STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Haven Nursing Home	105 Rodgers Park Cynthiana, KY 41031

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44001 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents were treated with dignity and respect related to privacy and providing a privacy/dignity bag to cover an indwelling urinary catheter bag for 1 of 13 sampled residents (Resident (R) 9). Observations on 01/21/2025, 01/22/2025, 01/23/2025, and 01/24/2025 revealed R9 was not provided a dignity cover for her catheter bag. R9's Foley catheter bag was visible from the hallway with all observations. The findings include: Review of the facility's policy titled, Residents Rights, revised 12/15/2024, revealed the resident had the right to a dignified existence and the right to privacy. Per the policy, the facility protected and promoted the rights of each individual resident to maintain and enhance the resident's self-esteem and self-worth. Review of R9's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 11/17/2022 with diagnoses to include obstructive uropathy, protein calorie malnutrition, and ventral hernia. Review of R9's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/09/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 5 out of 15, which indicated R9 had severe cognitive impairment. Observation of R9 on 01/21/2025 at 2:00 PM; on 01/22/2025 at 9:15 AM; on 01/23/2025 at 3:23 PM; and on 01/24/2025 at 5:00 PM revealed the resident was sitting up in bed with a catheter bag anchored to the bed frame, which was draining and contained urine. The catheter bag was uncovered, and the resident's bed was visible from the hallway as the privacy curtain was not pulled. During an interview with Certified Nurse Aide (CNA) 6 on 01/22/2025 at 9:20 AM, she stated it was important to have a bag covering a resident's catheter bag to provide privacy. In further interview, CNA6 stated she did not know why R9 did not have a dignity bag over her catheter. (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: 185332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA2 on 01/23/2025 at 9:58 AM, she stated catheter bags should be covered to protect the resident's right to privacy. She stated that providing a dignity cover prevented embarrassment for the resident. CNA2 stated further that she did not know why R9 did not have a dignity cover over her catheter bag. During an interview with Licensed Practical Nurse/Unit Manager (LPN/UM) 2 on 01/22/2025 at 10:40 AM, she stated staff was trained to provide a privacy cover to all residents with catheter bags. She stated it was her expectation that all catheter bags were covered to protect the resident's right to privacy. She stated it was important to provide for the resident's right to privacy and dignity. In an interview with the Director of Nursing (DON) on 01/24/2025 at 10:30 AM, she stated all catheter bags should be covered to protect the privacy of the residents. She stated all staff had received education on resident rights upon hire and periodically as necessary. She stated it was her expectation that all catheter bags were covered to protect the resident's privacy. She stated that it was important to maintain privacy and dignity for the resident's well-being. During an interview with the Administrator on 01/24/2025 at 4:20 PM, she stated residents with urine drainage bags should have a dignity cover placed over the bag to protect the residents' right to privacy, maintain dignity, and prevent embarrassment. She stated nursing staff should be checking for dignity covers during their rounds. The Administrator stated it was her expectation that all staff provided each resident their privacy. She stated further it was her expectation that all residents were treated with respect and dignity.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 50990 Based on interview and review of the facility's policy, the facility failed to ensure all residents had the right to send and receive mail on Saturdays. This affected all 49 current residents residing in the facility. The findings include: Review of the facility's policy titled, Residents Rights, revised 12/15/2024, revealed the resident had the right to privacy in written communications, including the right to send and promptly receive mail. During the Resident Council meeting on 01/22/2025 at 2:00 PM, it was stated by all 12 residents in attendance that residents did not receive or send mail on Saturdays at the facility, and they did not receive packages unopened the day they were delivered to the facility. In an interview with the Social Services Director (SSD) on 01/24/2025 at 10:38 AM, she stated mail was not delivered on Saturdays. The SSD stated the Activities Director was responsible for delivering mail on Saturdays. However, she stated she had received many complaints about the Activities Director delivering mail and decided she would be responsible for delivering mail. The SSD stated her work schedule was Monday through Friday, and she did not work on the weekends. The SSD stated she was aware mail should be delivered to residents every day of the week that residents' mail was received by the facility. In an interview with the Activities Director on 01/24/2025 at 2:25 PM, she stated she did not work on the weekend; therefore, she was not available to deliver mail to the residents. The Activities Director stated the SSD told her residents had complained about not receiving a newspaper that was delivered on a Thursday until the following Monday. The Activities Director stated she came to work the next day after being off and was told by the Business Office Manager that the SSD would be delivering the mail to residents. In an interview with the Director of Nursing (DON) on 01/24/2025 at 4:35 PM, she stated she was unsure who got the mail from the mailbox, who was responsible for documenting how many pieces the facility received each day, and who was responsible for distributing the mail and packages to the residents. The DON stated she was unaware the residents were not receiving mail or packages on Saturdays. The DON stated residents not receiving their mail or packages on any day of the week that there were deliveries to the facility was a violation of their rights. In an interview with the Administrator on 01/24/2025 at 4:10 PM, she stated she expected residents to receive their mail upon delivery to the facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on interview, record review, review of the Hospice agreement, and review of the facility's policies, the facility failed to develop and implement a baseline care plan that included the instructions needed to provide an effective and person-centered care plan for the resident that met professional standards of quality care for 1 of 13 sampled residents, Resident (R) 102. Resident 102 was admitted to the facility on [DATE] with the physician's order, dated 01/14/2025, to admit with Hospice services. However, review of R102's Baseline Care Plan, not dated, revealed no focus area for Hospice care until 01/19/2025. The findings include: Review of the facility's policy titled, Care Plan Policy and Procedure, reviewed 08/27/2024, revealed the patient-focused approach sought favorable outcomes in consideration of each resident's characteristics, the severity of condition, strengths, needs, abilities, disabilities, disease, impairment, and significant factors. Per the policy, an initial plan of