STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185415	A. Building B. Wing	04/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elliott Nursing and Rehabilitation	Rt 32 East, Howard Creek Rd Sandy Hook, KY 41171

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46710 Based on observation, interview, record review, and review of the facility's policy, the facility failed to accommodate the resident's right to set her own daily schedule with respect to medication administration for 1 out of 31 sampled residents, Resident (R) 65. The findings include: Review of the facility's policy titled, Home-Like Medication Regimen, dated 03/01/2009, revealed facility staff members were to honor the residents' right to set their own daily schedule with respect to medication administration. Further review revealed the facility expected staff to administer morning medications when the resident got out of bed in the morning. Review of R65's Admission Record revealed the facility admitted the resident on 01/29/2024 with diagnoses including congestive heart failure, atrial fibrillation, and primary hypertension. Review of R65's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 02/06/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight of 15, indicating the resident was moderately cognitively impaired. Review of R65's Medication Administration Record (MAR) for 04/2024, revealed no information specifying the time the resident received blood pressure medication each day. Review of R65's Blood Pressure Summary from the electronic medical record, dated 04/16/2024 through 04/19/2024, revealed facility staff measured R65's blood pressure taken between 9:00 AM and 10:45 AM each morning. In an interview on 04/16/2024 at 11:17 AM, R65 stated she wanted her blood pressure medication at 8:00 AM but often had to wait between 10:00 AM and 11:00 AM. She further stated she had expressed this preference to a couple of staff members who administered medications. However, R65 did not recall the names of the staff members. (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: 185415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/18/2024 at 9:49 AM revealed R65 standing in the doorway to her room, dressed and groomed for the day, looking back and forth in the hallway. Continued observation revealed R65 pacing in her room and coming back to the doorway to look in the hall. Further observation at 9:58 AM revealed R65 asked State Registered Nurse Aide (SRNA) 4 where the nurse was because she was waiting for her medicine. Per observation, R65 told SRNA4 that she asked for her medication when the Kentucky Medication Aide (KMA) measured her blood pressure earlier that morning, but the KMA had not returned yet. Additional observation at 10:01 AM revealed KMA5 administered R65's morning medication. In an interview on 04/18/2024 at 4:40 PM, KMA 5 stated she was assigned to administer medications for the 300 and 400 Halls. She further stated R65 often stood in the doorway waiting on her medication because the resident was anxious to get her medications. Per interview, KMA5's process was to administer medications to the residents in the 400 Hall first because they had more disruptive behaviors than residents on the 300 Hall. KMA5 further stated it was her process to take blood pressures on all residents on the 300 Hall who received blood pressure medication and then go down the hall and administer the medication. In continued interview, KMA5 stated she preferred that process because she had to document the blood pressure reading before administering the medication, and she did not feel it was efficient to go back and forth to the medication cart between taking blood pressure measurements and preparing medications for administration for each resident. In an interview on 04/20/2024 at 11:48 AM, the Director of Nursing Services (DNS) stated she expected residents to receive medications when they wanted them, as long as it was medically safe to do so. In further interview, the DNS stated R65 was confused on admission and did not express preferences during the admission process. The DNS further stated R65 was more alert and aware after acclimating to life in the facility, but the DNS was not aware of the resident expressing a desire to receive medications at a specific time. In an interview on 04/20/2024 at 12:18 PM, the Executive Director (ED) stated she expected staff to follow the home-like medication policy and administer medications according to the resident's preference. Per interview, the ED was not aware of R65 expressing a preference for medication administration times.