STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185402	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Nursing and Rehabilitation Center	2500 North Elm Street Henderson, KY 42420

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - 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. Based on observation, interview, record review, and review of facility policy, the facility failed to implement a comprehensive person centered care plan for 2 of 23 sampled residents, (Resident (R)50, and R42). 1. Review of R50's comprehensive person centered care plan revealed the resident was to wear left and right hand and knee splints daily for six days. However, observation on 05/13/2025 at 12:03 PM and 2:18 PM, on 05/14/2025 at 9:10 AM, 11:23 AM , on 05/15/2025 at 9:20 AM and 11:30 AM of R50, revealed two hand splints lying on the resident's bedside table; and observation on 05/16/2025 at 10:18 AM revealed the hand splints were located in R50's closet. Additionally, observation on 05/13/2025 at 12:03 PM and 2:18 PM, on 05/14/2025 at 9:10 AM, 11:23 AM revealed R50 lying on her bed with no knee splints in place and her knees drawn up to her chest. 2. Review of R42's comprehensive person centered care plan revealed the resident was not to have chips and was to be supervised with all (oral) intake. However, observation on 05/13/2025 at 11:42 AM and 2:48 PM, revealed R42 self-propelling throughout the facility while eating a bag of potato chips unsupervised. The findings include: Review of the facility policy, Comprehensive Care Plans, Standard of Practice, reviewed on 04/2025, revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs was to be developed for each resident. Continued review revealed, each resident's comprehensive care plan was designed to identify problem areas, reflect the resident's needs, reflect treatment goals, timetables and objectives. Per review, the comprehensive care plan was also to identify professional services that were responsible for each element of care, and aid in preventing or reducing declines in the residents. Further review revealed functional level care plans were reviewed and updated when there was a significant change in the resident's condition, when the desired outcome was not met, or when the resident was readmitted to the facility from a hospital stay and at least quarterly. (continued on next page)

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	1. Review of the, admission Face Sheet for R50 revealed the facility admitted the resident on 06/29/2021, with diagnoses to include: persistent vegetative state; epilepsy, intractable, without status epilepticus: and encounter for attention to tracheostomy. Review further revealed R50 developed contractures to an unspecified joint of the left and right wrist on 02/20/2023. Review of the Significant Change in Status Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/20/2025, revealed under section B the facility assessed R50 as being in a persistent vegetative state. Further review revealed the Brief Interview for Mental Status (BIMS) assessment area had not been completed. Review of the Comprehensive Care Plan for R50 dated 06/13/2024, revealed the facility identified a focus problem that read splint and or brace assistance, the resident required the use of a splint/brace to prevent further contractures related to persistent vegetative state, anoxic brain damage, contracture of unspecified joint, and contracture of muscle. Per review, the interventions included: removing the Posey splints as needed to inspect skin; inspecting the splints for damage and reporting to therapy immediately; and removing splints as needed for ADL care. Continued review revealed the interventions also included: restorative nursing rehabilitation (rehab; for 90 days; and passive range of motion to bilateral lower extremities. Further review revealed the target goals dated 06/14/2024 were that the resident would tolerate resting hand splint to right hand without pain for five hours daily as resident allowed from 9:00 AM to 2:00 PM, six days a week through next review. In addition, review revealed the target goals also included: the resident would tolerate grip splint to left hand without pain for five hours daily as resident allowed from 9:00 AM to 2:00 PM, six days a week through next review. Review further revealed the target goals additionally noted the resident would tolerate Posey splints to bilateral knees without pain for six hours daily as resident allowed from 9:00 AM to 3:00 PM, six days a week through next review. However, observation on 05/13/2025 at 12:03 PM and 2:18 PM, on 05/14/2025 at 9:10 AM, 11:23 AM , on 05/15/2025 at 9:20 AM and 11:30 AM of R50, revealed two hand splints lying on R50's bedside table and the resident had no splints in place as per the care plan. Observation on 05/16/2025 at 10:18 AM, revealed the hand splints were located in R50's closet and the resident had no hand splints in place as per the care plan. Observation on 05/13/2025 at 12:03 PM and 2:18 PM, on 05/14/2025 at 9:10 AM, 11:23 AM also revealed R50 lying