care would be implemented by the nursing department upon admission, not to exceed 24 hours, and reviewed by the Interdisciplinary Team (IDT) team within 72 hours. Review of the facility's policy titled, Baseline Care Plan, not dated, revealed a baseline plan of care to meet the resident's immediate health and safety needs was developed for each resident within 48 hours of admission. Per the policy, the baseline care plan included instructions needed to provide effective, person-centered care of the resident that met professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident. This included any services and treatments to be administered by the facility and personnel acting on behalf of the facility. Review of the Hospice agreement Hospice-Nursing Facility Services Agreement, not dated, revealed the facility was responsible to provide facility services that met the personal care and nursing needs that would have been provided by a Hospice patient's primary caregiver at home in coordination with Hospice. The agreement also stated the facility shall perform facility services at the same level of care provided to each Hospice patient before hospice care was elected. Review of R102's Admission Record revealed the facility admitted the resident on 01/14/2025 with diagnoses of senile degeneration of the brain, Alzheimer's dementia, anxiety, and major depression. Review of R102's admission Physician's Orders, dated 01/14/2025, revealed to admit the resident to the facility with Hospice services. Review of R102's Baseline Care Plan, not dated, revealed no focus area for Hospice care until 01/19/2025. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Licensed Practical Nurse (LPN) 2, the Unit Manager on 01/23/2025 at 10:22 AM, she stated the nurse should start the baseline care plan upon admission and include Hospice services on the baseline care plan. In an interview with the Minimum Data Set (MDS) Coordinator on 01/23/2025 at 2:25 PM, she stated the baseline care plan should be started by the nurse upon admission and completed within 48 hours. She stated any changes to the care plan should be completed immediately. In an interview with the Director of Nursing (DON) on 01/23/2025 at 10:15 AM, she stated the baseline care plan was started upon admission. She stated Hospice services was not on the baseline care plan because it would not change the level of the resident's care. In an interview with the Administrator on 01/24/2025 at 4:10 PM, she stated the nurse started and completed the baseline care plan within 48 hours. She stated the basic information should be on the baseline care plan at admission, and Hospice services should be on the baseline care plan.

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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. 44001 Based on observation, interview, record review, and review of the facility's documents and policies, the facility failed to develop and implement a comprehensive, person-centered care plan to meet a resident's medical, nursing, and psychosocial needs for 2 of 13 sampled residents (Residents (R) 9, and R16). 1. R9 was admitted to Hospice on 01/17/2025. However, review of the person-centered care plan revealed the Hospice care area was not developed until 01/21/2025, four days after admission to Hospice care. 2. R16 did not have a person-centered care plan developed to address the resident's non-compliance with medical treatments and regimens or interventions to address the resident's respiratory care and ordered oxygen therapy. Refer to F695 The findings include: Review of the facility's policy titled, Care Plan Policy and Procedure, reviewed 08/27/2024, revealed the patient-focused approach aimed for favorable outcomes by considering each resident's characteristics, the severity of their condition, strengths, needs, abilities, disabilities, diseases, impairments, and significant factors. 1. Review of R9's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 11/17/2022 with diagnoses to include obstructive uropathy, protein calorie malnutrition, and ventral hernia. Review of R9's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/09/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 5 out of 15, which indicated R9 was severely impaired. Review of R9's Physician Orders, located in the resident's electronic health record (EHR), revealed on 01/17/2025 the resident was admitted to Hospice services with a diagnosis of incarcerated ventral hernia with gastric obstruction. Review of R9's Comprehensive Care Plan [CCP], dated 12/16/2024, located in the resident's EHR, revealed the Hospice care focus was not developed until 01/21/2025, four days after R9's admission to Hospice services. During an interview with the MDS Coordinator on 01/23/2025 at 2:25 PM, she stated R9's CCP should have been developed immediately to include interventions for Hospice care when the resident was admitted to Hospice services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R16's Face Sheet, located in the resident's EHR, revealed the facility admitted the resident on 08/07/2024 with diagnoses to include acute on chronic respiratory failure with hypercapnia, acute on chronic respiratory failure with hypoxia, and encephalopathy. Review of R16's quarterly MDS, with an ARD of 12/24/2024, located in the resident's EHR, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated R16 was cognitively intact. Further review revealed the resident was not assessed for respiratory treatments or oxygen therapy. Review of R16's Physician Orders, dated 11/12/2024, located in the resident's EHR, revealed to administer oxygen at 3 LPM continuous by nasal cannula. Review of R16's Comprehensive Care Plan [CCP], dated 01/02/2025, located in the resident's EHR, revealed the facility did not care plan the resident to include supplemental oxygen therapy management. Observations of R16's room with her oxygen concentrator revealed: 1) on 01/21/2025 at 2:45 PM the liter flow rate was set at 4.5 LPM; 2) on 01/22/2025 at 10:50 AM the liter flow rate was set at 5 LPM; and on 01/23/2025 at 9:34 AM and 01/24/2025 at 1:46 PM the liter flow rate was set at 4 LPM. During an interview with Licensed Practical Nurse (LPN) 2, Unit Manager, on 01/23/2025 at 10:22 AM, she stated R16 was non-compliant with care and believed that the resident was care planned for noncompliance. She did not know what the focus of the resident's CCP was related to the noncompliance or if it was specific to respiratory care and ordered oxygen therapy. During an interview with the Infection Preventionist (IP) on 01/23/2025 at 12:00 PM, she stated R16 was non-compliant with care and would adjust the settings on the oxygen concentrator, and R16 was care planned for noncompliance. However, she did not know what the focus of the CCP was related to the noncompliance or if it was specific to respiratory care and ordered oxygen therapy. During an interview with the MDS Coordinator on 01/22/2025 at 9:35 AM, she stated the CCP was developed and updated by the MDS Nurse and nursing staff. She stated the CCP was a working document and was to reflect the resident's current status. Additionally, she stated the CCP gave direction to the staff for providing individualized care to residents. She stated changes in residents' conditions were discussed every morning at the Interdisciplinary Team (IDT) meeting. The MDS Coordinator stated each team member contributed to developing an individualized