STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185312	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonecreek Health and Rehabilitation	4747 Alben Barkley Drive Paducah, KY 42001

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure residents were able to exercise their right to view the results of the facility's State Survey Agency's (SSA's) results and the facility's Plan of Correction. Additionally, the facility failed to post signage related to reviewing the survey results and failed to ensure residents and/or family members were aware of the location of the survey results. Observations on 07/28/2024 through 8/01/2024, revealed the survey results were not readily accessible to residents, family members, and legal representatives of the residents. Further observation revealed no signage posted informing residents and visitors where survey results were available for viewing. The findings include: Review of the facility's policy titled, Resident Rights dated 03/18/2024, revealed residents had the right to exercise their rights to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights and to be supported by the facility in the exercise of those rights. Observation on 07/28/2024 at 11:45 AM, in the entry way and lobby area, revealed no signage posted indicating where the facility's survey results were available to view. Further observation revealed the SSA Surveyor was unable to locate the survey results in the facility until 08/01/2024, when the Surveyor asked asked to the results. The receptionist phoned the Administrator and provided the survey results that she removed from a drawer at the front desk. During the Resident Group interview on 07/30/2024 at 3:06 PM, with nine facility residents, Resident (R) 2 stated the Activity Director (AD) talked about the survey results; however, R2 did not know where the results were located in the facility. Additionally, R18 and R63 stated they were unaware of where the survey results were located in the facility. Review of the Minimum Data Set (MDS) Assessment for Resident (R)2, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER: Stonecreek Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4747 Alben Barkley Drive Paducah, KY 42001	

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the Quarterly MDS Assessment for R18 dated 05/30/2024, revealed the facility assessed the resident as having a BIMS score of 15 out of 15, indicating intact cognition. In an interview with R18 on 07/30/2024 at 3:32 PM, she stated she was not sure where the (facility's) survey (results) book was located and had never examined the survey book. Review of the Quarterly MDS assessment dated [DATE] for R63 revealed the facility assessed the resident as having a BIMS score of 15 out of 15, indicating intact cognition. In an interview with R63 on 07/30/2024 at 3:32 PM, she stated she was not sure where the survey book was located and had never examined the survey book Review of the Quarterly MDS Assessment for R10 dated 06/20/2024, revealed the facility assessed the resident as having a BIMS score of 15 out of 15, indicating intact cognition. In an interview with R10 on 07/30/2024 at 3:32 PM, she stated they had discussed the survey results in meetings, but she was not sure where the survey book was located and had never examined the survey book. Review of Resident Council meeting minutes for May, June and July 2024, revealed the Activity Director had discussed the location of the survey results binder with residents during the council meetings. In an interview with the Activity Director on 08/01/2024 at 9:35 AM, she stated she discussed the survey results with the residents during resident council meetings. She stated the survey results binder should be located in the lobby area; however, did not know why it was not there. In an interview with the Administrator on 08/01/2024 at 7:29 PM, she stated she was aware the survey results were to be available for residents, staff, family and visitors. The Administrator stated she did not know signage had be be posted regarding the survey results. She stated the facility had experienced a large turnover in staffing and the receptionist did not know the results had to be out and visible to the public. The Administrator stated it was her responsibility to ensure the survey results were out for residents and visitors.

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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** 37031 Based on interview, record review and review of the facility policy, the facility failed to develop a comprehensive person-centered care plan which included timeframes and measurable results to meet each resident's medical, nursing, mental and psychological needs as identified in the comprehensive assessment for three residents, (R)7, R48 and R14 out of 25 total of sampled residents. The findings include: Review of the facility policy titled, Comprehensive Care Plans dated 08/30/2022 and reviewed/revised on 02/2024, 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. Continued review revealed the comprehensive care plan was to include measurable objectives and timeframe's to meet the resident's needs as identified in the resident's comprehensive assessment. Further review revealed the objectives were to be utilized to monitor the resident's progress, and alternative interventions were to be documented, as needed. In addition, policy review revealed qualified staff responsible for carrying out (residents') interventions specified in the care plan were to be notified of their roles and responsibilities regarding the interventions, initially and when changes were made. 1(a). Review of the face sheet for R7 revealed the facility admitted the resident on 12/19/2022, with diagnoses of atherosclerotic heart disease, chest