on her bed with no knee splints in place as per the care plan and she had her knees drawn up to her chest. In interview with Restorative Aide (RA) 8 on 05/16/2025 at 9:45 AM, she stated she was told that morning by the Director of Rehab (DoR) that R50 was to resume restorative services including the splinting next week. She reported when residents went on restorative programs she received training from the DoR and signed a paper. RA 8 said R50 was to have left and right hand splints and knee splints to both legs, and was to wear the splints six hours a day. She stated R50 received passive range of motion (ROM) to her extremities before the splints were applied. The RA further stated the restorative binder had all residents' restorative programs in it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with Kentucky Medication Aide (KMA) 4 on 05/15/2025 at 9:57 AM, she stated she was providing care for R50 and the resident required total care. She stated resident information was located on the computer that information told staff what care a resident needed. KMA 4 said she did recall seeing R50's splints and assumed they were applied by therapy. When asked by the State Survey Agency (SSA) Surveyor about R50's knee splints and hand splints lying on the overbed table, she reported therapy was responsible for applying the splints. The KMA further stated she was not sure if R50 had restorative programs and she did not know who, other than therapy, would apply the resident's splints. In interview with the Unit Manager (UM)/Restorative Nurse on 05/16/2025 at 11:10 AM, she stated she just started overseeing the facility's Restorative Programs in April of this year. She stated therapy communicated with her when residents were given a restorative program. The UM/Restorative Nurse reported she updated the residents' care plans and included the restorative information in the restorative binder for staff. She said she had received R50's communication form just this week for the hand splints; however, had not received a form for the knee splints. The UM/Restorative Nurse explained therapy did splinting when residents were receiving their services. She said R50 had received splinting for a long time and that was why it was care planned. The UM/Restorative Nurse further stated as the restorative program had not been written the care plan was not being followed. 2. Review of the admission Facesheet for R42 revealed the facility admitted the resident on 03/13/2020, with diagnoses that included: Idiopathic Epilepsy; Dysphagia; and Profound Intellectual Disabilities. Review of the Quarterly MDS Assessment with an ARD of 02/11/2025, revealed the facility assessed R42 to have a BIMS score of zero out of 15, indicating the resident was rarely or never understood. Review of R42's comprehensive care plan revealed the facility had developed a dietary care plan with an implementation date of 06/19/2020, with interventions that included a regular diet with thin liquids advanced dysphagia consistency. Further review revealed the interventions further noted R42 was to have: supervision with all intake: have no chips, bread, whole potatoes, or caffeinated beverages; and finger foods as allowed. In interview with UM of unit 1 and 2 on 5/16/25 at 11:28 AM, she stated care plans were double checked in the morning meetings and clinical meeting to see if staff were implementing the care plans. She further stated she did not think staff would not follow R42's care plan and let her walk around with something that she should not have. In interview with the Director of Nursing (DON) on 05/16/2025 at 11:32 AM and at 11:40 AM, she stated her expectations for implementing residents' care plans was for the interventions to be placed into the facility's Resident Care Profile for the nursing assistants. She reported care plans were reviewed in the morning meetings and nurses could access the care plan interventions from the point of login in order to know how to provide care for the resident. The DON further stated any new orders put into the facility's computer system were to be included in the resident's care plan as well. In interview with the Administrator on 05/16/2025 at 11:56 AM, she stated she expected facility staff to follow residents' care plans and implement interventions.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, record review and review of facility policy, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion (ROM) for 1 of 23 sampled residents, (Resident (R)50). R50 was care planned with interventions to have left and right wrist and knee splints daily for six days. However, observation revealed two hand splints lying on R50's bedside table or located in the resident's closet. Additionally, observation revealed R50 did not have knee splints on while in bed and the resident's knees were drawn up to her chest. The findings include: Review of the facility policy, Restorative Nursing Standards of Practice, revised 12/2023, revealed the facility strived to promote a restorative nursing program that encourages all residents to attain or