STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185382	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Center for Rehabilitation and Nursing	47 Margo Avenue Bardwell, KY 42023

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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. 50153 Based on interview, record review and review of facility policy, it was determined the facility failed to develop and implement a comprehensive person-centered care plan for one of one sampled residents (Resident (R) 12) receiving hemodialysis services. R12 began receiving off-site hemodialysis services on 12/26/2024; however, the facility failed to include the hemodialysis services on the resident's Comprehensive Care Plan. The findings include: Review of the facility policy titled, Comprehensive Care Plan with a revision date of 02/2024 revealed the Comprehensive Care Plan will describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Review of the facility policy titled, Hemodialysis with a revision date of 02/24/2024, revealed the facility will provide the necessary care and treatment consistent with professional standards of practice, physician orders, and the comprehensive care plan to meet the special medical and nursing needs of residents receiving hemodialysis. Record review revealed the facility admitted R12 on 09/21/2022 with diagnoses which included: schizophrenia disorder, bipolar type; hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease; type 2 diabetes mellitus without complications; and chronic obstructive pulmonary disease. Review R12's of the most recent Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/20/2024 revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, indicating moderate cognitive impairment. Review of the facility's CMS-802 (Matrix of resident care needs) revealed the matrix indicated zero residents were receiving dialysis in the facility. Review of the nursing progress notes revealed the R12 received the first hemodialysis treatment via perm-a-cath on 12/26/2024. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders dated 01/29/2025 revealed R12 attends hemodialysis off-site three times per week. The order included the pick up time, location, and phone number of the hemodialysis facility. Review of R12's Comprehensive Care Plan revealed the plan did not address that the resident was receiving hemodialysis services. During an interview on 01/30/2025 at 11:05 AM, the Minimum Data Set Nurse (MDS) nurse stated she would expect R12 to have a care plan related to dialysis. The MDS nurse stated that while she does have a large role in the development of the care plan, all nurses in the facility are capable of making entries in the care plan. During an interview on 01/29/2024 at 10:15 AM, the Director of Nursing (DON) stated R12 had begun hemodialysis in December of last year. She further stated that there were no other residents who were receiving dialysis currently and it had been a while since there was a resident who received dialysis. The DON stated that dialysis was addressed in the nutrition care plan for R12 but that the resident was not specifically care planned for hemodialysis. The DON stated the hemodialysis services for R12 should have been reflected in the resident's care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50153 Based on observation, interview, and review of facility policy, the facility failed to ensure that drug records were in order and that an account of all controlled drugs was maintained by the facility for one of four medication carts and one (1) of one (1) medication storage room. Observation during a narcotic count of the 100 Hall medication cart on 01/30/2025 at 11:00 AM with Licensed Practical Nurse (LPN) 2 revealed the narcotic count was incorrect for six narcotic medications belonging to four different residents (Resident (R) 4, 5, 10, and R16). The findings include: Review of the facility policy titled, Medication Storage in The Facility - Controlled Substance Storage dated May 2022, revealed that at each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items was conducted by two licensed nurses and was documented. Further review of the policy revealed that any discrepancy in controlled substance counts was reported to the Director of Nursing (DON) immediately. On 01/30/2025 at 11:00 AM, the narcotics in the 100 Hall medication cart were counted with LPN2 and there were discrepancies with six of the narcotic medications. 1. Resident (R) 16's tramadol count was 49; however, according to the narcotic record, the count was 53. 2. R16's liquid Morphine amount on the count sheet was 9.25 milliliters (ml); however, observation of the bottle revealed 8 ml. 3. R16's refrigerated liquid lorazepam count was 28.25 ml; however, observation of the bottle revealed approximately 24 ml. 4. R10's oxycodone/acetaminophen (APAP) count was 39; however, according to the narcotic record, there should have been 40. 5. R5's liquid Morphine on the count sheet was 6.75 ml; however, observation of the bottle revealed four ml in the bottle. 6. R4's liquid Morphine on the count sheet was 14 ml; however, observation of the bottle revealed eight ml in the bottle. In an Interview on 01/30/2025 at 11:30 AM, LPN2 stated she did not count the narcotics when she accepted the medication cart keys when her shift started on 01/30/2025. She stated the cart had been counted this morning by Kentucky Medication Aide (KMA) 5 who was working dayshift and the LPN from night shift. LPN2 stated she trusted that the narcotic count was correct but didn't complete a narcotic count. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/30/2025 at 11:45 AM, KMA5 stated she counted the cart with the night shift nurse, LPN7. She stated it was chaotic this morning due to a resident having behaviors and that she must have missed it due to the distractions in the vicinity. KMA5 stated it was difficult concentrating and that she failed to notice the counts were not correct. KMA5 stated during the narcotic count this morning, she counted the pills and the night nurse had the count sheet which she used to call out the number of pills listed on the sheet. Per KMA5, she checked the pills to see if the number matched the count sheet. She stated if the count was wrong, the staff counting would figure it out. KMA5 stated if she had noticed the discrepancy, she would have told the dayshift LPN or the DON. KMA5 stated that dayshift did not typically count the liquid controlled substances in the refrigerator because night shift was typically the ones who give the liquid narcotics. In an interview on 01/30/2025 at 12:10 PM, the DON stated there was not a history of discrepancies with narcotic medication counts in the facility and if there was a discrepancy, the staff was supposed to notify her. However, staff did not notify her of a narcotic count discrepancy this morning, 01/30/2025. The refrigerator controlled substance container was obtained from the refrigerator and accessed by the DON to confirm the count of the liquid lorazepam for Resident (R)16, the DON advised the bottles of liquid lorazepam leak but did not verbalize a method of accounting for loss due to leakage. In an interview on 01/30/2025 at 6:30 PM, LPN6 stated she has received education regarding narcotic handling. LPN6 reported that two nurses work at night. LPN6 verbalized that if a narcotic was dropped, it was wasted with another nurse as a witness. She stated if the narcotic count was incorrect, she was to notify the DON immediately. LPN6 also stated if she had to leave during her shift, she would complete a narcotic count when she left and when she returned. In an interview on 01/30/2025 at 6:39 PM, LPN7 stated she had been trained upon hire regarding handling of narcotics and verbalized that a narcotic should be signed out at the time the medication was removed from the cart. Per LPN7, she had completed the narcotic count with KMA5 at the end of her shift on the morning of 01/30/2025. LPN7 stated, It was so crazy this morning, we had a rough night with another resident, and I get distracted. I called the numbers on the count sheet. LPN7 stated that if there was a discrepancy she was to call the DON for further instructions. In an interview with the DON and the Regional Resource Nurse on 01/30/2025 at 5:21 PM, the DON stated the Pharmacy representative looks at expiration dates for the medications on the carts but does not complete a narcotic count. The DON and Regional Resource Nurse advised it was their expectation that narcotics were counted, according to facility policy. They also stated that documentation of wasted narcotics should be documented according to facility policy. In an interview on 01/30/2025 at 6:06 PM, the Administrator stated it was important to follow the process for narcotic medication counts. She stated moving forward focused attention would be placed in this area including Quality Assurance and Performance Improvement follow up.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on observation, interview and review of facility policy, it was determined the facility failed to ensure that foods brought in by family and/or visitors were stored in a safe and sanitary manner for four of 13 sampled residents (Resident (R) 5, 6, 37, and R50) with personal in room refrigerators. The findings include: On 01/28/2025 and 01/30/2025, the State Survey Agency (SSA) requested a policy on resident refrigerators. On 01/30/2025 at 4:50 PM, the Director of Nursing (DON) stated the facility did not have a policy on resident personal refrigerators. Review of facility policy, Use and Storage of Foods Brought in by Family or Visitors, revised on 01/06/2025, revealed. it was the right of the residents of the facility to have food brought in by family or other visitors; however, the food must be handled in a way to ensure the safety of the resident. Family members or other visitors may bring the resident food of their choosing. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. The prepared food must be consumed by the resident within three days. If not consumed within three days, food would be thrown away by facility staff. The facility will not be responsible for maintaining any reusable items. Facility staff would assist residents in accessing and consuming food that were brought in by the resident and family if the resident is not able to do so on their own. 1. Observation on 01/28/2025 at 9:46 AM in room [ROOM NUMBER]B of R5's personal refrigerator revealed a temperature check form taped to the outer door, dated January 2025, with the last temperature reading recorded on 01/24/2025. The temperature reading on thermometer located inside the door read fifty-four (54) degrees Fahrenheit (F). The inside of the refrigerator was dirty and there were 2 styrofoam containers, and a paper plate covered with aluminum foil visible inside the refrigerator. The freezer had a large amount of ice build up that was brown in color which looked like a soda may have leaked in the freezer. Certified Nursing Assistant (CNA) 1 and CNA2 were observed in the hall and the surveyor requested they check the resident's refrigerator. CNA1 and CNA2 checked refrigerator and removed the items (styrofoam containers, foil covered plate and molded food items) from the refrigerator. Continued observation with CNA1 and CNA2, of R5's refrigerator revealed a large foam container, not labeled or dated, with left over dessert (cake) that was covered with black specks, a foam container, not labeled or dated, with left over food that appeared to be turkey and dressing, a small piece of ham, and green beans. The ham had a circular area of green and white mold, the green beans were completely covered with a green mold, the turkey had spots of green and white mold. The paper plate contained 3 partially eaten desserts with green mold. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation with CNA1 and CNA2 on 01/28/2025 at 9:55 AM, in room [ROOM NUMBER]A of R6's personal refrigerator revealed a temperature check form taped to the outer door dated January 2025. Further observation revealed the form has no temperature recordings for January 2025. The temperature reading on the thermometer located inside the refrigerator read fifty (50) degrees F. Observed inside the refrigerator was four chocolate drinks with an expiration date of 12/22/2024, a Ziploc bag not labeled or dated that contains 4 pieces of lunch meat (bologna) that was a light brown in color with black mold present on the edges, and packaged lunch meat (ham) with an expiration date of 12/19/2024. Further observation revealed the CNAs removed the old and molded food from R6's refrigerator. 