had been NA #3/SRNA #3's preceptor/trainer since she started. She stated she was not there the night of R1's fall. However, SRNA #5 stated NA #3/SRNA #3 had been trained fully on transfers, reading and following the care plans and finding help if she did not understand or remember how to follow a task. She further stated she had told NA#3/SRNA #3 to always ask her trainer or another person/nurse/SRNA if she needed help with any task. During a phone interview, on [DATE] at 9:30 AM, with SRNA #7, she stated she was working on [DATE] and NA #3 was supposed to come to her if she needed help or had questions. She denied that NA #3 had asked her any questions on [DATE]. SRNA #7 stated she came out of a resident's room and saw R1 on the floor with NA#3 and the charge nurse with the resident. During an interview with the Director of Nursing (DON), on [DATE] at 9:16 AM, he stated he received a phone call related to R1 sustaining a fall and when he arrived at the facility an investigation was initiated. He stated, R1 was being pushed into the hall, and had to have taken a head first fall onto the floor. He further stated R1 was an AM get up which meant the night shift assisted her out of the bed to get her ready for breakfast prior to the end of the shift. The DON stated on the morning of R1's fall, she was being pushed in a wheelchair without leg rests even though it was safer for her to have leg rests on the wheelchair. He stated the resident had not been sitting properly in the wheelchair at the time of the fall. He stated these safety measures were on the resident's Comprehensive Care Plan and Resident Profile Care Plan (Kardex) prior to the fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview with the Medical Director, on [DATE] at 3:48 PM, he stated he had just left the faciity on [DATE] and was called by the facility to advise related to R1's fall. He stated he gave staff the orders to send the resident to the Emergency Department at the local hospital for evaluation and treatment. He further stated he was aware of the resident's outcome. He stated the executive staff had a meeting the day of R1's fall regarding the facility's plan for corrective action which included further education for staff. During an interview with the Administrator, on [DATE] at 4:10 PM, he stated he was aware of R1's fall and it was an unfortunate occurrence. He further stated after the fall, the facility started working on the Root Cause of the incident and education was started immediately for all nursing staff related to the need to follow the care plans, as this was important for the safety of the residents.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37031 Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. This affected Residents (R), R1, R46, R53, R54, R88, R91 and R403. On 05/10/2024, reconciliation of the controlled drugs, on the East Hall with Licensed Practical Nurse (LPN) #4, revealed narcotics and scheduled drugs had not been signed out on the narcotic sign out book as administered. The findings include: Review of the facility's policy titled, Controlled Substances, dated 08/22/2019 and revised 08/19/2023, revealed the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Review of the facility's policy titled, Medication Administration, dated 01/21/2023 and revised 02/20/2024, revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The Policy Explanation and Compliance Guidelines included: Sign Medication Administration Record (MAR) after the medication was administered. For those medications requiring vital signs, record the vital signs onto the MAR. If the medication is a controlled substance, sign the narcotic book. During a narcotic count on 05/10/2024 at 9:00 AM, with LPN #4, there were discrepancies in the controlled substance drug count and the narcotic sign out sheets. After two (2) discrepancies were found, LPN #4 stated this State Surveyor would find several drugs which had not been signed out on the narcotic sign out sheets. She stated she had not signed out her controlled substance drugs during her morning medication pass, even though she had administered the controlled medications. She stated it was quicker for her to administer the medications and sign them out later. There was a discrepancy in the controlled substance drug count and the narcotic sign out sheets for the following residents: 1. The facility admitted Resident #1 on 01/06/2024 with diagnoses which included paraplegia and spina bifida. During the controlled drug count, an Oxycodone 10 mg (milligram)/325 mg tablet (narcotic pain medication) was missing. 2. The facility admitted Resident #46 on 06/23/2022 with diagnoses which included vascular dementia and chronic pain syndrome. During the controlled drug count a 0.5 mg Alprazolam tablet (anti-anxiety medication) was missing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility admitted Resident #53 on 04/03/2023 with diagnoses which included polyneuropathy and rheumatoid arthritis. During the controlled drug count a 0.5 mg Clonazepam tablet (medication used to treat anxiety and neuropathic pain) was missing. 