pain, diabetes mellitus, chronic kidney disease, and contractures of left hip, right knee, and left knee. Review of the Quarterly Minimum Data Set (MDS) Assessment for R7 dated 07/27/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, meaning R7 had intact cognition. Review of the Comprehensive Care Plan for R7 dated 12/22/2022, revealed the facility developed a problem for Respiratory/Pulmonary related to nicotine dependence with cigarettes. Continued review revealed on 05/29/2023, the facility noted R7 was to be free from injuries related to unsafe smoking practices with approaches (interventions) that included educating the resident about smoking risks and hazards. Further review revealed additional approaches included educating the resident and/or responsible party of the facility's policy on smoking locations, times, and safety rules. During observations on 07/30/2024 at 3:20 PM; 07/31/2024 at 10:55 AM; and 08/01/2024 at 9:22 AM, R7 was observed in his room with an opened pack of cigarettes and a lighter either lying on his overbed table or on his bed. Continued observation revealed a lock box sitting on the bedside table. In interview, on 08/01/2024 at 9:22 AM, R7 stated, when asked about the lock box, it was for his cigarettes and lighter to be stored in. In addition, R7 further stated he was about to go out and smoke and he had just taken the cigarettes and lighter out of the lockbox. However, the State Survey Agency (SSA) Surveyor had observed R7 in the smoking area prior to the interview. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1(b). Review of the face sheet for R48 revealed the facility admitted him on 05/06/2022, with diagnoses of chronic obstructive pulmonary disease (COPD), acquired absence of right and left legs below knees and personality disorder. Review of the Quarterly MDS assessment dated [DATE] revealed the facility assessed R48 to have a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. Review of the Comprehensive Care Plan for R48 dated 06/12/2022, revealed the facility noted under the category of Activities of Daily Living (ADLs) Functional Status/Rehabilitation Potential the resident was an independent smoker dated 06/12/2022. Continued review revealed a goal target date of 08/29/2024 revealed a goal for R48 to not suffer injury from unsafe smoking practices through the next review date. Further review revealed approaches included on 06/12/2022 to instruct R48 on the facility policy regarding smoking locations, times, and safety. Additional review revealed an approach start date of 06/12/2022, noting R48 might smoke unsupervised, with a last reviewed/revised date of 07/18/2024. During observations of R48 on 07/30/2024 at 3:04 PM; 07/31/2024 at 10:40 AM; and 08/01/2024 at 1:33 PM, the resident was observed sitting on his bed with cigarettes and lighter lying either at the end of the bed or on his overbed table. In interview at 07/30/2024 at 3:04 PM and 08/01/2024 at 1:33 PM, R48 stated he was going out to smoke soon or had just returned from smoking were the reasons given for him not having the lighter and cigarettes stored in the locked box. During an interview with the Activities Director (AD) on 08/01/2024 at 9:57 AM, regarding the smoking policy and residents keeping a lock box with cigarettes and lighters in their rooms, she stated the lock boxes had been in residents' rooms for a few years. She stated it was her responsibility to ensure the residents had cigarettes to smoke during their smoke breaks. The AD stated R7 and R48 were independent smokers and were able to smoke whenever they wanted; however, they had also been observed to smoke in restricted areas like the front of the building and in the vending machine area. She further stated she also developed residents' comprehensive care plans related to smoking and should have included the lock boxes for their smoking paraphernalia on their care plans. In an interview conducted with the MDS Coordinator on 08/01/2024 at 3:45 PM, she stated the Activities Director usual responsibility was to develop the residents' smoking care plans. She also stated however, it was my responsibility to ensure it (smoking) was on the residents' care plans. The MDS Coordinator further stated she was unaware of the locked boxes in the residents' rooms used for storage of their cigarettes and lighters. In an interview on 08/01/2024 at 5:32 PM, the Administrator and DON stated they were unaware the residents' care plans did not reflect the lock boxes being used as an approach for safety. 2. Review of R14's Face Sheet, revealed the facility admitted the resident on 11/04/2022, with diagnoses to include; hereditary spastic paraplegia, Parkinson's Disease with dyskinesia, and multiple sclerosis. Review of the Annual MDS assessment dated [DATE], revealed the facility assessed R14 to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed the facility also assessed R14 as dependent on staff for transfers. (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 R14's Comprehensive Care Plan dated 11/11/2022, revealed the facility had developed a focus problem related to Activities of Daily Living (ADL's), self-care performance deficit related to impaired mobility. Continued review revealed an intervention dated 11/11/2022, for R14's transfers with assist of two staff and use of a mechanical lift. Observation on 07/29/2024 at 6:50 PM, State Surveyor Agency (SSA) Surveyor observed Certified Nursing Assistant (CNA) 17 enter R14's room with a mechanical lift. The SSA Surveyor waited 4-5 minutes and entered R14's room and observed R14 lying on the bed and CNA 17 was moving the lift away from the bed. Further observation revealed no other staff present in R14's room therefore, CNA 17 had utilized the mechanical lift alone when transferring R 14 to bed. Review