care plan. Per the interview, the IDT consisted of the Director of Nursing (DON), IP, Nurse Managers, MDS Coordinator, Social Worker, Physical Therapy, and the Activities Director. During additional interview with the MDS Coordinator on 01/23/2025 at 2:25 PM, she stated the CCP should address the resident's needs based on diagnoses and assessments. She stated a noncompliant resident with a specific treatment or medication regimen should be cared for and planned with interventions to address their needs. She stated the MDS assessment and the CCP should show the resident received oxygen therapy. The MDS Coordinator was unaware of why R16's care plan did not address her noncompliance with her treatments, medications, and ordered oxygen therapy. During an interview with the DON on 01/23/2025 at 10:15 AM, she stated she expected staff to implement care planned interventions. She further stated following the plan of care was important to provide appropriate, resident-specific care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 01/24/2025 at 4:20 PM, she stated she was familiar with R16's non-compliance behavior. She stated R16's CCP should have been developed to address the resident's oxygen therapy and non-compliance with her treatments and medication regimen. She stated if R16 was adjusting her oxygen flow, it should have been addressed in the care plan. Additionally, she stated R9's CCP should have been developed immediately to include interventions for Hospice care when the resident was admitted to Hospice services. She stated staff nurses and the MDS nurse were responsible for ensuring the resident had a person-centered care plan. She stated the DON audited the care plans for accuracy. She stated a CCP was important to ensure the resident's well-being and safety. She stated it was her expectation that staff developed and implemented the resident's care plan to ensure care was delivered as prescribed. During an interview with the Medical Director on 01/24/2025 at 4:15 PM, he stated it was his expectation that nursing staff provided, developed, and implemented a CCP to ensure the facility maintained the resident's highest practicable level of functioning and well-being.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44001 Based on observation, interview, record review, and facility policy review, the facility failed to provide oxygen therapy according to the Physician's Order for 1 of 13 sampled Residents (Resident (R) 16). Observations on 01/21/2025, 01/22/2025, 01/23/2025, and 01/24/2025 revealed staff failed to ensure R16's oxygen flow was set at three liters per minute (LPM) per the Physician's Orders. The findings include: Review of the facility's policy titled, Oxygen Usage Policy, reviewed 11/22/2024, revealed it was the policy of the facility to ensure proper use of oxygen for residents. Per the policy, regular assessments would be done to monitor oxygen needs and adjust the setting as necessary. Also, documentation and monitoring would include oxygen flow rate. Review of R16's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 08/07/2024 with diagnoses to include acute on chronic respiratory failure with hypercapnia, acute on chronic respiratory failure with hypoxia, and encephalopathy. Review of R16's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/24/2024, located in the resident's EHR, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated R16 was cognitively intact. Further review revealed the resident was not assessed for respiratory treatments or oxygen therapy. Review of R16's Comprehensive Care Plan [CCP], dated 01/02/2025, located in the resident's EHR, revealed the facility did not care plan the resident to include supplemental oxygen therapy management. Review of R16's Physician Orders, dated 11/12/2024, located in the resident's EHR, revealed to administer oxygen at 3 LPM continuous by nasal cannula. Review of R16's Medication Administration Record [MAR], dated 01/01/2025 to 01/24/2025, located in the resident's EHR, revealed no orders for oxygen at 3 LPM continuous by nasal cannula. Review of R16's Treatment Administration Record [TAR], dated 01/01/2025 to 01/24/2025, located in the resident's EHR, revealed no orders for oxygen at 3 LPM continuous by nasal cannula. Observation of R16's room on 01/21/2025 at 2:45 PM revealed R16's oxygen concentrator's liter flow rate was set at 4.5 LPM. Observation of R16's room on 01/22/2025 at 10:50 AM revealed R16's oxygen concentrator's liter flow rate was set at 5 LPM. Observation of R16's room on 01/23/2025 at 9:34 AM revealed R16's oxygen concentrator's liter flow rate was set at 4 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of R16's room on 01/24/2025 at 1:46 PM revealed R16's oxygen concentrator's liter flow rate was set at 4 LPM. During an interview with R16 on 01/23/2025 at 9:34 AM, she stated her oxygen flow rate should be set at 3 LPM. She stated she did not change the settings. She further stated, It's [oxygen concentrator] old and won't hold the setting. When asked if anyone had come in to check the concentrator, she stated, No. During an interview with the Infection Preventionist (IP) Nurse on 01/21/2025 at 2:04 PM, she stated the medication nurse was responsible for ensuring oxygen settings were correct. She stated she expected the oxygen settings to be correct as per the physician's order for R16. She stated nursing staff should check any resident on oxygen every shift to ensure oxygen flow was at the correct setting. During additional interview with the IP on 01/23/2025 at 12:00 PM, she stated R16 was non-compliant with care and would adjust the settings on the oxygen concentrator. The IP stated the resident was care planned for noncompliance. She stated maintaining the correct oxygen setting was the responsibility of the medication nurse, but anyone in the room could check to ensure it was at its ordered flow. She stated she did not know why R16 had not been cared planned for oxygen therapy and why oxygen orders were not on the MAR or TAR. The IP stated it was important to follow physician orders for the staff to provide care as ordered. During an interview with the Director of Nursing (DON) on 01/22/2025 at 9:50 AM, she stated it was her expectation that nurses checked the oxygen settings at least once during their shift and periodically as they went in the residents' rooms during their shift. She stated she did not know why R16's oxygen order was not included on the MAR or TAR. The DON stated it was important to follow physician orders to ensure care was delivered as prescribed by the physician. During an interview with the Administrator on 01/24/2025 at 4:20 PM, she stated to ensure the resident's well-being and safety, it was her expectation that staff followed the physician orders to ensure care was delivered as prescribed. During an interview with the Medical Director on 01/24/2025 at 4:15 PM, he stated R16 had chronic respiratory failure and had been hospitalized recently. He stated R16 was non-compliant with medical treatments. The Medical Director stated his expectation was that nursing staff provided ordered care for the residents to maintain the residents' highest practicable level of function and well-being.