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50192 Based on interview, record review, review of the facility's incident report, and review of the facility's policy, the facility failed to ensure residents were free from abuse for 2 of 31 sampled residents (Residents (R) 48 and 64a). On 02/17/2024, R48 reported that R64a hit him in the chest area and punched him in the nose, causing his nose to bleed. The findings include: Review of the facility's policy titled, Abuse, Neglect, and Exploitation Policy, undated, revealed the facility was to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse was defined as .willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish . and instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Review of the facility's Incident Report, dated 02/17/2024, revealed on 02/17/2024 at 6:30 PM, R48 reported that R64a hit him in the nose. Per the report, R48 reported that he heard R64a in his bathroom and stated he told R64a that it was not the resident's bathroom. R48 stated R64a hit him in the nose and stomach. R48 suffered a bloody nose and was sent to the hospital emergency room for evaluation and treatment. The report stated his nose was not broken per the hospital record and both residents were eventually returned to the facility. Psychiatric consultations were initiated for R48 and R64a. 1. Review of R64a's closed record Face Sheet revealed the facility admitted the resident on 01/19/2024 with diagnoses that included severe dementia with other behavioral disturbances, anxiety disorder, and a history of alcohol abuse. Review of R64a's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/26/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three out of 15. This score indicated severe cognitive impairment. Review of R64a's admission Care Plan, dated 01/20/2024, revealed the resident rejected care and made inappropriate comments, exhibited delusional thoughts, and had auditory hallucinations. Further review revealed R64a startled easily. Review of R64a's Incident Note, dated 02/17/2024 at 8:30 PM, revealed R64a .hit another resident in the nose and kicked him in the chest. Further review of the Note revealed the resident was unable to recall the event. He was put on 1:1 supervision immediately. Skin assessment complete. Interview with R64a was not obtained as the resident was not in the facility during the time of the State Survey Agency (SSA) survey. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R48's Face Sheet revealed the facility admitted the resident on 02/04/2022 with diagnoses of altered mental status, moderate dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depression. Review of R48's quarterly MDS, with an ARD of 02/05/2024, revealed the facility assessed the resident as having a BIMS score of 12 out of 15. This score indicated the resident was cognitively intact. Review of R48's Incident Note, dated 02/18/2024, revealed R48 stated, I was kicked in the stomach and punched in the nose. R48 reported when he told R64a that it was not his bathroom, R64a then became agitated and proceeded to kick him in the chest, and punch him in the nose. During an interview with R48 on 04/16/2024 at 10:30 AM, he stated R64a used to wander all the time. From the day of the incident, R48 recalled hearing the door handle to his room wiggle and he opened the door. R48 stated R64a was standing there so he said Boo and closed it back. R48 stated the next thing he knew R64a was in his bathroom and he told R64a he was in the wrong room. R48 stated R64a told him that he (R48) was not going to tell him (R64a) what to do, and then R64a started kicking R48. R48 stated, I was in the wheelchair so he [R64a] kicked me in the chest. I grabbed the door handle to help me from rolling back. He [R64a] lost his balance and couldn't use his feet anymore and punched me in the nose. R48 stated he got a bloody nose, the facility sent him to the hospital emergency room to make sure it was not broken, and it was not. During an interview with State Registered Nurse Aide (SRNA) 7 on 04/18/2024 at 12:00 PM, she stated she was the first to observe the incident. She stated she had been in another room and came out to see R48 covered in blood from a nosebleed and reported that R64a had kicked him in the chest area and then punched him in the nose. She stated she requested the help of Kentucky Medication Aide (KMA) 8. She further stated R48 and R64a were immediately separated, and Licensed Practical Nurse (LPN) 3 was notified. During a telephone interview with LPN3 on 04/17/2024 at 7:40 PM, she stated she was at the facility on the day of the incident. She stated she did not see what happened but came back to help after she was notified. During an interview with the Executive Director on 04/20/2024 at 8:25 AM, she stated she spoke to the staff that responded first, SRNA7, and confirmed R64a was on one-to-one supervision. She stated that per her interview with R48, the resident (R64a) had been wandering around as if in a cloud, or someone who was lost. She stated both R48 and R64a were sent to the hospital for evaluation, and no residual injuries were noted. She stated she expected that abuse would be reported immediately and the safety of the residents would be ensured.