of the Resident Profile (the facility's CNA Care Guide) dated 11/11/2022, revealed R14 required assistance of two staff members and use of a mechanical lift for transfers. In an interview with R14 on 07/29/2024 at 7:00 PM, he stated that had not been the first time only one staff member had transferred him with the lift onto his bed. He stated he was unsure how many staff were to transfer him. R14 further stated sometimes it was two people and sometimes it was only one person. In an interview with CNA 17 on 07/29/2024 at 6:55 PM, she stated R14 required assist of two staff and the mechanical lift for transfers. She stated she had not been able to find anyone to help her put R14 to bed. CNA 17 stated there had been another aide on the floor, but she was assisting residents on another hall. She stated there was a nurse on the unit; however, she had not asked the nurse for help. CNA 17 further stated it was important to follow R14's care plan as the mechanical lift could tilt and the resident could sustain a fall. In an interview with the DON on 08/01/2024 at 2:24 PM, she stated she expected staff to follow the residents' care plans and ensure residents' safety. She further stated by not following the care plan CNA 17 had not ensured R14's safety. In an interview with the Administrator on 08/01/2024 at 7:29 PM, she stated she was not clinical; however, she expected nursing staff to follow the facility's policies and follow residents' care plans. She stated the care plan directed staff on how to care for the residents. The Administrator stated nurses were to ensure residents' care plans were followed and that outcomes would be different for each resident. She stated R14's safety was why two staff were used. The Administrator stated CNAs had access to the residents' care guides Matrix (charting system) and were educated to review and chart on residents on a daily basis. She further stated overall she expected staff to follow the care plan. 44370

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50153 Based on observation, interview, record review and review of facility policy, it was determined the facility failed to enter wound treatment orders upon receipt of the orders for two of 25 sampled residents (R)237 and R99. The findings include: Review of the facility policy titled, Clean Dressing Change dated 03/12/2024, revealed It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Further review revealed Physician's orders were to specify the type of dressing and frequency of changes. 1. Review of R237's record revealed the facility admitted the resident on 07/25/2024, from an acute hospital setting, with diagnosis that included a Stage 4 pressure ulcer of the sacrum; other pulmonary embolism (blood clot blocking artery in the lung) with acute cor pulmonale (type of acute right side heart failure), and unspecified severe protein calorie malnutrition. Review of the Brief Interview for Mental Status (BIMS) assessment revealed the resident was severely cognitively impaired as evidenced by a score of five out of 15. Review R237's acute Continue Care Hospital document titled, Patient Discharge Instructions and Treatment Form dated 07/25/2024, for R237 revealed Wound Care instructions for the sacrum wound and left heel. Continued review revealed the sacral wound care instructions included a wound vac (vacuum) to be changed three times a week and wound care instructions for the left heel and wound prevention for the bilateral heels. Review of the Admission Observation information for R237 dated 07/25/2024 at 5:50 PM, revealed it noted the presence of a Stage 4 ulcer of the resident's coccyx/sacrum and redness of the left heel. Review of the Wound Management Detail Report for R237 completed 07/26/2024 at 12:31 PM, revealed the resident had a pressure ulcer on sacrum. Per review, a Corrected Wound Edit History on 07/30/2024 at 9:38 AM, for R237 noted the wound to be a Stage 4 with measurements documented. Review of the Date of Service Progress Note for R237 dated 07/29/2024, the documented by the Advanced Practice Registered Nurse (APRN) revealed in the Assessment / Plan for staff to Continue wound vac from hospital. Review of the 07/25/2024 Progress Note at 18:53 for R237, revealed it read, Has a large open area on coccyx to have wound vac applied. Review of the Progress Notes dated 07/26/2024 at 6:42 AM, and 07/27/2024 at 6:32 AM revealed no documented evidence of a wound treatment in the notes. Review of the Progress Note entered on 07/27/2024 at 3:20 PM, revealed dressing changed to coccyx/sacrum and remains excoriated along peri wound. Silicone sacral dressing applied. Review of the Progress Note documented on 07/28/2024 at 2:26 PM, revealed the dressing to R237's coccyx/sacrum C/D/I (clean, dry, and intact) at that time. Additional review of the Progress Notes revealed no documented evidence of the wound vac being applied. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Daily Skilled Service nursing note for R237 dated 07/25/2024 at 6:11 PM, revealed documentation for Skin and Wound Management noted as Wound Vac to Coccyx. Review of the Daily Skilled Service Observation documentation on 07/27/2024 at 3:32 PM for R237 revealed wound care treatment with no documented details of what treatment was performed. Review of an additional Daily Skilled Service Observation note entered on 07/28/2024 at 2:30 PM, revealed Skin and Wound Management Interventions were in place with no details of the treatment services provided. Further review of the Daily Skilled Service Observation notes revealed no documented evidence of the wound vac having been applied as per Physician's orders. Review APRN 20's Healing Partners Visit note dated 07/30/2024, revealed an assessment of the resident's wound characteristics was completed, the wound debrided (the process of removing dead skin and foreign material from a wound). Further review revealed a new recommendation and order for Dakin's (an antimicrobial solution) gauze and cover with bordered gauze to be completed twice a day. Review of R237's Medication Administration Summary for 07/01/2024 through 07/30/2024, revealed no documentation noting treatment orders addressing the resident's wound on the sacrum or heel, nor of treatment having been performed to the wound. Review of all orders for R237, both active and inactive, for the time period of 07/01/2024 through 07/30/2024, revealed no wound care orders for the resident's sacral wound until 07/30/2024 (five days after the resident's admission) at 5:35 PM, when an order was entered for Dakin's solution 0.125% gauze with bordered gauze to be completed twice a day as ordered. In an interview with Licensed Practical Nurse (LPN) 5 on 07/31/2024 at 3:32 PM, she stated she was not aware of the treatment orders from the referring facility (acute hospital) for R237. She stated she did not recall seeing anything in R237's paperwork about his wounds. The LPN stated she had measured the wound the day after his admission and a wet to dry dressing was in place at that time with a border gauze over it. LPN 5 said she did not recall if that dressing had been dated or not. She stated she had observed redness around the wound and stated she recalled there was tunneling (when a wound extends deeper into the tissue than its surface, creating a channel or tunnel) of the wound, but was not sure if there had been undermining (when significant erosion occurs underneath the visible wound margins resulting in more extensive damage beneath the skin surface). Per LPN 5's interview, she was told from the nurse who had been assigned to care for R237 to apply a normal saline wet to dry dressing to the wound. She stated she did not recall if she documented the dressing change though in R237's electronic medical record (EMR) or not. The LPN stated she had not seen R 237's wound since she assessed the wound the day after his admission. She further stated she did not know if there was a facility protocol for wounds and verbalized if a resident did not have an order, the nurse should call the Medical Doctor or the Nurse Practitioner for orders. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In an interview with the admitting nurse, LPN 6 on 07/31/2024 at 3:56 PM, she stated she received report from the referring facility (acute care hospital), but had written her notes on regular paper. LPN 6 stated she had not seen a paper from the referring facility with wound care instructions on it. She stated there was another nurse assisting with putting in the orders for R237's admission, and she had not known the ancillary orders were not entered. The LPN stated she asked the medical APRN about a dressing order, but the APRN did not feel comfortable giving her an order. Per LPN 6's interview, she did not know who first put a normal saline wet to dry dressing on R237's wound, and she did not return to work again until the following Thursday. She further stated the wound vac had been available in R237's room at the time of his admission and she asked the nurse who relieved her to apply the wound vac. LPN 6 additionally stated she did not know why the wound vac was not placed.

In an interview with LPN 9 on 07/31/2024 at 4:20 PM, she stated she made rounds with the wound APRN as well as worked as a floor nurse. LPN 9 stated she was not there the day R237 came in, but worked on the floor the weekend after his admission. She stated she recalled placing a wet to dry dressing on R237's wound during her shifts as she had been assigned the resident. The LPN said she had received the instruction in report and stated she was asked to talk to the wound APRN on Tuesday when the APRN made rounds at the facility. LPN 9 stated she just charted in the nurse's notes or observation documentation that the wound care was done. She went on to say that Medical Director 19 delegated the wound care to the wound APRN. LPN 9 further stated R237's wound looked about the same on Tuesday as it had when she cared for the resident as the assigned nurse the previous weekend.

In an interview on 08/01/2024 at 9:45 AM, with Medical Doctor 19, he stated he was the Physician for R237. He stated he was aware R237 had been admitted with a Stage 4 wound to the coccyx. The Medical Director stated he recalled a nurse contacted him regarding the peri wound status and the wound vac not having been placed as ordered. He stated he recalled giving the order to apply a saline wet to dry dressing until the wound APRN saw R237 on Tuesday; however, did not recall who contacted him. He further stated the wound APRN recommendations were to be implemented as orders and he expected nursing staff to contact him if there was a question or concern.

In an interview with the Regional Resource Nurse (RRN) on 08/01/2024 at 8:25 AM, the RRN produced a timeline validating wound care was provided for R237. The RRN verified the order had not been entered. During the interview, RRN also provided documentation of education initiated on 07/31/2024, addressing the necessity of entering an order into the facility's Matrix Electronic Medical Record (EMR) MATRIX. Per the RRN's interview, the educational inservice titled, MD Order was initiated on 07/31/2024 for all licensed staff related to the person receiving treatment orders, as well as verifying the treatment on the TAR in MATRIX prior to performing the treatment.

2. Review of R99's medical record revealed the facility admitted the resident on 02/17/2024, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD); aspiration pneumonitis; Chronic Kidney Disease, Stage 4 (severe); and chronic systolic (congestive) heart failure.

