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	07/25/2025

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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately reflect with the Minimum Data Set (MDS) assessment, the resident's status for 1 of 29 sampled residents. (Resident (R)15). The Significant Change MDS dated [DATE] and the Quarterly MDS dated [DATE], did not document R15 as receiving Hospice Care. The findings include:Review of R15's Face Sheet revealed the facility admitted R15 on 03/16/2025 with diagnoses to include Acute Respiratory Failure, Dementia, and Anxiety. Review of R15's medical record revealed the resident started on Hospice care on 3/10/2025.Review of the Significant Change MDS dated [DATE] and the Quarterly MDS dated [DATE] revealed no documented evidence the facility coded R15 as receiving Hospice care in section O. During an interview with the MDS Nurse, on 07/24/2025 at 1:04 AM, she stated there were two places for coding Hospice care. She stated in section J under prognosis if a resident has less than six months to live, that would be checked, but Hospice care should be checked under section O for R15 and neither MDS assessment was coded in section O for Hospice care. During an interview with the Director of Nursing (DON) on 07/25/2025 at 12:03 PM, she stated it was her expectation that the MDS records would accurately reflect each resident. During an interview with the Administrator on 07/25/2025 at 12:15 PM, she stated it was her expectation that MDS assessments should reflect R15's Hospice care to be accurate.

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 Based on observation, interview, record review and review of the facility's policy, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care which included the minimum healthcare information necessary to properly care for a resident, Resident (R)144 and R154.R144 was admitted with diagnoses of dysarthria which was not documented with any goals or interventions/strategies for staff to use when communicating with R144.R154 was admitted with needs for dialysis and oxygen therapy which were not accurately documented on his baseline care plan. The findings include: Review of the facility policy titled, “Baseline Care Plan Policy”, dated effective 09/23/2022 and as last reviewed on 01/31/2025 revealed a baseline care plan was developed and implemented to promote continuity of care and communication among facility stakeholders to increase resident safety and safeguard against adverse events that are most likely to occur right after admission. Review of the policy guidelines revealed the baseline care plan would be developed and implemented within 48 hours of a resident’s admission and would include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and preadmission screening and resident review (PASRR) if applicable. 1) Review of R154’s “Face Sheet”’ revealed the facility admitted him on 02/20/2025 with diagnoses to include fracture of the right femur, end stage renal disease (ESRD) with dependence on renal dialysis, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and respiratory failure with hypoxia. Review of R154’s, “Progress Note” dated 02/20/2025 at 4:47 PM revealed he was alert and oriented to person, place, time and event and was able to make his needs known. Review of R154’s hospital discharge note dated 02/20/2025 documented he had chronic respiratory failure due to COPD and had used oxygen at home and at the hospital set at 2-4 liters per nasal cannula. Further review of the hospital discharge note revealed R154 had ESRD and was being followed by nephrology and had hemodialysis (HD) on Mondays, Wednesdays and Fridays each week. Review of R154's, “Clinical Orders” dated 02/21/2025 revealed orders for oxygen therapy at 2 Liters via nasal cannula continuously and Dialysis on Monday, Wednesday and Friday. Review of R154’s 48-Hour Baseline Care Plan” (BCP) dated 02/20/2025 completed by Licensed Practical Nurse (LPN)1 revealed she had not checked the box for Oxygen usage and had checked the box marking R154 was not receiving dialysis. Licensed Practical Nurse (LPN2) who completed the BCP for R154 was no longer employed at the facility and no current phone number could be provided. Review of R154’s care plan dated 02/21/2025 revealed plans of care had been initiated for social isolation, depression and insomnia, drug related side effects related to psychotropic medications for depression and insomnia, plans for discharge and advance directive/code status. However, further review revealed no care plan for R154 to address the needs for dialysis or usage of oxygen. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/23/2025 at 11:04 AM with the MDS Nurse 1, she stated she had been at the facility for four months and did not complete baseline care plans, the admission nurse for the resident being admitted would complete them. During an interview on 07/25/2025 at 10:15 AM with LPN5 he stated when completing a BCP for a resident, information received from the hospital during report would include how the resident transferred, took medications, diet and fluid consistency, toileting habits, how the resident communicated, possession of hearing aids/dentures/glasses, pain medication and last dose, use of oxygen and need for dialysis. LPN5 further stated staff used the BCP and the Resident Profile/admission assessment as a guide to care for the resident until the CCP was completed which was done by MDS. LPN5 did not know if the information