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F 0656 Level of Harm - 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. 46710 Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to develop and implement comprehensive, person-centered care plans for 2 of 31 sampled residents, Resident (R) 9 and 65. R9 developed a facility acquired stage 3 pressure ulcer. Observation and documentation revealed R9 was not repositioned routinely as per the intervention on the care plan. R65 expressed a preference for taking her blood pressure medication at 8:00 AM. However, the resident stated she often did not receive it until two to three hours later. The facility failed to develop the resident's care plan to include this preference. (Cross Reference F561 and F686) The findings include: In an interview on 04/18/2024 at 8:37 AM, the Executive Director (ED) stated the facility did not have a care planning policy; they followed the Resident Assessment Instrument (RAI) manual in lieu of a policy. Review of the RAI manual, dated 10/2023, revealed the resident care plan must include measurable objectives and time frames to describe the services the facility provided for the resident. Further review revealed the facility was to assess the resident for the resident's preferences and care plan interventions to accommodate those preferences. Continued review revealed the facility was to assess the resident for pressure ulcer risk factors and develop and implement interventions based directly on the resident's individual risks, including monitoring for effectiveness of the interventions. 1. Review of R9's Admission Record revealed the facility admitted the resident on 02/17/2020 with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke), type 2 diabetes, and cognitive communication disorder. Review of R9's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/15/2023, revealed the facility assessed the resident as dependent on staff to roll from side to side and back to a supine position. Further review revealed the facility assessed the resident as at risk for the development of pressure ulcers. During this assesement, the facility documented R9 was free of pressure ulcers. Review of R9's Care Plan, revised 02/01/2024, revealed the facility identified the resident as at risk for altered skin integrity and included the intervention for staff to assist with bed mobility to turn and reposition routinely, which was added to the care plan on 02/17/2020. Further review of the care plan revealed R9 required extensive assistance of two staff members for bed mobility. Review of the facility's document Pressure Ulcer-Weekly Observation-V2, dated 01/17/2024 revealed that date was the first time the facility identified the stage 3 pressure ulcer on R9's lower back. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Tasks tab documentation in the electronic medical record, under Monitor-Turn and Reposition, dated 01/01/2024 through 01/17/2024, revealed no documented evidence facility staff turned R9 according to the care plan. Further review revealed facility staff charted turning R9 fewer than eight times per day on 11 of 17 sampled days with no documented refusals. Review of R9's quarterly MDS, with an ARD of 03/08/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as dependent on staff to roll from side to side and back to a supine position. Continued review revealed the facility assessed the resident as having a stage 3 pressure ulcer that was not present on admission/reentry to the facility. Observations on 04/19/2024 from 8:35 AM through 11:48 AM, revealed facility staff failed to reposition R9 during those three hours and 13 minutes. During the observation time frame, the State Survey Agency (SSA) Surveyor observed the resident lying in a supine position, placing her weight on the pressure wound. Continued observation at 11:48 AM revealed R9 complained of pain on her sacrum when staff repositioned her. In an interview on 04/19/2024 at 2:32 PM, State Registered Nurse Aide (SRNA) 6 stated she was assigned to care for R9 that day. SRNA6 stated she failed to turn R9 every two hours as she should have that morning because she was very busy. She stated that repositioning a dependent resident according to the care plan was important to prevent development or worsening of pressure ulcers. In an interview on 04/19/2024 at 2:46 PM, Registered Nurse (RN) 2 stated repositioning should have been completed every two hours to promote tissue perfusion and prevent breakdown. In an interview on 04/19/2024 at 3:58 PM, the Registered Nurse Assessment Coordinator (RNAC) stated the care planned intervention for turning and repositioning R9 was vague because residents' care needs were different. She further stated routinely did not inform staff what frequency R9 needed to be repositioned based on her over all condition. In an interview on 04/19/2024 at 5:44 PM, the Director of Nursing Services (DNS) stated the care plan intervention to reposition a resident routinely meant staff were to turn a resident at risk for a pressure ulcer every two hours. 2. Review of R65's Admission Record revealed the facility admitted the resident on 01/29/2024 with diagnoses including congestive heart failure, atrial fibrillation, and primary hypertension. Review of R65's admission MDS, with an ARD of 02/06/2024, revealed the facility assessed the resident to have a BIMS score of eight of 15, indicating the resident was moderately cognitively impaired. Review of R65's Care Plan, dated 01/31/2024, revealed the facility assessed the resident as at risk for cardiac dysfunction and included the intervention to administer medications as ordered. Further review revealed no interventions that mentioned honoring R65's preference to receive her blood pressure medicine at 8:00 AM. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R65's Medication Administration Record (MAR) for 04/2024, revealed no information specifying the time the resident received blood pressure medication each day. Review of R65's Blood Pressure Summary from the electronic medical record, dated 04/16/2024 through 04/19/2024, revealed facility staff measured R65's blood pressure between 9:00 AM and 10:45 AM each morning. In an interview on 04/16/2024 at 11:17 AM, R65 stated she wanted her blood pressure medication at 8:00 AM but often had to wait until 10:00 AM and 11:00 AM. She further stated she had expressed this preference to a couple of staff members who administered medications; however, R65 did not recall the names of the staff members. In an interview on 04/18/2024 at 4:40 PM, Kentucky Medication Aide (KMA) 5 stated she did not believe the resident had a care plan intervention to specify when staff should complete R65's medication administration. In further interview, KMA5 stated resident preferences should be included in the care plan and followed by staff. Per interview, KMA5 stated she could modify her routine for medication administration to give R65 her medication earlier, since the resident appeared to want her medications earlier than she had been getting them. In an interview on 04/19/2024 at 3:58 PM, the RNAC stated any nurses in the facility could add interventions, including resident preferences, to the resident's care plan. Per interview, the RNAC preferred staff to tell her about their added intervention so she could review it to make sure the new intervention was appropriate. In further interview, the RNAC stated she was not aware of R65 expressing preferences regarding medication administration times. In an interview on 04/20/2024 at 11:48 AM, the DNS stated the process for accommodating resident preferences for medication administration was for facility staff to ask the resident if they had any preferences on timing of medications. She further stated most residents were fine with flexible medication administration times and did not express a desire for staff to administer medications at specific times. Per interview, the DNS was not aware of R65 expressing a preference for administration of her morning medications. In an interview on 04/20/2024 at 12:18 PM, the Executive Director (ED) stated facility staff asked residents and families during the admission process if they had any preferences with medication administration changes. She further stated if residents were confused upon admission but later expressed to staff they wanted their medication earlier or later, the staff member should ensure that preference was documented on the care plan. The ED stated she was not aware of R65 expressing a preference for medication administration times. The ED stated she expected the facility to develop and implement individualized care plans because each resident had specific needs.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46710 Based on observation, interview, record review, and review of the American Nurse Journal, the facility failed to ensure residents received care consistent with professional standards for 1 of 4 sampled residents (Resident (R) 9) who were at risk for developing pressure ulcers. R9 developed a stage 3 pressure ulcer, and staff failed to turn and repostion the resident every two hours to prevent the pressure ulcer. (Cross Reference F656) The findings include: In an interview on 04/19/2024 at 5:44 PM, the Executive Director stated the facility did not have a policy on skin care and pressure ulcer prevention. Review of the American Nurse Journal, volume 16, number 7, as published by the American Nurse's Association, dated 07/2021, revealed nursing staff were to turn residents every two hours when the resident was in bed to prevent pressure injury to the skin. Review of R9's Admission Record revealed the facility admitted the resident on 02/17/2020 with diagnoses including hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke), type 2 diabetes, and cognitive communication disorder. Review of R9's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/15/2023, revealed the facility assessed the resident as dependent on staff to roll from side to side and back to a supine (laying on the back) position while in bed. Further review revealed the facility assessed the resident as at risk for the development of pressure ulcers. Continued review revealed the facility assessed R9 as free from pressure ulcers at the time of assessment. Review of R9's Care Plan, revised 02/01/2024, revealed the facility identified the resident as at risk for altered skin integrity and included the intervention for staff to assist with bed mobility to turn and reposition routinely, which was added to the care plan on 02/17/2020. Further review of the care plan revealed R9 required extensive assistance of two staff members for bed mobility. Review of the Tasks tab documentation in the electronic medical record, under Monitor-Turn and Reposition, dated 01/01/2024 through 01/17/2024 (17 sampled days), revealed no documented evidence the facility staff turned R9 according to the care plan. Further review revealed facility staff charted turning R9 fewer than eight times per day, ranging from one hour to seven hours between documented turns, on 11 of 17 sampled days with no documented refusals. Review of the facility's document Pressure Ulcer-Weekly Observation-V2, dated 01/17/2024, revealed that date was the first time the facility identified the stage 3 pressure ulcer on R9's sacrum (lower part of the back). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's document IDT [interdisciplinary team] Risk Review-v 10, dated 01/25/2024, revealed the facility assessed contributing factors to the development of R9's wound, including incontinence and decreased food intake. Further review revealed no documented evidence the facility discussed or investigated staff compliance with care planned interventions, including repositioning the resident. Review of R9's quarterly MDS, with an ARD of 03/08/2024, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as dependent on staff to roll from side to side and back to a supine position in bed. Continued review revealed the facility assessed the resident as having a stage 3 pressure ulcer that was not present on admission/reentry to the facility. Review of the Physicia's Wound Care Orders, dated 04/11/2024, revealed cleanse area to sacrum with wound cleaner, pat dry, apply calcium alginate and cover with foam dressing one time per day for wound healing. Continuous observation of R9 on 04/19/2024 from 8:35 AM through 11:48 AM revealed facility staff failed to reposition R9 during those three hours and 13 minutes. During the observation time frame, the surveyor observed the resident laying in a supine position, placing her weight on the pressure wound. Continued observation at 11:48 AM revealed State Registered Nurse Aide (SRNA) 7 and SRNA8 came to change R9 and R9 complained of pain on her backside (location of the pressure ulcer) when staff repositioned her. Observation on 04/19/2024 at 12:02 PM revealed Registered Nurse (RN) 2 completed a dressing change for R9. The wound had tissue loss, appeared to be a stage 3 pressure ulcer with no redness or signs of infection. In an interview on 04/19/2024 at 2:32 PM, SRNA6 stated she was assigned to care for R9 that day. In further interview, SRNA6 stated she failed to turn R9 every two hours as she should have that morning because she was very busy. She continued to state that repositioning a dependent resident according to the care plan was important to prevent development or worsening of pressure ulcers. In interview on 04/19/2024 at 2:46 PM, RN2 stated she was R9's nurse that day. In further interview, RN2 stated the nurse's role in pressure ulcer treatment and prevention was to change the dressings and administer supplements as ordered. She continued to state SRNAs were responsible for turning and repositioning. Additionally, RN2 stated repositioning should have been completed every two hours to promote tissue perfusion and prevent breakdown. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/19/2024 at 5:44 PM, the Director of Nursing Services (DNS) stated she expected staff to turn a resident at risk for a pressure ulcer every two hours. Per interview, the DNS stated she believed staff turned the residents in a timely fashion most of the time because if they did not everyone would have pressure ulcers. The DNS further stated turning and repositioning was not the only way to prevent a pressure ulcer. The DNS stated the facility did not perform audits of resident repositioning as part of a root cause analysis into development of a facility acquired pressure ulcer. Per interview, the DNS trusted staff members to comply with turning and repositioning standards of care because they knew her expectations. In an interview on 04/19/2024 at 7:32 PM, the Medical Director stated she defined an unavoidable wound as one that developed despite appropriate offloading, repositioning, and nutrition interventions. Per interview, the Medical Director stated she did not consider R9's pressure wound to be unavoidable because the resident had not significantly declined from her baseline. The Medical Director stated she had not identified a particular root cause of R9's wound but had noted the resident was in her wheelchair for long periods of time, and the IDT (members included the Activities Director, Dietary Manager, Infection Preventionist/Assistant Director of Nursing Services (IP/ADNS), DNS, and Executive Director (ED)) needed to evaluate encouraging the resident to take breaks from the wheelchair, even with a pressure redistribution cushion. In an interview on 04/19/2024 at 5:44 PM, the Executive Director (ED) stated she expected staff to follow a resident's care planned interventions to prevent pressure ulcers. She further stated routine repositioning meant every two hours. Per interview, the ED stated the facility's process to evaluate a resident who developed a pressure ulcer was to look at all the aspects of the resident's care, including nutrition and psychosocial needs, to determine what interventions would best help the resident. She further stated the IDT met once per week to discuss residents with pressure ulcers, and they had not identified any staff noncompliance with repositioning interventions. The ED stated the IDT did not determine if a wound was unavoidable; that was the role of the Medical Director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER: Elliott Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: Rt 32 East, Howard Creek Rd, Sandy Hook, KY 41171	