4. The facility admitted Resident #54 on 04/18/2024 was diagnoses which included: type 2 diabetes mellitus with diabetic peripheral angiopathy. During the controlled drug count, a Lyrica 200 mg capsule (medication used to treat nerve and muscle pain) was missing. 5. The facility admitted Resident #88 on 01/05/2024 with diagnoses of rheumatoid arthritis and anxiety. During the controlled drug count an Alprazolam 0.25 mg tablet tablet (anti-anxiety medication) was missing. 6. The facility admitted Resident #91 on 06/27/2023 with diagnoses which included polyosteoarthritis, polyneuropathy, sciatica and pain. During the controlled drug count a 300 mg Gabapentin capsule (medication used to treat nerve pain) was missing. 7. The facility admitted Resident #403 on 04/30/2024 with diagnoses which included pain in the right shoulder, and chronic pain syndrome. During the controlled drug count a Gabapentin 400 mg capsule (nerve pain medication) was missing. During interview with LPN #4, on 05/10/2024 at 9:10 AM, she stated she had not followed the facility's policy and should have signed out each individual controlled substance/narcotic as it was administered during her morning medication pass. During an interview with Registered Nurse (RN) #2, on 05/10/2024 at 10:15 AM, she stated she always signed out medications including narcotics and other controlled drugs as she administered them. During an interview with RN #4, on 05/10/2024 at 2:16 PM, she stated all medications should be signed out at time of administration. During an interview with RN #2, on 05/10/2024 at 3:07 PM, she stated all medications were to be signed out on the MAR at the time of administration. She stated if it was a narcotic or controlled drug it should be signed out on both the MAR and the narcotic sign out sheet. During an interview with the Director of Nursing (DON), on 05/10/2024 at 10:23 AM, he stated all medications should be signed out at time of administration which included narcotics/controlled drugs. Further, he stated if it was a narcotic or controlled drug it should be signed out on both the MAR and the narcotic sign out sheet. The DON stated it was his expectation that staff followed the facility's policies. During an interview with the Administrator, on 05/10/2024 at 10:48 AM, he stated medications should be signed out as per policy at time of administration. He further stated all nursing staff should follow the facility's policies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47798 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure food was stored in a sanitary manner. Observation of the kitchen, on [DATE] at 9:10 AM, revealed two (2) opened bags of grated parmesan cheese were stored in the refrigerator and were not sealed, labeled, or dated. The findings include: Review of the facility's policy titled, Food Receiving and Storage, revised [DATE], revealed foods should be received and stored in a manner that complied with safe food handling practices. Observation of the reach in refrigerator, on [DATE] at 9:10 AM, revealed two (2) opened bags of grated parmesan cheese that had were not sealed, labeled, or dated. During an interview with Cook #1, on [DATE] at 8:07 AM, she stated opened containers or packages of food should have a label for identification of the food, and a date to indicate when the food item was opened to ensure the food had not expired. Further, Cook #1 stated all opened food containers or packages should be sealed properly. During an interview with Cook #2, on [DATE] at 1:15 PM, she stated if a food product was opened, it should be marked with the open date. She stated after food had been opened for three (3) days, it was to be disposed of as it could possibly not be safe. Cook #2 stated if she noticed an item was not labeled or dated, she would throw it away because staff would not know how long it had been there. During an interview with the Director of Culinary Services, on [DATE] at 1:43 PM, she stated when a container was opened, staff should put the product into a bag and then label and date the bag with the date opened. She further stated the item should also be marked with the date denoting three (3) days after it was opened and it would be disposed on that date. She stated if staff forgot to label or date or properly seal a product it should be thrown away. The Culinary Manager stated she always tells her kitchen staff, if in doubt, throw it out. During an interview with the Administrator, on [DATE] at 5:07 PM, he stated he expected food to be labeled, dated, and sealed as appropriate and staff should follow the guidelines and policies.