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51155 Based on observation, interview, record review, and facility policy review, the facility failed to ensure all drugs used in the facility were labeled in accordance with professional standards. Observation revealed undated, opened, and expired medications in 3 of 4 medication carts and 1 of 1 treatment carts. Those medications included inhalers, an insulin vial, insulin pens, laxatives, antifungal powder, and topical creams. The findings include: Review of the facility's policy titled, Medication Storage, dated 08/22/2024, stated, Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs are returned to the dispensing pharmacy or destroyed. Review of the facility's dispensing pharmacy's form Medication Expiration Dating stated, The following medications must be dated once they are opened. The form listed insulin vials and insulin pens. 1. a. During observation on 01/22/2025 at 8:44 AM of the 200-Hall split medication cart revealed one Trelegy Ellipta inhaler (triple combination medication used to treat adult chronic obstructive pulmonary disease (COPD) and asthma) with an expiration date of 01/08/2025, which LPN1 instructed the staff member at the nurses' station to immediately order another for the resident. Additional observation revealed one opened and undated bottle of Acid Gone (an over the counter antacid) with no opened date. Continued observation revealed albuterol single packets in an opened foil package with no opened date. Furthermore, there were medications observed such as tiotropium bromide (a bronchodilator used to treat COPD and asthma) not in an original pharmacy package with no name; albuterol two vials not stored in a protective bag and no opened date; and one bottle of Robafen DM Cough Syrup not in the original packaging, with no label or opened date. b. Observation on 01/22/2025 at 10:00 AM of the medication cart for Rooms 206-212 revealed an opened multi-use vial of insulin lispro (used to treat diabetes mellitus) with an expired date of 01/16/2025 written on the vial; a bottle of lactulose (used to treat constipation) 10 grams with an expired date of 01/02/2025 written on the label; an albuterol inhaler (a bronchodilator) opened and undated; a fluticasone inhaler (a corticosteroid used to treat asthma) opened and undated; and five insulin pens opened and unbagged in the same compartment together. Further observation revealed unwasted narcotics found in the narcotic box for a resident who had expired on 01/19/2025. c. Observation on 01/22/2025 at 10:25 AM of the medication cart for Rooms 200 through 205 revealed three opened insulin pens in the same compartment and unbagged. During an interview on 01/22/2025 at 10:00 AM with Licensed Practical Nurse (LPN) 3, she stated she was unaware the insulin was expired, and it should have been discarded by the expiration date. She stated expiration dates should be checked prior to administering any medication. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Haven Nursing Home	105 Rodgers Park Cynthiana, KY 41031

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation on 01/22/2025 at 10:18 AM of the treatment cart revealed the Pharmacy Technician was going through the cart with a lot of medications on top of it. When asked what she was doing, she stated she went through the cart once a month and paired the medications out of bags with the correct empty bag, placing the medication back in the bag. Observation 01/22/2025 at 10:20 AM of the treatment cart revealed nystatin powder with no label, and unbagged and opened tubes of antifungal cream, clotrimazole cream, miconazole cream, and ketoconazole cream (all anti-fungal medications). Further observation revealed a tube of MediHoney (used to treat wounds and burns) was also unbagged and opened. During an interview on 01/24/2025 at 10:43 AM with LPN 4, she stated medication should be dated upon opening, and the date checked before every administration. She stated medication without opened or expired dates should be removed from the medication cart and discarded. She stated this was important to decrease the risk of medication errors. During an interview on 01/24/2025 at 9:36 AM with Staff Development, she stated the process when opening and administering medications included to date the medication with the date it was opened so staff would know when to discard it. She stated weekly audits were performed on the medication carts on Mondays. She stated any expired or undated medication should be removed from the carts and replaced. She stated narcotics were removed and wasted by the Director Of Nursing (DON). She stated any home medications brought in for resident use should be discussed with the facility pharmacy. She stated keeping the medication carts free from expired medication was important to prevent harm to residents. During an interview on 01/24/2025 at 10:20 AM with the Director of Nursing (DON), she stated it was her expectation that medications be dated upon opening. She stated carts were checked weekly for insulin expiration dates. She stated no medication should be in the cart and in use if unlabeled because staff would not know which resident it belonged to. The DON stated narcotics were kept in the cart and included in the count until she wasted the narcotic. She stated wasting narcotics was usually done as soon as possible. When asked about the narcotics for the expired resident, she stated she was told about the medications, and she forgot about them. The DON stated it was important to keep the medications dated and unnecessary medication removed from the cart to decrease the risk of medication errors. During an interview on 01/24/2025 at 4:30 PM with the Administrator, she stated it was her expectation that medications be put back in the proper packaging/bags when they were placed back into the medication cart, and they needed to be dated. She stated her expectation was that the dates should be checked every time the medication was used. She stated if a medication had no label or an expired date, then it should be removed from the cart. She stated any narcotic that needed to be wasted should be reported to the DON. She stated it was important so residents did not receive wrong or expired medications. 51417

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 51155 Based on observation, interview, record review, review of the facility's job descriptions, and review of the facility's plan of correction (PoC), dated 03/12/2024, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) process. The facility failed to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focused on indicators of the outcomes of care and quality of life that were achieved and sustained. Observation on 01/22/2025 at 10:00 AM revealed insulin lispro was opened, in use, and dated with an expiration date of 01/16/2025. Review of the previous survey, dated 01/07/2024 to 01/11/2024, revealed a repeat issue was found with the expired insulin being used. This affected all 49 current residents residing in the facility. Refer to F761 The findings include: Review of the facility's Director of Nursing job description, dated 06/17/2023, revealed the tasks included but were not limited to: maintaining compliance with state and federal regulations; being an active member of the QAPI Committee; coordinating and/or developing on-going QAPI activities or nursing services to monitor nursing compliance with standards and regulatory requirements through rounds, interviews, and record reviews; compiling summary of findings of the QAPI Committee; and participating in the preparation of the PoC response to an inspection survey and implementing