Review of the Admission MDS assessment dated [DATE], revealed the facility assessed R99 to have a BIMS score of 12 out of 15 indicating the resident was cognitively intact.

Review of the 02/17/2024 Admission Assessment information revealed the presence of a wound on R99's coccyx and foot; however, with no orders entered for treating those skin areas. Per record review, R99 had been by the Wound Care APRN on 02/22/2024 with treatment orders given.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R99's February and March 2024 Physician orders and Treatment Administration Record (TAR) revealed no orders noted for wound care until mid-March. Review of the weekly Wound APRN Notes dated 03/07/2024 through 03/28/2024, revealed R99's wounds were improving week - to - week. In interview on 08/01/2024 at 6:08 PM, the former Unit Manager/LPN 4 (UM/LPN 4) stated she personally completed the treatments for R99 every day, including on the weekend because she had been on-call. She stated she also completed the treatments because she took special interest in R99 due to knowing the resident's daughter. Former UM / LPN4 further stated she used to be the wound care nurse and had a great memory for treatment orders and had been very active and involved in the care of the residents on her unit. In an interview with the Director of Nursing (DON) on 08/01/2024 at 03:10 PM, DON stated it was her expectation that orders would be entered on the same day they are received. In an interview with the Administrator on 08/01/2024 at 06:30 PM, the Administrator stated it was her expectation that orders were entered into the EMR and expected nurses to follow the orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 observation, interview, record review, and review of the facility policy, the facility failed to have an effective system in place to ensure residents' safety and adequate supervision was provided to prevent accidents related to smoking in prohibited areas and smoking paraphernalia not being kept in secured locations for three residents (R) 7 and R48) out of twenty-five total sampled residents. R48 was observed smoking in a prohibited area, and R7, R14, and R48 were all observed with smoking paraphernalia lying on their beds and bedside tables and not secured in the bedside lockbox provided as required. In addition, the facility failed to ensure staff utilized a mechanical lift (as required) during transfer of R14. The findings include: Review of the facility policy titled, Accidents and Supervision dated 01/02/2020, with a revision date of 02/21/2024, revealed the resident environment was to remain as free of accident hazards as was possible, and they were to receive adequate supervision and assistive devices to prevent accidents. Continued review revealed ensuring adequate supervision and assistive device to prevent accidents included: identifying hazards and risks; evaluating and analyzing hazards and risks; implementing interventions to reduce hazards and risks and monitoring effectiveness; and modifying interventions when necessary. Review of the facility policy titled, Resident Smoking dated 03/2020, revised 05/20/2024, revealed, it was the policy of the facility to provide a safe and healthy environment for residents including safety as related to smoking. Per policy review, smoking was prohibited in all areas except the designated smoking area. Continued review revealed a Designated Smoking Area sign was to be prominently posted. Further review revealed the safety measures to be provided included a designated smoking area to be located away from exits and a common space to be utilized to protect non-smoking residents from second-hand smoke. In addition, review revealed all smoking materials were to be maintained in a secure location either with the resident or with facility staff. 1(a). Review of the face sheet for R7 revealed the facility admitted the resident on 12/19/2022, with diagnoses of atherosclerotic heart disease, chest pain, diabetes mellitus, chronic kidney disease, and contractures of left hip, right knee, and left knee. Review of the 07/27/2024 Quarterly Minimum Data Set (MDS) Assessment for R7 revealed the facility assessed him to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating he was cognitively intact. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Stonecreek Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4747 Alben Barkley Drive Paducah, KY 42001	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of R7 on 07/30/2024 at 3:20 PM, revealed him in his room with an opened pack of cigarettes and a lighter lying on the overbed table. Per observation, a lock box was sitting on the resident's bedside table. When questioned regarding the lock box at the time of observation, R7 stated it was for storage of his cigarettes and lighter. He further stated he was about to go out and smoke and had just taken the cigarettes and lighter out of the lockbox. R7 said he was aware his cigarettes and lighter were to be locked in the lock box when not in use. However, during an earlier observation of the resident by the State Survey Agency (SSA) Surveyor, R7 was observed in the smoking area. In an observation and interview on 07/31/2024 at 10:55 AM of R7, the resident was in his room with his cigarettes and lighter again sitting on the overbed table. He stated he had just returned from smoking and had not locked his cigarettes and lighter away yet. In additional observation on 08/01/2024 at 9:22 AM of R7, the resident was in his room with his cigarettes and lighter lying on the overbed table. R7 was watching television (TV), but stated he would be going out to smoke soon. 1(b). Review of the face sheet for R48 revealed the facility admitted him on 05/06/2022, with diagnoses that included chronic obstructive pulmonary disease (COPD), personality disorder, and acquired absence of right and left legs below knees. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed him to have a BIMS score of 14 out of 15, which indicated he was intact cognitively. Observation on 07/30/2024 at 3:04 PM, of R48 revealed he was in his room with cigarettes and a lighter lying on his bed, with a lock box sitting on the bedside table. He stated he was going out to smoke soon and that was why the cigarettes were out. R48 further stated he had been smoking most of his life and had smoked here since his admission, and knew the cigarettes and lighter were to be locked up. Observation on 07/31/2024 at 10:40 AM, of R48 revealed he outside on the smoking porch smoking. Continued observation at 10:55 AM, revealed R48 was back in his room with the cigarettes lying on the overbed table. The resident stated he had not had time to return the cigarettes to the lock box. Observation on 08/01/2024 at 1:33 PM, of R48 revealed him sitting on bed with his cigarettes and lighter at the end of the bed. R48 stated he would be going out to smoke soon. In interview on 08/01/24 at 9:57 AM, the Activities Director (AD) stated residents who were independent smokers, had a lock box to store their cigarettes and lighters in located in their rooms. She stated she knew there was a form the nurses filled out to assess residents in order for residents to independently smoke. In interview on 08/01/24 05:32 PM, the Director of Nursing (DON) and Administrator stated they were not aware of R48 smoking in a restricted smoking area. They stated if the residents doing that did not follow the policy, their smoking privileges would be revoked. In additional interview on 08/01/2024 at 5:40 PM, the Administrator stated she expected the residents to follow the facility's policy regarding smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In additional interview on 08/01/2024 at 5:55 PM, the DON she expected all residents to follow the facility's policies. She further stated those particular residents (R7 and R48) were difficult to manage regarding their smoking. 2. Review of the facility policy titled, Safe Handling/Transfers, dated 02/2024, revealed it was the facility's policy to ensure residents were handled and transferred safely to prevent or minimize risks for injury. Continued review revealed the facility's policy to provide and promote a safe, secure and comfortable experience for the resident in accordance with current standards and guidelines. Further review revealed all residents required safe handling when transferred to prevent or minimize the risk for injury to themselves and employees assisting them. Review of the Face Sheet for R14 revealed the facility admitted him on 11/04/2022, with diagnoses that included: multiple sclerosis, hereditary spastic paraplegia, and Parkinson's Disease with dyskinesia. Review of the Annual MDS assessment dated [DATE], revealed the facility assessed R14 to have a BIMS score of 15 out of 15 indicating he was intact cognitively. Additional MDS review revealed the facility also assessed the resident as dependent on staff for transfers. Review of the Comprehensive Care Plan for R14 dated 11/11/2022, revealed the facility had developed a focus problem for Activities of Daily Living (ADL's) due to self-care performance deficit related to impaired mobility. Review of the care plan further revealed intervention dated 11/11/2022, for R14 to be transferred with a mechanical lift and assist of two staff. Review of the 11/11/2022, Resident Profile (the Certified Nursing Assistant [CNA] Care Guide) revealed the facility noted R14 required assistance of two staff members and use of mechanical lift for transfers. Observation on 07/29/2024 at 6:50 PM, revealed CNA 17 enter R14's room with a mechanical lift with no other staff member present. Continued observation, after four to five minutes later, when the State Survey Agency (SSA) Surveyor entered R14's room, revealed the resident was lying on his bed and CNA 17 was moving the mechanical lift away from the bed. Further observation revealed no other staff present to have assisted with R14's transfer, therefore, CNA 17 had utilized the mechanical lift alone when transferring the resident. In interview on 07/29/2024 at 7:00 PM, R14 stated CNA 17's transfer of him alone, had not been the first time only one staff member had transferred him to bed. R14 further stated he was not sure how many staff were to transfer him, and sometimes it was two people and sometimes it was one person. In interview on 07/29/2024 at 6:55 PM, CNA 17 stated R14 required a lift and assist of two staff for transfers. CNA 17 stated she had not been able find anyone to help her transfer R14 to bed. CNA 17 said there had been another CNA, but that aide had been assisting on another hall. She stated a nurse had been on the unit, but she had not asked the nurse for help. The CNA also stated it was important to follow R17's care plan as the lift could tilt and the resident could fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/01/2024 at 2:24 PM, the DON stated CNA 17 had been sent home after being made aware R14 transferred R14 without using two staff (as required). The DON stated all staff were to ensure residents' safety and CNA 17, by not following R14's care plan and using two staff had not ensured the resident's safety. In an interview on 08/01/2024 at 7:29 PM, the Administrator stated she expected staff to follow the facility's policies and residents' care plans. The Administrator said residents' care plan directed staff on how to care for the resident. She stated R14's safety was why two staff were used and CNA's had access to residents' care guides in Matrix (charting system). The Administrator additionally stated she expected staff to follow the (residents') care plan. 44370