maintain their highest practical level of function. Per review, residents were to be evaluated for potential nursing restorative nursing needs on admission, quarterly, and with a change in condition. Continued review revealed a restorative nursing program might be developed independently by nursing. Further review revealed the dedicated restorative nursing process owner, a licensed nurse, was to complete a periodic evaluation of the resident's progress and goals at a minimum of quarterly, to determine any required changes to their restorative nursing program. In addition, review revealed a restorative program progress note was to be documented in the resident's medical record within the seven day assessment look back period. Review of R50's admission Face Sheet, revealed the facility admitted the resident on 06/29/2021, with diagnoses that included: encounter for attention to tracheostomy; persistent vegetative state; and epilepsy intractable, without status epilepticus. Review revealed R50 had developed contractures to an unspecified joint of the left and right wrist on 02/20/2023. Review of the Significant Change in Status Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/20/2025, revealed under section B the facility assessed R50 as being in a persistent vegetative state and the Brief Interview for Mental Status (BIMS) assessment was not completed. Review of the, Restorative Monthly Summary, dated 04/08/2025 and created on 05/16/2025, revealed, resident has bilateral posy splints to knees six hours daily for 90 days, and passive ROM to bilateral lower extremities (BLE) for 15 minutes daily for 90 days, passive ROM to BUE, left grip splint and right-hand resting hand splint. Continued review revealed, resident was progressing with splinting to bilateral knees and passive ROM to BLE with restorative programs. Further review revealed R50 continued with good progress, passive range of motion bilateral upper extremities, left grip splint, and right resting hand splint added to program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Restorative Monthly Summary dated 04/30/2025 and created on 05/16/2025, revealed, the bilateral posy splints to knees six hours daily for 90 days; passive ROM to BLE for 15 minutes daily for 90 days; and passive ROM to BUE, left grip splint, and right resting hand splint. Per review, R50 was progressing with splinting to bilateral knees and passive ROM to BLE restorative programs; passive ROM to BUE left grip splint and right resting hands splint. Review further revealed R50 continued with good progress. Resident tolerating well, will continue at this time. However, observation of R50 on 05/13/2025 at 12:03 PM and 2:18 PM, on 05/14/2025 at 9:10 AM, 11:23 AM , on 05/15/2025 at 9:20 AM and 11:30 AM, revealed two hand splints lying on the resident's bedside table and the resident had no splints in place. Observation on 05/16/2025 at 10:18 AM, also revealed hand splints located in R50's closet and the resident had no hand splints. Additionally, observation on 05/13/2025 at 12:03 PM and 2:18 PM, on 05/14/2025 at 9:10 AM, 11:23 AM also revealed the resident had her knees drawn up to her chest while lying on her bed with no knee splints in place. In interview on 05/16/2025 at 9:45 AM, Restorative Aide (RA) 8 stated she was responsible for the facility's resident restorative programs. She said the restorative program included ambulation, transfers, ROM and splinting. RA 8 explained the purpose of the restorative programs was to improve or maintain a resident's function. She stated R50 had been on restorative services for a year or more; however, had to the hospital and received therapy when she came back. RA 8 reported restorative staff were not currently doing the restorative programs or the splinting for R50. She said the Director of Rehab (DoR) had told her that morning that R 50 was to resume restorative services including splinting next week. The RA reported R50 got left and right hand splints and knee splints to both legs, and was to wear the splints six hours a day. She further stated R50 received passive ROM to her extremities before the splints were applied. In addition, she said she received training from the DoR when residents went on restorative programs and she signed a paper after the training. In interview on 05/16/2025 at 10:02 AM, the Physical Therapist (PT) stated R50 had been receiving PT services to manage her spasms and keep her knees from getting tight. She said R50 had knee splints and that she had been wearing them for a while. The PT reported R50's last therapy treatment day was 05/13/2025, and she had been responsible for applying the resident's knee splints while she was receiving therapy services. She stated at the end of treatment on 05/13/2025, she gave the Rehab Director a form with her recommendations for restorative services. The PT said she provided training to the RA's on applying and removing the splints. She further stated her expectation had been for the RA's to start the programs for R50 the next day, as there was a potential for the resident to decline