Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluegrass Care & Rehabilitation Center	3576 Pimlico Parkway Lexington, KY 40517

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49050 Based on interview, record review, and review of the facility's policy, the facility failed to send a copy of the transfer or discharge notice to a representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 4 residents investigated for the discharge process, Resident (R) 111. The findings include: Review of the facility's policy titled, Transfer /Discharge Policy, dated 03/24/2024, revealed the facility must notify the Ombudsman of a facility-initiated transfer or discharge notice to a representative of the Office of the State LTC Ombudsman. Review of R111's Face Sheet revealed the facility admitted the resident on 10/23/2021 with diagnoses of renal and perinephric abscess, schizoaffective disorder (bipolar type), and dementia in other diseases classified elsewhere with behavioral disturbances. Further review revealed R111 was discharged on Friday, 11/12/2021 at 2:39 PM. Review of R111's Discharge Note, dated 11/10/2021 at 4:14 PM and signed by the Physician's Assistant, revealed R111 would be going back to the group home where he lived prior to hospitalization and coming to the facility. The note stated R111 would have 24/7 (around the clock) care there. Per the note, R111 had remained medically stable during his stay at the facility, completed his intravenous antibiotic, and was safe to return back to his group home. Review of Notification of Discharge, from the Social Services Director (SSD), revealed no Ombudsman notification was completed for R111's 11/12/2021 discharge. During an interview with the SSD on 08/30/2024 at 11:29 AM, she stated she would wait until the end of each month and send an email to the Ombudsman with all the discharges from the month. She stated, in regard to R111, when she looked through the records, there was no documentation of notification of the 11/12/2021 discharge sent to the Ombudsman. During an interview on 08/30/2024 at 4:43 PM with the Administrator, she stated Social Services sent a monthly discharge list to the Ombudsman for the previous month, the first of the next month. She stated, in this situation, that procedure was not followed.

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 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 44000 Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a Baseline Care Plan within 48 hours for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care for 1 of 30 sampled residents, Resident (R) 212. The facility admitted R212 on 08/21/2022 after a fall that resulted in a vertebrae fracture and facial bruises. R212's care plan for pain was not developed within 48 hours. Cross reference F697 The findings include: Review of R212's Face Sheet revealed the facility admitted the resident on 08/21/2024 with diagnoses which included displaced fracture of sixth cervical vertebra, need for assistance with personal care, and diabetic nephropathy. Review of the facility's policy titled, Comprehensive Care Plans, last revised 02/09/2024, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs. Review of R212's 48-Hour Care Plan, dated 08/22/2024 at 2:25 PM , revealed no documented evidence the facility implemented interventions for pain. Observation on 08/26/2024 at 1:36 PM revealed R212 was sitting in the wheelchair, and she had bruising around both eyes and was wearing a neck brace. During interview at the time of the observation, R212 stated she slipped on a rug in the kitchen and fell , hitting her head and back on the counter. She stated her pain was mainly in her right arm. R212 stated she was having pain and asked for pain medication this morning, but the nurse told her it was not available. R212 stated the pain was bad; but, she was not crying and was able to eat breakfast and lunch. Review of R212's Medication Administration Record (MAR) revealed R212 did not receive pain medication of oxycodone 5 mg (an opioid pain reliever) until 08/26/2024 at 3:30 PM. Continued inteview with R212 on 08/26/2024 at 3:00 PM revealed she was given Tylenol when her narcotic pain medication was not availble and it helped somewhat. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 08/26/2024 at 2:48 PM with Licensed Practical Nurse (LPN) 2/Unit Manager who documented R212's care plan, she stated she developed the 48-hour care plans with the resident's record, family, or the resident. She stated the care plan was an observation, and she answered each individual question on the care plan. She stated when she came to the pain section, she asked R212 if she was in any pain, and since R212 stated, No, she clicked No on the care plan. She stated she made a mistake, and she should have clicked Yes and addressed pain on the care plan. During interview with the Administrator on 08/28/2024 at 10:35 AM, she stated when a resident was having pain she expected staff to provide pain relief. She also stated she expected the staff to follow the facility's care plan policies.