any follow-up QAPI required for any nursing allegations. Review of the facility's Nursing Home Administrator job description, undated, revealed the Administrator was to oversee QAPI and other facility committees and ensure the facility operates in compliance with all local, state, and federal regulations. Review of the facility's acceptable PoC, for the Standard Recertification/Abbreviated/Extended Survey, concluded on 01/11/2024, revealed the facility was to implement the PoC to ensure the facility achieved substantial compliance by 03/06/2024. However, the facility had a repeat deficiency following the latest survey, concluded on 01/24/2025. Further review of the facility's PoC, for the survey with an exit date of 01/11/2024, revealed the Director of Nursing (DON) or Licensed Practical Nurse (LPN) 6 would monitor compliance regarding labeling and storage of medications. Furthermore, the PoC stated the weekly, monthly, and random audits would be performed by either the DON or LPN6. The weekly audits were performed by LPN6 monthly, and random audits were performed by the pharmacy technician. Review of the facility's Audits revealed the facility would perform weekly audits for four weeks, monthly audits for two months, then random through the QAPI process to ensure medications were dated as indicated, and no expired medications were in the medications carts. The review of Audits performed by LPN6 revealed audits were completed on 02/20/2024, 02/26/2024, 03/07/2024, and 03/15/2024. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Quality Improvement: Quality Assurance RX LTC Tech Summary Report, of audits performed by the pharmacy technician for expired and undated insulin revealed on 03/18/2024 there was expired glucose solution and undated glargine; on 04/10/2024 there was expired humulin R, glargine, and lispro, also undated; on 05/15/2024 there was expired aspart; on 06/12/2024 there was expired glargine and undated novolin R; on 08/14/2024 there was expired glargine and novolin 70/30; on 09/18/2024 there was expired glargine and undated lantus; and on 10/14/2024 there was expired novolog. Observation on 01/22/2025 at 10:00 AM revealed insulin lispro was opened, in use, and dated with an expiration date of 01/16/2025. (Refer to F761) The State Survey Agency (SSA) Surveyor was unable to interview the DON regarding QAPI because she was unavailable, unreachable, and out of the facility on 01/24/2025. During an interview on 01/24/2025 at 4:30 PM with the Administrator, she stated it was the responsibility of the DON to monitor QAPI audits. She stated this was important to ensure compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44001 Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, review of the manufacturer's instructions for use, and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 26 sampled and supplemental residents, Residents (R) 44 and R21. Additionally, the failed to assess and monitor the building's water system for Legionella and other opportunistic waterborne pathogens affecting the total census of 49. 1. Observation on 01/22/2025 at 11:40 AM with Licensed Practical Nurse (LPN) 3 revealed she did not don (put on) personal protective equipment (PPE) in an enhanced-barrier precaution (EBP) room before she provided direct care. Further observation revealed LPN3 failed to prevent contamination of surfaces and clean the glucometer according to the Environmental Protection Agency (EPA) registered disinfectant manufacturer's instructions. 2. Observation on 01/23/2025 at 12:20 PM with Registered Nurse (RN) 1 after administering medication to R21 revealed RN1 cleaned the stethoscope while still wearing dirty gloves. 3. Review of the facility's documentation related to water management and Legionella prevention and detection revealed there was no documentation that control measures to include visible inspections, disinfection, and temperature controls were monitored, documented, and audited. Furthermore, the facility failed to provide documentation of a process flow diagram for the facility's water flow to include identified areas where Legionella could grow and spread. The findings include: Review of the CDC's guideline, provided by the facility, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 09/10/2021, revealed reusable medical equipment should be cleaned and disinfected according to manufacturer's instructions or the facility's policies before and after use. The guidelines stated facilities should maintain separation between clean and soiled equipment to prevent cross-contamination. Further review of the guidelines revealed staff should be trained in the correct steps for cleaning and disinfection of shared equipment. Review of the facility's policy titled, Infection Control Policy and Procedure/Surveillance Plan, reviewed 09/14/2024, revealed the facility 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 per accepted national standards and guidelines. Continued review revealed annual skill checkoffs would be performed by the Infection Preventionist (IP) and would cover the use of PPE, isolation precautions, and the safe handling of contaminated equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled, Enhanced Barrier Precautions, revised 11/17/2024, revealed it was the facility's policy to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug resistant organisms [MDRO]. Furthermore, the policy stated that EBP reduced transmission of MDROs through gown and glove use during high resident care activities. Review of the facility's policy titled, Shared Equipment, reviewed 08/22/2024, revealed it was the facility's policy to attempt to decrease the risk of spreading infection and disease through infection control standards for cleaning medical equipment before and after each individual resident use and follow the direction for dwell times (the amount of time a disinfectant must remain visibly wet to kill a pathogen). Review of the facility's policy titled, Glucometer Cleaning Policy and Procedure, reviewed 03/30/2024, revealed it was the facility's policy to ensure each resident was provided with a clean and non-infectious glucometer. Further review revealed nursing staff would clean the glucometer with SaniCloth wipes and allow the glucometer to sit and dry for three minutes before and after each use. Review of the cleaning and disinfecting instructions for the Assure Prism Multi-Blood Glucose Monitoring System, no date, revealed to minimize the risk of transmitting bloodborne pathogens, the exterior of the glucometer should be cleaned of all dirt, blood, and bodily fluids before performing the disinfection procedure, which would prevent the transmission of bloodborne pathogens. Per the instructions, the exterior of the glucometer should remain wet for the appropriate dwell time according to the disinfectant's instructions. Review of the cleaning and disinfecting instructions for SaniCloth wipes revealed if visibly soiled use one or more wipes as necessary to wet surfaces sufficiently and to thoroughly clean the surface. According to the instructions, all surfaces must remain visibly wet for a two-minute dwell time to assure complete disinfection of all pathogens. 