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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. 37031 Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for two (2) of 29 sampled residents, Resident 7 (R7) and R16. Observation on 05/08/2024, of R7's left heel wound dressing change, revealed the Assistant Director of Nursing (ADON), removed the soiled dressing and failed to perform hand hygiene before donning clean gloves. After the dressing change, the ADON failed to wash her hands before exiting the room. Observation of perineal care (pericare), on 05/08/2024 for R16, revealed State Registered Nurse Aide (SRNA) #2, placed R16's dirty cloths on the resident's bedspread. SRNA #2 failed to wash her hands or perform hand hygiene. The SRNA pulled the resident's bed linens up, and pulled the bedside curtain open and did not wash her hands. The findings include. Review of the facility's policy titled Infection Prevention and Control Program, dated 09/03/2021 and revised 02/21/2024, revealed the facility established and maintained 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. Further, all staff were responsible for following all policies and procedures. All staff shall assume that all residents were potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures. All staff shall use personal protective equipment (PPE)according to established facility policy governing the use of PPE. Review of the facility's policy, Standard Precautions Infection Control Protocol, dated 2020, revealed Hand Hygiene is to be done, after touching blood, body fluids, secretions, excretions, contaminated items; before and after removing PPE; between resident contacts; before meals and after using the restroom. 1. Review of the facility's policy titled, Wound Care-Dressing Change, dated 01/02/2020 and revised 04/11/2024, revealed the purpose of this procedure was to provide guidelines for the care of wounds to promote healing. Steps in the Procedure included: Wash and dry hands thoroughly, put on exam gloves and remove dressing. Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Put on gloves. Clean wound making sure cleanser does not leave the clean field. Wash hands and don gloves. Apply clean dressing. Discard items into designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry hands thoroughly. Wipe reusable supplies with alcohol as indicated. Wash and dry hands thoroughly. Review of R7's Face Sheet revealed the facility admitted the resident on 11/06/2023 with diagnoses that included polyosteoarthritis, hypertensive heart disease, chronic kidney disease, and pressure induced deep tissue damage of the left heel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/08/2024 at 12:20 PM, of R7's left heel wound dressing change, performed by the ADON (Assistant Director of Nursing), revealed she donned gloves and removed the soiled dressing from the wound. After removing the dressing and her gloves, she failed to wash her hands before donning new gloves. She cleaned the wound and with the same gloves applied the clean dressing to the wound. The ADON then removed her gloves, and failed to wash her hands before exiting the room. During an interview with the ADON on 05/08/2024 at 1:45 PM, she stated it was difficult performing the dressing change with someone watching her. She stated she should have washed her hands after removing the soiled dressing. Further, the ADON stated she should have performed hand washing and gloving at the appropriate times during and after the dressing change. The ADON stated during interview on 05/08/2024 at 2:00 PM, that she was the facility's Infection Preventionist. She stated, she made rounds observing staff for the appropriate use of personal protective equipment and proper handwashing techniques. She further stated, its a lot easier to make sure everyone else is washing their hands properly than performing under pressure myself. However, she stated everyone needs to follow the facility infection control policies. 2. Review of the facility's policy titled, Perineal Care, dated 01/02/2020 and revised 03/02/2024, revealed, it was the facility's practice to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Handwashing was to be done prior to starting and putting on gloves, and with change of gloves when soiled with cleaning. Also, remove gloves and discard and perform hand hygiene. Review of R16's Face Sheet revealed the facility admitted the resident on 12/20/2021 with diagnoses including Alzheimer's disease, dementia, anxiety disorder and depression. Observation of R16's perineal care on 05/08/2024 at 2:40 PM, performed by State Registered Nurse Aide (SRNA) #2, revealed after performing pericare, she placed R16's dirty cloths on the end of the bed on the bedspread as she did not have a bag open and available to place the dirty cloths. Further observation revealed she removed her soiled gloves and placed them in the trash can. However, she failed to wash her hands or perform hand hygiene. She then pulled the resident's bed linens up and into place, pulled the bedside curtain open, bagged the trash and wash cloths, then opened the resident's door. Observation revealed she walked out of the resident's room and entered the dirty utility room, raise the lids of the trash and linen cans, and placed them in the cans. She then walked to the nurse's station and washed her hands. During an interview on 05/05/2024 at 2:48 PM with SRNA #2, she stated she could not recall anything she did wrong related to infection control during or after performing perineal care for R16. However, she then stated she should have had an open bag ready to place the soiled wash cloths in after use. During an interview with the Staff Development Coordinator, on 05/08/2024 at 3:00 PM, she stated the staff was inserviced on correct hand washing multiple times a year and she completed random spot checks to make sure staff was using proper handwashing. She further stated more education would be needed related to handwashing and infection control. (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 05/08/2024 at 3:40 PM, he stated it was his expectation that all staff follow the wound care, perineal care, and handwashing policies to ensure no cross contamination from resident to resident. He also stated the Staff Development Coordinator (SDC) inserviced staff often on infection control. During an interview with the Administrator, on 05/10/2024 at 4:10 PM, he stated it was his expectation staff followed the handwashing and infection control policies as written.