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 44000 Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 2 residents investigated for pain management, Resident (R) 212. R212 did not receive oxycodone (an opioid pain reliever) as scheduled on 08/26/2024 because the nurse said it was unavailable. However, the medication was in the facility's emergency medication kit (EMK). The findings include: Review of the facility's policy titled, Ordering and Receiving Controlled Medications, dated 01/2023, revealed in an emergency situation, verbal authorization could be given by the prescriber to the pharmacist for a new order as described by state law. Review of the facility's policy titled, Medication Administration, last revised 06/24/2024, revealed medications were administered as prescribed in accordance with the manufacturer's specifications and good nursing principles and practices. Review of R212's Face Sheet revealed R212 was hospitalized due to a fall from 08/16/2024 to 08/21/2024. The facility admitted the resident on 08/21/2024 with diagnoses of displaced fracture of the sixth cervical vertebra, need for assistance with personal care, and type 2 diabetes. Review of R212's Orders, revealed R212 had an order for oxycodone (opioid pain medication) 5 milligram (mg) related to pain, twice a day as needed (PRN). Review of the EMK revealed the kit contained six oxycodone 5 mg tablets. Observation on 08/26/2024 at 1:36 PM revealed R212 was sitting in the wheelchair, she had bruising around both eyes and was wearing a neck brace. During interview at the time of the observation, the resident stated she was having pain and asked for pain medication this morning, but the nurse told her it was not available. R212 stated the pain was bad; but, she was able to eat breakfast and lunch. During interview with Licensed Practical Nurse (LPN) 2/Unit Manager on 08/26/2024 at 2:48 PM, she stated R212 received oxycodone at 8:30 PM on 08/25/2024. She stated Advanced Practice Registered Nurse (APRN) 1 was at the facility this morning, but she did not think to ask her for a one-time order for oxycodone. She also stated she did not think to take the oxycodone from the EMK. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with APRN1 on 08/27/2024 at 8:56 AM, she stated she was called on 08/26/2024 in the morning to write a stat prescription for oxycodone to be given to R212. She stated she then went into R212's room and interviewed R212. She stated R212 told her she was having continued moderate pain in the right arm. APRN1 stated she told R212 the provider, who specializes in pain management would be in that morning to evaluate and treat the pain. Review of the House Stock Kit Withdrawal Log revealed on 08/26/2024 at 3:15 PM oxycodone 5 mg was removed for R212 by LPN2/Unit Manager and Certified Nurse Aide/Certified Medication Technician (CNA/CMT2). Review of R212's Medication Administration Record (MAR) revealed R212 received oxycodone 5 mg on 08/26/2024 at 3:30 PM. During interview with the Director of Nursing (DON) on 08/28/2024 at 10:01 AM, she stated the pain medication for R212 should have been taken from the EMK and given to R212 on 08/26/2024 in the morning when the resident requested the medication. During interview with the Administrator on 08/28/2024 at 10:35 AM, she stated she expected all staff to know what was in the EMK. The Administrator stated when a resident was having pain she expected staff to provide pain relief.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46710 Based on observation, interview, record review, and facility policy review, the facility failed to store medications and biologicals in accordance with professional standards for 2 of 6 residents observed for medication administration, Resident (R) 121 and R122 and 2 of 2 medication refrigerators. The findings include: Review of the facility's policy titled, Medication Administration, revised 06/24/2024, revealed the facility's nursing staff was to administer medications at the time they were prepared. 