1. Review of R44's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 05/03/2024 with diagnoses to include chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, and unstageable wound with dressing to right foot. Review of R44's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/03/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 11 out of 15, which indicated R44 had moderate cognitive impairment. Review of R44's Physician Orders, dated 01/24/2025, located in the resident's EHR, revealed there was an order for EBP for a wound with a dressing. Observation of LPN3 on 01/22/2025 at 11:40 AM revealed she gathered a glucometer, lancet, testing strips, and alcohol wipes, and placed them into a plastic tray before taking them into R44's room. She set the tray on a barrier cloth on the bedside table and performed a finger stick test. LPN3 did not put on a gown before performing the finger stick on R44. After completing the procedure, LPN3 discarded the barrier sheet from under the tray and placed the tray on an unclean surface. She returned the tray to the medication cart without placing a barrier sheet underneath the contaminated tray. LPN3 then cleaned the contaminated glucometer using one disinfectant wipe and wiping it for 24 seconds. She then placed the device inside the contaminated tray. Furthermore, LPN3 did not adhere to the required dwell time of two-minutes as specified in the wipe's instructions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/22/2025 at 11:50 AM, LPN3 stated each medication cart had at least one glucometer that was shared among residents. When asked what the dwell time for the wipes was, LPN3 stated, Two minutes. However, she could not articulate the definition of dwell time. She stated any equipment taken into a resident's room must be cleaned and disinfected before being used on another resident to prevent the spread of infection or bloodborne pathogens. LPN3 stated further that she did not wear a gown because she believed that performing a fingerstick did not meet the EBP requirements for high-risk direct care. Additionally, LPN3 stated she had received infection prevention and control practice (IPCP) education upon hire and had also received education through in-service trainings provided by the Infection Preventionist/Wound Care Nurse (IP/WCN). She stated the importance of following infection control protocols and EBP requirements was to prevent the spread of infection among staff and residents. After the interview, LPN3 retrieved the glucometer and plastic tray from the medication cart and cleaned them according to facility protocols before using them on a different resident. During interview with the IP/WCN on 01/23/2025 at 12:00 PM, she stated the facility followed CDC guidelines and recommendations related to IPCP. She stated she provided education to all staff related to IPCP, and all staff was trained on the use of PPE and isolation precautions to include EBP. She stated gowns and gloves must be worn whenever staff entered an EBP room if high-contact care was provided. She stated high contact care included the use of devices. Per the interview, the IP/WCN stated she had not observed any concerns related to staff's failure to follow IPCP or EBP protocols. She stated it was her expectation that all staff followed IPCP. The IP/WCN stated it was important for the safety of residents and staff and to prevent the spread of infection. She also stated nursing staff was trained to clean and disinfect the glucometer after each use using SaniCloth cleaning and disinfectant wipes with a two-minute dwell time. She stated contaminated glucometers should be placed on a barrier cloth to prevent the spread of infection and cleaned, then disinfected for the appropriate time and stored separately to keep clean. 2. Review of R21's Face Sheet, located in the resident's EHR, revealed the facility admitted the resident on 10/16/2020 with diagnoses including esophageal obstruction, acute pancreatitis, congenital stenosis, and stricture of the esophagus. Review of R21's quarterly MDS, with an ARD of 11/25/2024, revealed the facility assessed the resident to have a BIMS score 15 out of 15, indicating the resident had intact cognition. Observation on 01/23/2025 at 12:20 PM with RN1 after administering medication to R21 revealed RN1 cleaned the stethoscope with an alcohol wipe while still wearing the gloves that she wore when she provided physical contact and medication administration to R21. After cleaning the stethoscope, the dirty gloves were doffed (removed) and discarded, and RN1 washed her hands. During an interview on 01/24/2025 at 10:17 AM with the Director of Nursing (DON), she stated she expected staff to remove dirty gloves, use proper hand hygiene, and re-glove to clean a piece of equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During additional interview with the DON on 01/24/2025 at 10:30 AM, she stated all staff received IPCP training upon hire and periodically throughout the year. In addition, the DON stated staff was updated on current CDC guidelines when they changed. She stated the Unit Managers audited staff for compliance. However, she stated there was no documentation of staff IPCP audits. Per interview, it was the DON's expectation that all staff maintained IPCP guidelines at all times to decrease the potential spread of infection. During an interview on 01/24/2025 at 4:25 PM with the Administrator, she stated common sense told one to clean equipment with clean gloves. She stated she expected her staff to use clean gloves after patient care when encountering equipment. 3. Review of the facility's policy titled, Legionella Prevention Policy and Procedure, dated 10/13/2024, revealed the facility would attempt to decrease the risk of exposure to Legionella bacteria to residents, staff, and visitors. Policy review revealed weekly water temperature checks, empty room faucet and eyewash station flushes, and cleaning of the ice machines would be performed and logged. Review of the CDC's Guideline Developing a Legionella Water Management Program, revealed a key component of the water management program (WMP) was a flow diagram used to describe the facility's water systems and identify areas at risk for Legionella growth and spread. Review of the facility's documentation related to their water management revealed there was no documentation that control measures to include visible inspections, disinfection, and temperature controls were monitored, documented, and audited. Furthermore, the facility failed to provide documentation of a process flow diagram for the facility's water flow to include identified areas where Legionella could grow and spread. Review of the facility's WMP revealed the facility did not include a flow diagram to describe the facility's water system or identify where in the facility there were areas at risk for Legionella or other waterborne pathogens to grow and spread. During an interview with the Maintenance Director on 01/22/2025 at 9:11 AM, he stated he did not know about the facility's WMP. He stated he checked water temperatures throughout the building and documented them on a sheet of paper. During an interview with the Administrator on 01/22/2025 at 9:40 AM, she stated she was responsible for water management in the facility. She stated she performed in-house monitoring of the water supply quarterly using a testing kit. The Administrator stated the facility did not have a flow diagram to describe the water system and identify areas where Legionella could grow. She stated she was familiar with the CDC's tool kit to help facilities development of a WMP. She stated further that she had not completed a Legionella Environmental Assessment Form (LEAF) to help identify areas at risk for Legionella growth and spread. She stated the Maintenance Director performed water monitoring and flushing. During an interview with the Infection Preventionist (IP) on 01/22/2025 at 1:37 PM, she stated the Administrator was responsible for the WMP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Administrator on 01/24/2025 at 4:20 PM, she stated it was her expectation that staff followed the facility's IPCP policies and procedures to prevent the spread of infection to residents and staff. During an interview with the Medical Director on 01/24/2024 at 4:15 PM, he stated the facility followed CDC guidelines and recommendations. The Medical Director stated it was his expectation that the facility followed all its policies and procedures, and he further expected the DON and the IP to oversee and implement infection prevention and control policies. 51417