due to her muscle tone. The PT additionally said the knee splints only controlled the knees and helped keep R50 out of a frog position. In interview on 05/16/2025 at 10:49, the Director of Rehab (DoR) stated R50 was not currently on their caseload and had been discharged from therapy services on 05/08/2025. She stated when residents were discharged from therapy services a discharge notice was given to the Restorative Nurse. She reported she expected restorative programs to start immediately, and discharge training was provided to the RA's on how to apply and remove any devices. The DoR said R50 had worn splints for years and there had been no changes made to her splinting programs. She stated she was responsible for applying R50's hand splints while she had been on the therapy case load. The DoR explained she had not been aware R50 had not been wearing the hand splints since she was discharged from therapy services. She further stated R50's hand splints had been maintaining and preventing her from declining. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 05/16/2025 at 11:10 AM, the Unit Manager (UM)/Restorative Nurse stated she just started overseeing the facility's Restorative Programs in April of the current year. She said therapy made her aware of restorative programs through the Therapy to Restorative Communication form. The UM/Restorative Nurse explained a resident would not get restorative programs until the necessary information was placed in the restorative binder. She reported she had received R50's Communication form just this week regarding the hand splints; however, had not received a form for the resident's knee splints. The UM/Restorative Nurse said when residents were receiving therapy, therapy did residents' splinting. She further stated the RA's applied and removed residents' splints when on the restorative program. In interview on 05/16/2025 at 11:32 AM, the Director of Nursing (DON) stated she had been the facility's DON for one month. She said when a resident required a restorative program, therapy communicated with the UM/Restorative Nurse on what the program was for each resident and whether it was to be done by RA's or the staff on the floor. She stated she did not know how it was communicated to staff. The DON reported she expected restorative programs to be initiated timely so that programs could be started as the residents could potentially have negative outcomes.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, record review, the facility failed to ensure residents received and consumed foods in the appropriate form or the appropriate nutritive content as prescribed for 1 of 23 sampled residents, (Resident (R)42). R42 had a diet order for supervision with all (oral) intake and to have no chips. However, observation on 05/13/2025 at 11:42 AM and 2:48 PM, revealed R42 self-propelling throughout the facility while eating a bag of potato chips unsupervised. The findings include: A policy was requested however, the Administrator stated the facility did not have a policy related to the deficient practice. Record review revealed the facility admitted R42 on 03/13/2020, with diagnoses that included Dysphagia, Idiopathic Epilepsy, and Profound Intellectual Disabilities. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 02/11/2025 for R42, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero out of 15, indicating the resident was rarely or never understood. Review of R42's Diet Order dated 02/05/2025, revealed the resident had a regular advanced Dysphagia diet ordered that required supervision with all intake, no chips, bread, whole potatoes, or caffeinated beverages. Review of R42's lunch meal tray card dated 05/13/2025, revealed the resident was to be supervised during meal times. Further review of the lunch meal tray card revealed R42 had diet restrictions that included no potato chips, bread, whole potatoes, or french fries. However, observation of Resident 42 on 05/13/2025 at 11:42 AM and at 2:48 PM, revealed R42 self-propelling a wheelchair throughout the facility while eating a bag of potato chips unsupervised. In interview on 05/16/2025 at 11:12 AM, Licensed Practical Nurse (LPN) 4 stated nursing placed residents' diet orders in the computer and dietary checked to make sure they matched what the resident received. She stated if a resident's meal tray and meal ticket were not correct they took the tray back to the kitchen and got them to fix it. LPN 4 said R42 had a history of grabbing things off the snack cart all the time. She reported R42 did not like it when you try to take things away from her and that might have been why she had the bag of chips. LPN 4 further stated if she saw R42 on the hall with something she tried to take it away from her for her own safety. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 5/16/2025 at 11:28 AM, the Unit Manager (UM) of units 1 and 2 stated if Resident 42 picked things up sometimes it was very hard to get it back from her. She said sometimes staff tried to get the resident to trade the restricted item for something she could have. The UM stated sometimes that worked and sometimes it did not. She reported most likely someone might have tried to take the chips away from her but were unsuccessful. The UM stated she did not think staff would just let R42 walk around with something she was not supposed to have. She further stated a possible outcome of R42 having food she should not have, could be the resident getting strangled or choked and no one was supervising her. In interview on 05/16/2025 at 11:40 AM, the Director of Nursing (DON) stated they had to keep an eye on R42 because she was a wanderer and went in and out of other residents' rooms and took their things. She said the staff had to constantly take things away from R42 that she was not supposed to have. The DON reported a potential outcome for R42 having a restricted food item, was she could potentially have a choking episode and aspirate on the food, especially chips. She further stated R42 was supposed to be on increased supervision only if she was eating or drinking. In interview on 05/16/2025 at 11:56 AM, the Administrator stated one day R42 had a (chip) bag, but it had been empty. She stated R42 like to take things off of tables and desks because she liked the colors of the bags and was very sneaky. The Administrator said somehow R42 just gets a hold of things she should not have; however, she expected staff to follow residents' dietary orders and care plan.

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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. Based on observation, interview, record review, and review of facility policy, 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 1 of 5 residents sampled for wound care out of the total sample of 23 residents (Resident (R)21). Staff providing R21's wound care failed to utilize proper hand washing during the resident's wound care procedure. The findings include: Review of the facility policy, Hand Hygiene, undated, revealed hand hygiene meant cleaning your hands by using either handwashing (washing hands with soap and water) or using hand sanitizer. Per review, hand hygiene was to be performed; before and after glove use; and before and after having contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressing. Review further revealed gloves were to be changed and hand hygiene performed before moving from a contaminated body site to a clean body site during resident care. Review of the Face Sheet for R21 revealed the facility admitted the resident on 11/13/2024, with diagnoses which included: pressure wound to right heel; asymptomatic human immunodeficiency virus (HIV) infection status; acute kidney failure; and anxiety disorder. Review of the Significant Change Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/11/2025, revealed the facility assessed R21 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. During observation on 05/15/25 at 3:38 PM of wound care to R21's right heel revealed the Wound Care Nurse (WCN) failed to wash her hands after removing the soiled dressing. Per observation, the WCN rolled the soiled dressing up in the right hand glove. Continued observation revealed however, after placing the soiled glove containing the soiled dressing in the trash, the WCN donned another glove on her right hand. Observation revealed she then proceeded to cleanse the right heel wound. The Registered Nurse/MDS Nurse (who was assisting the WCN) picked up R21's foot after it was cleansed; however, placed the foot back on the soiled absorbent pad, then picked the resident's foot back up at the request of the WCN. Further observation revealed the clean wound dressing was applied without the nurses re-cleansing the wound. During interview on 05/15/2025 at 4:25 PM, with the RN/MDS Nurse she stated she thought she placed the foot back down on a clean area of the absorbent pad and not on dirty area. She further stated she should not have laid R21's foot down to ensure the foot stayed clean. During an interview with the WCN on 05/16/2025 at 9:05 AM, she stated she should have washed her hands after removing the soiled dressing and before donning new gloves. She further revealed she should always wash her hands before and after gloving. (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 with the Administrator on 05/16/2025 at 10:38 AM, she stated she expected staff to wash their hands prior to donning gloves. She stated she also expected staff to wash their hands after doffing their gloves. The Administrator further stated she expected staff to follow the facility policies as written. During an interview with the Director of Nursing (DON) on 05/16/25 at 10:43 AM, she stated she expected staff to wash their hands prior to donning gloves and between removal and donning new gloves. She said she also expected if a wound had been cleansed prior to the new dressing application, the wound should not be placed back on the soiled barrier. The DON reported if that occurred the wound would require re-cleaning. She further stated she expected staff to follow the facility's handwashing and wound care policies as written.