1, Review of R121's Face Sheet revealed the facility admitted the resident on 08/24/2024 with diagnoses including acute COVID, muscle weakness, and unspecified dementia. Review of R121's Medication Administration Record (MAR) for 08/01/2024 through 08/30/2024 revealed that on 08/30/2024, Certified Medication Aide (CMA) 11 documented he gave famotidine 20 milligrams (mg, for heartburn), losartan 100 mg (for high blood pressure), metformin 500 mg (for diabetes to lower blood sugar), polyethylene glycol 17 G (for constipation), and tamsulosin 0.4 mg (for urinary retention), all administered by mouth for morning medication administration. Review of R122's Face Sheet revealed the facility admitted the resident on 08/29/2024 with diagnoses including respiratory failure, urinary tract infection, and depression. Review of R122's MAR for 08/01/2024 through 08/30/2024 revealed CMA11 documented he gave cefdinir 300 mg (antibiotic), docusate sodium 100 mg (stool softener), doxycycline monohydrate 100 mg (antibiotic), ferrous sulfate 325 mg (iron supplement for anemia), furosemide 40 mg (diuretic), pantoprazole 40 mg (antiacid), potassium chloride 20 milliequivalents (mEq, supplement), prednisone 20 mg (steroid), ropinirole 2 mg (to treat restless leg syndrome), sertraline 25 mg (antidepressant), and ertugliflozin 5 mg (for diabetes to lower blood sugar), all administered by mouth for morning medication administration. Observation on 08/30/2024 at 11:22 AM revealed CMA11 prepared medications for R122, but when he went to administer the medications, he found R122 was not in her room. Further observation revealed CMA11 stated he would look for R122 in the therapy gym and would return in a few minutes. Continued observation at 11:25 AM revealed CMA11 returned with the same medication cup in his hand and placed it in the top drawer of the medication cart alongside a second cup labeled with R121's room number. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/30/2024 at 11:27 AM revealed CMA11 removed a medication cup from the top drawer of the medication cart labeled with R121's room number and handed it to R121. Per observation, CMA11 assisted R121 to bring the cup to the resident's mouth to take the medications. Continued observation revealed the North Unit Manager (NUM) walked by and saw the prepared medication cup for R122 in the top drawer of the medication cup while R121 was attempting to swallow his pills. The NUM told CMA11 that storing prepared medications in the medication cart was not an acceptable practice, and those medications would need to be discarded. Additional observation revealed CMA11 told the NUM the pills had been in the locked medication cart. Per observation, the NUM educated CMA11 that he should look for the resident prior to pulling the resident's medications to see if the resident was available and wanted their medicines. In an interview on 08/30/2024 at 2:21 PM, CMA11 stated he placed R121's medications in the top of the medication cart because when he went to give the medications, the resident was in the bathroom and asked him to come back. In further interview, CMA11 stated he went to find R122 after preparing her medications, but the resident was not in the therapy gym or the dining room, so he also placed her medications in the cart. In continued interview, CMA11 stated pulling medications took a long time, and he did not want to get behind schedule by pulling medications twice. Additionally, CMA11 stated the NUM educated him that he should have discarded any medications he was not able to promptly administer. In an interview on 08/30/2024 at 11:36 AM, the NUM stated it was not an acceptable practice for nurses or CMAs to store prepared medications in a locked drawer of the medication cart if the resident was not available. She further stated her expectations for medication storage were for staff to keep the medications in the pharmacy sleeves until they confirmed with the resident that they were available and wanted to take all their medications. In continued interview, the NUM stated storing prepared medication cups in the top drawer of the medication cart increased the chances for a medication error and would make it difficult for a resident to exercise their right to refuse any particular medication. In an interview on 08/30/2024 at 3:24 PM, the Director of Nursing (DON) stated if a nurse or CMA had a cup of medications prepared for a resident and they were unable to find them quickly in their room, the therapy gym, or other location, they should discard the medications and pull them when the resident returned. In an interview on 08/30/2024 at 4:51 PM, the Administrator stated she did not see a problem with staff having a labeled medication cup in the top drawer if it was for only one resident and the cart was locked. She further stated she did not believe it was acceptable to store prepared medication cups in the top drawer for more than one resident. 