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 44001 Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) document, and review of the facility's policy, the facility failed to ensure the medical record included documentation of the resident's or resident representative's (RR) education regarding the benefits and potential side effects of immunizations for 5 of 5 residents sampled for immunizations (Resident (R) 6, R9, R16, R21, and R44). The findings include: Review of the facility's policy titled, Immunization/Vaccination Policy and Procedure, dated 11/09/2024, revealed the facility would educate and offer residents available immunizations against infections to minimize the risk of acquiring or transmitting disease. Per the policy, residents would be assessed for medical contraindications of immunizations and receive education regarding the benefits and potential side effects of the immunizations. Review of the documentation provided to residents regarding vaccine education showed the facility stated they offered residents the CDC's Vaccine Information Sheets (VIS) for the COVID-19 and Respiratory Syncytial Virus (RSV) vaccines, both dated 10/19/2023. The facility did not offer residents current 2024-2025 VIS sheets. 1. Review of R6's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 05/07/2024 with diagnoses to include debility, asthma, and seizure disorder. Review of R6's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/30/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of five out of 15, which indicated R6 had severe cognitive impairment. Review of R6's Immunization Record, located in the resident's EHR, revealed R6 received his RSV vaccine on 10/03/2024. He received his influenza vaccine on 10/07/2024. For both immunization records, No was answered to the question about whether education was provided by the nurse. There was no documentation that the RR was provided updated vaccine information. Other vaccine information was historical. R6 was non-interviewable, and his RR was not contacted. 2. Review of R9's Face Sheet, located in the resident's EHR, revealed the facility admitted the resident on 11/17/2022 with diagnoses to include obstructive uropathy, protein calorie malnutrition, and ventral hernia. Review of R9's quarterly MDS, with an ARD of 12/09/2024, revealed the facility assessed the resident to have a BIMS score of 5 out of 15, which indicated R9 had severe cognitive impairment. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R9's Immunization Record, located in the resident's EHR, revealed R9 received her RSV vaccine on 10/03/2024. She received her last influenza vaccine on 11/17/2022. For both immunization records, No was answered to the question about whether education was provided by the nurse. There was no documentation the RR was provided updated vaccine information. Other vaccine information was historical. Resident 9 was non-interviewable, and her RR was not contacted. 3. Review of R16's Face Sheet, located in the resident's EHR, revealed the facility admitted the resident on 08/07/2024 with diagnoses to include acute on chronic respiratory failure, encephalopathy, and non-compliance with medical regimen. Review of R16's quarterly MDS, with an ARD of 12/26/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated R16 was cognitively intact. Review of R16's Immunization Record, located in the resident's EHR, revealed R16 received her RSV vaccine on 10/03/2024. She received her influenza vaccine on 10/14/2024. For both immunization records, No was answered to the question about whether education was provided by the nurse. There was no documentation the resident was provided updated vaccine information. Other vaccine information was historical. During an interview with R16 on 01/23/2025 at 9:34 AM, she stated she was not provided a VIS to read or sign prior to administration of her last vaccines. She stated education regarding the benefits and risks and potential side effects associated with the vaccine was good information to have to make an informed decision. 4. Review of R21's Face Sheet, located in the resident's EHR, revealed the facility admitted the resident on 10/16/2020 with diagnoses to include esophageal obstruction, acute pancreatitis, and congenital stenosis and stricture of the esophagus. Review of R21's quarterly MDS, with an ARD of 12/26/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated R21 was cognitively intact. Review of R21's Immunization Record, located in the resident's EHR, revealed R16 received his RSV vaccine on 10/03/2024. He received his Influenza vaccine on 10/14/2024. For both immunization records, No was answered to the question about whether education was provided by the nurse. There was no documentation the resident was provided updated vaccine information. Other vaccine information was historical. During an interview with R21 on 01/23/2025 at 9:55 AM, he stated he did not remember any education about the vaccines or that he was given a VIS to read or sign prior to administration of his last vaccines. He stated he was just asked if he wanted the vaccine. 5. Review of R44's Face Sheet, located in the resident's EHR, revealed the facility admitted the resident on 05/03/2024 with diagnoses to chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, and unstageable wound to right foot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Grand Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Rodgers Park Cynthiana, KY 41031	