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50153 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure drugs and biologicals were stored in accordance with the manufacturer's specifications and accepted professional nursing principles and practices for one (1) of two (2) medication rooms audited. Observation on [DATE] at 10:40 AM, of the medication room that serviced rooms on the facility's 100 and 200 halls revealed one (1) open and undated multidose vial of medication and sixty-two (62) wound care products that were beyond the expiration date printed on the label. The findings include: Review of the facility's policy titled, Medication Administration with a revision date of [DATE], revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state .and in accordance with professional standards of practice in order to prevent contamination or infection. Further review revealed the person administering the medication was to, Identify the expiration date. If expired, notify nurse manager. Observation on [DATE] at 10:40 AM, of the medication room that served the 100 and 200 halls, revealed one (1) opened and undated bottle of Tubersol (an injectable solution used for testing for tuberculosis) available for use in the refrigerator. Continued observation revealed nine calcium alginate 12 rope dressing material (utilized for wounds) with an expiration date of [DATE]; ,d+[DATE] x 2 calcium alginate with silver dressing materials with an expiration date of [DATE]; nine 4 x 8 calcium alginate with silver sheets with an expiration date of [DATE]; and one (1) package of Promogran collagen matrix (also utilized for wounds) with a printed expiration date of [DATE], all available for use beyond the printed expiration date on the packaging. During an interview on [DATE] at 6:04 PM, with Licensed Practical Nurse (LPN) 10 and LPN 4, stated it was important to date all medications when opened, and not use them or other products beyond the expiration date, to avoid a potential inaccurate result, loss of potency, allergic or skin reactions. In an interview on [DATE] at 6:22 PM, the DON stated when opening a multidose medication, the vial was to be dated with the opened date and placed in to the refrigerator and tossed after 30 days. In an interview with the Administrator on [DATE] at 6:22 PM, she stated it was her expectation for staff to 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** 44370 Based on observation, interview, review of facility policy, and review of the FDA Food Code 2022 the facility failed to thaw, store, label and date food in accordance with professional standards for food service safety. Observation revealed meat thawing in sinks, meat on a tray out at room temperature (temp). Additionally, observation revealed expired and/or outdated food in the walk in cooler. The findings include: 1. A policy on thawing of frozen foods was requested from the Dietary Manager on [DATE]; however, such policy was not received. Review of the FDA Food Code 2022 Chapter 3. Food, Chapter [DATE].13 Thawing, revealed the time/temperature control for safety was that food should be thawed (A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less Pf; or (B) Completely submerged under running water . Observation on [DATE] at 11:14 AM, during the initial kitchen tour, revealed in one of the sinks of the three compartment sinks were three thawing packaged whole pork loins. Continued observation revealed in another sink area a large roll of ground beef was lying on a tray. In an interview with the [NAME] on [DATE] at 3:18 PM, she stated she had been employed at the facility for six months. She stated meat was to be thawed in the cooler on the lowest shelf and on a tray for food safety. The [NAME] further stated frozen meat was not to be thawed at room temperature. During an interview with the Dietary Manager (DM) on [DATE] at 11:25 AM, she stated the pork loin and ground beef should have been placed on a tray and thawed in the cooler for food safety. She stated meats were not to be thawed in the sink or at room temperature. In an interview with the Administrator on [DATE] at 7:29 PM, she stated kitchen staff were expected to follow policy and procedure when thawing meats; however, she did not know what the facility policy was. In an interview with the Regional Director of Operations (RDO) on [DATE] at 8:01 PM, she stated all staff had been educated on thawing meats on the bottom shelf in the walk-in (cooler) or under cool running water. 2. Review of the facility policy titled, Food storage, Cold, undated, revealed it was policy to ensure all time/temperature control for safety, frozen and refrigerated food items be appropriately stored in accordance with guidelines of the FDA Food Code. Continued review revealed the dining service director or cook were to ensure all food items were stored properly in covered containers labeled and dated and arranged in a manner to prevent cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of walk in cooler on [DATE] at 11:14 AM, revealed the following items were expired/outdated: a large plastic container ,d+[DATE] full of sliced peaches dated [DATE]; a small container ,d+[DATE] full of pears with white green substance undated; a jar with 4 whole boiled eggs that were brown in color, dated [DATE]; a large container ,d+[DATE] full of Parmesan cheese dated [DATE]; a plastic container of banana pudding dated [DATE]; a bag ,d+[DATE] full of shredded cheese dated [DATE]; and a small container of bacon grease dated [DATE]. During continued interview with the DM on [DATE] at 11:25 AM, she stated she had been on vacation last week and the cooks had been responsible for checking the coolers (for expired/outdated food) while she was off. The DM stated all staff had been educated on food storage and signs were all over the kitchen to remind staff to label and date all items. She further stated staff had also been educated on checking the coolers on a daily basis. In an interview with the [NAME] on [DATE] at 3:18 PM, she stated she had been employed at the facility for 6 months. The [NAME] stated all items were to be labeled and dated before storing in the coolers. She