2. Review of the facility's policy titled, Storage of Medication, dated 01/2023, revealed medications and biologicals were stored properly, following manufacturers or provider pharmacy recommendations to maintain their integrity and to support safe effective drug administration. Per the policy, outdated, contaminated, discontinued, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from pharmacy. Observation on 08/26/2024 at 3:55 PM of the medication room refrigerator on the South Hall revealed R34's Magic Mouthwash expired 08/24/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with Licensed Practical Nurse (LPN) 3 at the time of the observation, she stated if a resident received expired medications the medication might not be effective, and there could potentially be harm to the resident. Observation on 08/26/2024 at 4:05 PM of the medication room refrigerator on the North Hall revealed the following six expired doses of the antibiotic Daptomycin 300 mg/106 milliliters (ml) for R106. Two doses expired on 08/10/2024, and four doses expired on 08/24/2024. Further observation revealed the following six expired doses of the antibiotic Daptomycin 450 mg/109 ml for R211. All six expired doses expired on 08/25/2024. Additional observation revealed R18's Magic Mouthwash expired 08/20/2024. During interview with LPN4 at the time of the observation, she stated she checked the expiration date and the rate. She stated she was supposed to check to verify the medications were not expired. She stated if she used expired medications, the resident could have a reaction. During interview with the DON on 08/28/2024 at 10:01 AM, she stated she was not made aware of expired medications. She stated the nurses checked to see if the medications were expired prior to using the medications. During interview with the Administrator on 08/28/2024 at 10:35 AM, the Administrator stated her expectation was for the staff to follow the facility's policy and remove any expired medications.

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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. 49050 Based on observation, interview, record review, and review of the facility's policy, the facility failed to implement enhanced barrier precautions (EBP) related to medication administration and resident care for 1 of 28 residents in EBP, Resident (R) 53. Observation on 08/30/2024 revealed Licensed Practical Nurse (LPN) 3 failed to don (put on) a gown and gloves when providing direct resident care to R53 related to application of a medication patch and taking a blood pressure. The findings include: Review of the facility's policy titled, Enhanced Barrier Precautions, dated 03/25/2024, revealed EBPs were indicated for residents who had chronic wounds and or indwelling medical devices regardless of multi-drug resistant organism (MDRO) status. Observation on 08/30/2024 at 9:12 AM of the signage on R53's door revealed it informed all care givers everyone must clean their hands, including before entering and when leaving the room. It also stated, providers and staff must wear gloves and gown for the following high-contact resident care activities. The activities listed were dressing; bathing/showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting; device care or use with a central line, urinary catheter, tube feeding, or tracheostomy; and wound care for any skin opening requiring a dressing. Further observation on 08/30/2024 at 9:12 AM of medication administration revealed LPN3 prepared medication to administer to R53 who had a suprapubic catheter in place. After the medication was brought into R53's room, LPN3 took R53's blood pressure without donning a gown or gloves. She started the administration of crushed medication mixed with pudding in medicine cups. She then administered the polyethylene glycol to R53. At that point, the Infection Prevention (IP) Nurse entered the room and spoke to LPN3 about proper donning of gown and gloves when providing care. LPN3 stated she thought that gown and gloves were only necessary when providing physical (dressing change, catheter care) care to R53. The IP then re-educated LPN3 on the purpose and indications of when to don personal protective equipment (PPE, gown and gloves) for residents with EBP. After receiving education, LPN3 donned gown and gloves. LPN3 applied two lidocaine patches on R53's right lateral chest and lateral abdomen. During an interview with the IP Nurse on 08/30/2024 at 11:14 AM, she stated she was also the Staff Development Nurse and expected nursing staff to understand when to use PPEs in relation to EBPs. She stated, That is why I came to [R53's] room when I was informed [LPN3] had not donned a gown and gloves when taking vitals [blood pressure] or administering medications. She stated she knew when the new policy was enacted in May 2024, she provided education to the entire staff on when the regulations were changed. She stated now that there had been an identified gap in education for the staff, she would be reeducating all staff. The IP Nurse stated when the facility had a skills fair in December for nurses and aides, she tested staff to make sure they had been educated properly. She stated, Obviously there was a breakdown with that one staff member, but it could happen to other staff. I want to make sure all staff know how improper practice can negatively impact residents. (continued on next page)

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