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. 46710 Based on observation, interview, record review, review of the facility's policy, review of manufacturer's guidelines, and review of the Environmental Protection Agency (EPA) disinfectant registry, the facility failed to ensure staff cleaned and disinfected the blood glucose monitor (glucometer) after obtaining a blood glucose reading on 1 of 7 residents who shared the glucometer on the 100 hall, to include Resident (R57) and R24. On 04/18/2024 at 6:05 PM, the survey team provided a copy of the Immediate Jeopardy (IJ) Template to the Executive Director and notified her that staff failure to disinfect the glucometer after obtaining Resident 57's blood glucose measurement constituted IJ at 42 CFR S483.80 F880 Infection Prevention & Control. The survey team determined the IJ first existed on 04/18/2024, when surveyors observed Licensed Practical Nurse (LPN) 3 failed to disinfect the glucometer on the 100 Hall, where six residents shared the glucometer with one resident (R24) diagnosed with viral hepatitis (a bloodborne illness). This failure created the potential for the shared glucometer, which had not been properly disinfected, to transmit a bloodborne illness to the six uninfected residents. The facility provided an acceptable IJ removal plan on 04/20/2024 at 10:35 AM. The survey team validated through observations, interviews, and record reviews that the facility removed the IJ on 04/19/2024, following the facility's implementation of the IJ removal plan. The deficient practice remained at a D (no actual harm, with the potential for more than minimal harm) scope and severity following removal of the IJ. The findings include: Review of the facility's policy titled, Blood Glucose Monitoring, dated 2023, revealed facility staff members were to disinfect shared glucometers per manufacturer's recommendation after each use. Review of the manufacturer's guidelines for the glucometer EvenCare ProView Blood Glucose Monitoring System, dated 2018, revealed facility staff members were to use an EPA registered disinfectant to sanitize the glucometer. Further, it stated disinfection should occur after use on each patient (resident). Review of the EPA registry of disinfectants from https://www.epa.gov/pesticide-registration/epas-registered-antimicrobial-products-effective-against-bloodborne#products, as of 04/18/2024, revealed the list did not include Medline alcohol swabs. Review of the facility's Census, dated 04/16/2024, revealed seven residents on the 100 Hall received blood glucose checks (which would have used the shared glucometer), including R57 and R24. Review of the facility's list of Residents with Bloodborne Illnesses, dated 04/18/2024, revealed R24, residing on the 100 Hall, had viral hepatitis. 1. Review of R24's Admission Record revealed the facility admitted the resident on 03/09/2020 with diagnoses including viral hepatitis C, viral hepatitis B, and type 2 diabetes. Further review revealed R24 lived on the 100 Hall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elliott Nursing and Rehabilitation	Rt 32 East, Howard Creek Rd Sandy Hook, KY 41171

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of R57's Admission Record revealed the facility admitted the resident on 03/29/2024 with diagnoses including type 2 diabetes, chronic kidney disease, and unspecified dementia. Further review revealed R57 lived on the 100 Hall. Observations of LPN3 on 04/18/2024 at 12:47 PM, revealed LPN3 placed the glucometer on R57's bedside table without a barrier. Further observation revealed LPN3 used the glucometer on R57. The LPN took the glucometer from R57's room and placed it back in the medication cart drawer with the second glucometer and testing supplies without disinfecting the soiled glucometer. In an immediate interview, on 04/18/2024 at 12:50 PM, LPN3 stated she had not thought about it until asked, but she should have cleaned the glucometer prior to placing it back in the medication cart drawer after use. She proceeded to wipe the glucometer down with a Medline alcohol swab and replaced it in the same drawer without a barrier. LPN3 stated she received training during orientation to disinfect the glucometer after every use, but she forgot to do so in this instance. In further interview, LPN3 was unable to state which wipes the facility management trained her to use to disinfect the glucometer. Per interview, LPN3 stated disinfection was important to prevent cross contamination. In an interview on 04/18/2024 at 12:55 PM, Registered Nurse (RN) 1 stated she typically used the Micro-Kill wipes to disinfect the glucometer after use, but she believed the Medline alcohol swabs were also acceptable to use for disinfection. In an interview on 04/18/2024 at 1:59 PM, the Infection Preventionist/Assistant Director of Nursing Services (IP/ADNS) stated she expected staff to clean the glucometers with one Micro-Kill wipe and then wrap the glucometer in a second Micro-Kill wipe for one (1) minute, which was the disinfection time listed by the manufacturer. In continued interview, the IP/ADNS stated the facility did not have an auditing process to ensure compliance with the glucometer cleaning policy after nursing staff completed orientation. In an interview on 04/20/2024 at 11:48 AM, the Director of Nursing Services (DNS) stated she expected staff to clean the glucometers after each use according to policy and the glucometer's manufacturer's guidelines. In an interview on 04/20/2024 at 12:18 PM, the Executive Director (ED) stated she expected staff to follow the facility's policy on glucometer cleaning and disinfection. In further interview, the ED stated the facility investigation into LPN3's actions after measuring R57's blood glucose found that LPN3 failed to disinfect the glucometer according to the facility's policy.