stated items stored were good for three days once opened. She stated the morning cook was supposed to check the cooler daily for items that were out of date. She further stated the evening cook was to check at the end of the shift. In an interview with the Regional Director of Operations (RDO) on [DATE] at 8:01 PM, she stated she expected staff to label and date all items prior to putting them in the walk-in cooler. She stated all staff had been educated on doing that. She stated the managers and cooks were to check the coolers in the morning when opening the kitchen and in the evening when closing the kitchen. In an interview with the Administrator on [DATE] at 7:29 PM, she stated the kitchen staff were expected to follow policy and procedures on labeling and dating food items before placing them in the walk-in cooler. She further stated she expected staff to check for expired food items and dispose of them if not within the appropriate date.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 44370 Based on observation and interview the facility failed to ensure garbage was stored appropriately and covered, away from food preparation (prep) areas in the kitchen. Observation revealed a large, uncovered trash receptacle almost full of trash, which was stored approximately four steps away from the food prep area. The findings include: During an interview with the Dietary Manager on 07/30/2024 at 11:25 AM, she stated she expected the staff to keep the trash bins covered and away from the food prep area. Observation on 07/30/2024 at 11:14 AM, revealed a large, uncovered trash receptacle 3/4 full of trash stored approximately four steps away from the food prep area in the kitchen. In an interview with the [NAME] on 08/01/2024 at 3:18 PM, she stated trash bins should always be covered. She further stated the trash bins should not have been stored that close to the food prep area. In an interview with the Dietary Manager (DM) on 07/30/2024 at 11:25 AM, she stated the trash bins should have been stored in a corner area of the kitchen and away from the food prep area. She further stated the bins should have been covered at all times. In an interview with the Regional Director of Operations (RDO) on 08/01/2024 at 8:01 PM, she stated she expected staff to ensure the trash bins were moved away from the food prep areas. In addition, she stated she expected staff to always keep the trash bins covered. In an interview with the Administrator on 08/01/2024 at 7:29 PM, she stated her expectation was that the trash containers be covered and moved away from any area where food was being served or prepared.

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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. 50153 Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to maintain safe and sanitary infection control precautions during wound care for 1 of 3 residents sampled for wound care out of 25 totaled sampled residents, (R)237. The finding include: Review of the facility's policy, Infection Prevention and Control Program with a revision date of 02/01/2024, revealed the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary and comfortable environment. Per review, the facility's infection prevention program was also to help prevent the development and transmission of communicable diseases and infections. Continued review revealed All staff were to assume all residents were potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Review of the facility's policy titled, Clean Dressing Change with a revised date of 03/12/2024, revealed it was the policy of the facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Record review revealed the facility admitted R237 on 07/25/2024, with a chronic Stage 4 wound to the sacrum. Review of R237's current Physician's orders revealed the wound care and dressing change orders were for Dakin's solution 0.125% (a topical antiseptic used to treat and prevent infections in wounds, burns, and other areas) wet to dry dressing and cover with a bordered gauze twice daily. Observation on 08/01/2024 at 11:20 AM, of wound care for R237, revealed Licensed Practical Nurse (LPN) 6 cleaned the overbed table, laid a clean barrier on the table, and placed the wound care supplies onto the clean barrier. Continued observation revealed the wound care supplies included an unopened package of non-sterile 4 x 4's dressings, wound cleanser spray, the Dakin's solution, a bordered gauze dressing and a non-sterile cup. Per observation, LPN 6 washed her hands and donned a gown and gloves. Observation revealed LPN 6 proceeded with the wound care procedure and cleansed the wound with the wound cleansing spray and patted the wound bed with a non-sterile gauze she had laid onto the clean barrier. LPN 6 was then observed to discard the used 4x4 into a waste bag; however, without changing gloves, the LPN removed additional non-sterile 4x4's dressings from the non-sterile 4 x 4 package. Further observation revealed LPN 6 then applied the secondary bordered gauze dressing and removed her gloves and performed hand hygiene. In interview on 08/01/2024 at 11:55 AM, LPN 6 stated she was not aware she had reached into the 4x4 package with a used glove. LPN 6 was then observed to remove the 4x4 dressing package from the treatment 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 interview on 08/01/2024 at 3:59 PM, Staff Development Coordinator (SDC) 2 revealed staff were educated annually through the competency skills fair regarding infection control and wound care. SDC 2 stated competency skills were completed through observation of staff performing the task utilizing a mannequin. The SDC stated staff were evaluated and educated during the observation. SDC 2 further stated the competency skills fair would be completed in the near future. In interview on 08/01/2024 at 6:30 PM, the Administrator stated it was her expectation staff followed the facility's policies.