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R44's quarterly MDS, with an ARD of 12/03/2024, revealed the facility assessed the resident to have a BIMS score of 11 out of 15, which indicated R44 had moderate cognitive impairment. Review of R44's Immunization Record, located in the resident's EHR, revealed R44 declined the influenza vaccination for this season. He had also declined the pneumococcal vaccination. For both immunization records, No was answered to the question about whether education was provided. There was no documentation the resident was provided updated vaccine information. During an interview with R44 on 01/22/2025 at 11:52 AM, he stated he declined both immunizations when offered. He stated he was not provided a VIS to read or sign. During an interview with the Infection Preventionist (IP) on 01/23/2025 at 12:00 PM, she stated the facility followed the CDC's recommendation for all immunizations and vaccines. She stated the facility provided vaccine education to residents. The IP stated she did not know why the sampled resident files did not have vaccine education documentation. The IP did not answer why the facility was using outdated VIS sheets from 2023 for the 2024-2025 vaccines. The IP stated it was important for the facility to educate and offer residents recommended vaccines and follow CDC's recommendations for vaccines and immunizations to prevent the spread of diseases and infections. During an interview with the Director of Nursing (DON) on 01/24/2025 at 10:30 AM, she stated the facility followed CDC recommendations for resident and staff immunizations and vaccines. She stated it was important for residents to be educated about and offered all recommended immunizations and vaccines. She stated the IP provided updated VIS information to educate staff and residents. Furthermore, she stated immunization or declination of the vaccine should be documented in resident files as part of a comprehensive infection control program. During an interview with the Administrator on 01/24/2025 at 4:20 PM, she stated it was important the facility maintained the appropriate documentation to reflect that it provided the required COVID-19 vaccine education to employees to comply with CDC recommendations and adhere to the facility's infection control program. The Administrator stated the IP Nurse was responsible for infection control oversight, but everyone must follow policies. She stated further that following policy and CDC guidelines was important for the safety of residents and staff. During an interview with the Medical Director on 01/24/2024 at 4:15 PM, he stated the facility followed CDC guidelines and recommendations. The Medical Director stated it was his expectation that the facility followed all its policies and procedures, and he further expected the DON and the IP to oversee and implement infection prevention and control policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Haven Nursing Home	105 Rodgers Park Cynthiana, KY 41031

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44001 Based on interview, record review, review of the Centers for Medicaid and Medicare Services (CMS) document, and review of the facility's policy, the facility failed to maintain documentation of screening, education, offering, and current COVID-19 vaccination status for 4 of 4 sampled staff, Licensed Practical Nurse (LPN) 2, LPN7, Certified Nurse Aide (CNA) 2, and the Business Office Manager (BOM). The findings include: Review of the CMS's Center for Clinical Standards and Quality/Quality, Safety & Oversight Group's QSO-21-19-NH Memo, dated 05/01/2021, revealed Long-term Care facilities (LTC) must offer staff vaccination against COVID-19 when vaccine supplies were available to the facility. Per the memo, LTC facility's must screen staff prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine whether they were appropriate candidates for vaccination. Per the guidance, the vaccine might be offered and provided directly by the LTC facility or indirectly, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity. Review of the facility's policy titled, Immunization/Vaccination Policy and Procedure, dated 11/09/2024, revealed the facility would educate and offer staff members and volunteer workers available immunizations against infections to minimize the risk of acquiring or transmitting disease. Per the policy, staff and volunteers would be assessed for medical contraindications of immunizations and receive education regarding the benefits and potential side effects of the immunization. The policy stated staff was encouraged to be immunized annually to prevent infection and transmission of infectious diseases and its complications. 1. Review of LPN2's employee file revealed no documented evidence noting the LPN was offered the COVID-19 vaccination. Additionally, there was no documentation that education regarding the benefits, risks, and potential side effects of the vaccine was provided to the employee. During an interview with LPN2 on 01/22/2025 at 9:40 AM, she stated she received education regarding the COVID-19 vaccine, but she did not recall if she signed any documentation acknowledging the education or being offered the COVID-19 vaccination. 2. Review of LPN7's employee file revealed no documented evidence noting the LPN was offered the COVID-19 vaccination. Additionally, there was no documentation that education regarding the benefits, risks, and potential side effects of the vaccine was provided to the employee. LPN7 was unavailable for interview. 3. Review of CNA2's employee file revealed no documented evidence the facility had provided CNA2 with education regarding the benefits, risks, and potential side effects of the vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA2 on 01/23/2024 at 9:38 AM, she stated she received education regarding the COVID vaccine but did not sign any documentation acknowledging the education or offering of the COVID-19 vaccination. 4. Review of the BOM's employee file revealed no documented evidence the facility had provided the BOM with education regarding the benefits, risks, and potential side effects of the vaccine. The BOM was unavailable for interview. During an interview with the Infection Preventionist (IP) on 01/23/2025 at 12:00 PM, she stated the facility followed the Centers for Disease Control and Prevention's (CDC) recommendation for all immunizations and vaccines. She stated the facility provided vaccine education to staff on hire. The IP stated she did not know why the sampled employee files did not have the employee's COVID-19 vaccine education documentation. However, she stated it was important for the facility to educate staff about and offer the COVID-19 vaccine. Additionally, the IP stated the facility should keep documentation of employees' immunizations or declinations of the vaccine in their files. She stated it was important to follow the CDC's recommendations for infection prevention and control to prevent the spread of diseases and infections. During interview with the Director of Nursing (DON) on 01/24/2025 at 10:30 AM, she stated the facility followed infection control guidelines as per the CDC to include recommendations for staff immunizations and vaccines. She stated knowing the employees' vaccination status was essential for everyone's safety. She stated it was important for staff to be educated about and offered the COVID-19 vaccine. Furthermore, she stated the staff members' immunizations or declinations of the vaccine should be documented in their files, as part of a comprehensive infection control program. During an interview with the Administrator on 01/24/2025 at 4:20 PM, she stated it was important that the facility maintained the appropriate documentation to reflect that it provided the required COVID-19 vaccine education to employees to comply with CDC recommendations and adhere to the facility's infection control program. The Administrator stated the IP Nurse was responsible for infection control oversight, but everyone must follow policies. She stated further that following policy and CDC guidelines was important for the safety of residents and staff. During an interview with the Medical Director on 01/24/2024 at 4:15 PM, he stated the facility followed CDC guidelines and recommendations. The Medical Director stated it was his expectation that the facility followed all its policies and procedures, and he further expected the DON and the IP to oversee and implement infection prevention and control policies.