3. Observation in room [ROOM NUMBER] of R50's personal refrigerator revealed a temperature check sheet form attached to the outside of the door which had no temperatures recorded for January 2025. The current temperature inside the refrigerator was 40 degrees F and there were no items observed in the refrigerator. 4. Observation in room [ROOM NUMBER] of R37's personal refrigerator revealed a temperature check sheet form attached to the outside of the door which had no temperatures recorded since 01/24/2025. The current temperature inside the refrigerator was 38 degrees F. The freezer was observed to have a large amount of ice built up. In interview on 01/28/2025 at 10:10 AM, CNA1 stated she thought maintenance was responsible for checking the temperatures on the resident refrigerators but was not sure. She further stated she thought maybe nursing staff was responsible for cleaning the refrigerators. She stated she had not been told to clean or check the resident refrigerators. CNA1 then stated that housekeeping was supposed to be checking the temperatures. She stated she would find out for sure and let me know. She stated fifty (50) degrees was too warm for a refrigerator and if a resident ate food that was molded or spoiled they could get sick. Interview with CNA2 on 01/28/2025 at 10:10 AM, she stated she did not know who was responsible for checking the refrigerators. In a follow up interview with CNA1 on 01/28/2025 at 2:25 PM, she stated she asked and there was some confusion on who was supposed to be checking the refrigerators. She stated she did not have a definite answer. In an interview on 01/30/2025 at 4:50 PM, the Director of Nursing (DON) stated the facility did not have a policy on resident personal refrigerators. When asked who was responsible for checking, cleaning and obtaining the temperatures, she stated there was some confusion on who was doing what. She stated everybody thought someone else was checking them. She stated they were in the process of fixing it. The DON stated a refrigerator at 50 degrees F was too warm and a resident could get sick if they ate spoiled food. During an interview with the Administrator on 01/30/2025 at 5:43 PM, she stated there was confusion about who was responsible for taking temperature readings and cleaning resident refrigerators. The Administrator stated she believed there was a policy in the admission paperwork, but she would have to review it. She stated fifty (50) degrees Fahrenheit was too warm for a refrigerator. She stated an outcome for residents consuming out-of-date or spoiled foods was that a resident could get food poisoning.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44370 Based on interviews and review of the facility's policy, it was determined the facility failed to ensure the individual assigned the responsibilities of the Infection Preventionist (IP) had received specialized training in infection control and prevention. This had the potential to affect all fifty (50) residents residing in the facility On 01/27/2025 at 7:05 PM, the entrance conference was conducted with the Administrator who revealed that the Staff Development Coordinator (SDC) was the designated Infection Preventionist (IP) for the facility. The findings include: Review of facility policy Infection Preventionist, revised 08/20/2024, revealed, the facility would employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program. Continued review revealed, that an infection preventionist was defined as an individual designated by the facility to be responsible for the infection prevention and control program. The facility would ensure the infection preventionist was qualified by education, training, experience or certification. Additionally, the IP must have obtained specialized Infection Prevention and Control (IPC) training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate of completion or equivalent documentation. Review of the facility policy, Infection Prevention and Control Program, revised on 02/21/2024, revealed, the facility would 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. Continued review revealed the designated Infection Preventionist (IP) was responsible for oversight of the program and served as a consultant to the staff on infectious diseases, resident room placement, implementing isolation precautions, and staff/resident exposure surveillance. All staff were responsible for following all policies and procedures related to the program. Review of The Centers for Disease Control and Prevention (CDC) certificate, provided by the facility, revealed the Director of Nursing had completed the Nursing Home Infection Preventionist Training Course on 05/11/2023. However, no certificate of completion was received for the SDC/IP. In interview with the Staff Development Coordinator/Infection Preventionist, RN, on 01/30/2025 at 2:43 PM, she stated she had been the designated IP since August 2024. When asked about her training, the IP stated she had not completed the specialized training on infection control. She stated she performed all duties related to infection control such as antibiotic stewardship, infection tracking, staff and resident vaccines and reported her findings to the Quality Assurance Performance Improvement (QAPI) meetings. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Director of Nursing (DON) on 01/30/2025 at 3:45 PM, she stated the Infection Preventionist had six months to complete the specialized training on infection control. She stated the IP had until mid February to complete the training. When asked if that was the requirement, the DON stated it was. The Surveyor requested to review the requirement. In a follow up interview with the DON on 01/30/2025 at 4:43 PM, she stated she had thought there was a six month window. She further stated she had completed the training and was the facility back up. She stated the SDC/IP was designated as the IP and performed all duties related to infection control. She stated the SDC was working on the training now. In an interview with the Administrator on 01/30/25 at 5:43 PM, she stated the facility was currently working on changing their enhanced barrier precautions guideline changes. She stated she was under the impression the SDC had six months to complete the specialized training on infection control. She further stated the SDC had been performing the duties of the IP.