on the BCP populated into the CCP. LPN5 stated the BCP should accurately capture all the resident needs for staff to effectively and safely care for the resident and any inaccurate or missed resident information could cause the resident harm. During an interview on 07/25/2025 at 11:00 AM with Registered Nurse (RN)4 she stated the 48-hour BCP was completed after receiving report from the hospital and after the resident arrived at the facility. RN4 stated if a resident required oxygen and dialysis that should be accurately documented on the BCP. She further stated if the BCP was not correct, there could be a negative outcome or situation of harm for the resident. During an interview on 07/25/2025 12:03 PM with the Director of Nursing (DON) she stated her expectation for MDS was to make sure the resident was care planned per regulation and was personalized to each resident. The DON stated orders, family interviews, and the hospital discharge summary all drove the care plans and the BCP was just a snapshot of the residents' immediate needs for care. She further stated the corporate nurse came in and reviewed care plans once a week to make sure there was a BCP in place until MDS completed the Comprehensive Care Plan (CCP) with the comprehensive assessment which was due fourteen (14) days after admission. The DON stated it was her expectation the admission nurse would code the resident assessment and the BCP correctly to promote accurate resident care, but sometimes the nurses were in a hurry and could make an error because “we are all human”. During an interview with the Administrator (Admin) on 07/25/2025 at 11:38 AM she stated she had previously been the facility DON since 2019 and took over as Administrator in November of 2024. The Admin stated the purpose of the BCP was to guarantee all the resident needed for care were in place. The admitting nurse would get a telephone report about the resident from the hospital and would then complete the admission observation form, which was in the admission packet, when the resident arrived. The admission assessment would include information from the residents discharge summary and the summary was used to generate all the resident orders into system, including medications, so they could be dispensed. The BCP was completed using a systems approach and included things like communication, vision, hearing, cognition, special equipment, activities of daily living, oxygen, dialysis, etc. The Admin stated resident orders were received, approved by the physician and entered into the system before the resident arrived. The Admin further stated the BCP did not populate to CCP but the MDS nurse would complete the CCP by using the resident’s admission orders, the BCP, the discharge summary, the residents history and physical, and the Certified Nurse Aide (CNA) Kardex and had 14 days from the resident’s admission to complete. Lastly, the Admin stated in the case of R154, her expectation was his need for oxygen therapy and for dialysis be captured correctly on his BCP to prevent the possible error of him not receiving the proper care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the facility's policy titled, Resident Rights, revision date 01/31/2025, revealed all residents have the right to be treated with dignity and respect. All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life. The policy further stated, when providing care and services, the stakeholders will respect the resident's individuality and value their input by providing them a dignified existence, through self-determination and communication with and access to persons and services inside and outside the facility. Review of R144's Face Sheet revealed the facility admitted R144 on 07/17/2025 with diagnoses to included cerebral infarction, unspecified, dysphasia (impairment of the power to speak or to understand speech) following cerebral infarction, and Alzheimer's disease, unspecified. Review of R144's admitting MDS assessment on 07/24/2025 revealed his BIMS score was 6 out of 15 indicating moderative cognitive impairment. Review of R144's 48-hour baseline care plan dated 07/17/2025 at 11:29 PM revealed the section titled, Communication Goal: Resident communication with staff will be understood. Resident's communication is understood was marked yes. There was no place to indicate on the 48-hour care plan to indicate speech difficulties or communication issues with R144. Observation on 07/22/2025 at 10:41 AM revealed R144 was laying in his bed with the head elevated. R144's eyes were closed and the top sheet was pulled to his waist. During interview at the time of observation, R144 attempted to answer questions from State Surveyor, but was not able to clearly speak his responses other than yes or no. R144 could possibly answer with one-word answers but struggled to enunciate words clearly or effectively. Observation on 07/22/2025 at 10:49 AM of R144 trying to communicate with State Registered Nurse Aide (SRNA)1 revealed SRNA1 was struggling to understand what R144 was trying to tell him. R144 appeared to become frustrated because on SRNA1 not understanding R144's need. Interview on 07/24/2025 at 8:31 AM with SRNA1 he stated he could understand R144 when R144 does not get upset or excited. SRNA1 stated he usually can help R144 with whatever he needs. SRNA1 was asked if he struggles understanding R144 and SRNA1 stated, Yes, it can be challenging at times. SRNA1 was asked, Do you feel that you can understand R144 enough to meet his needs? SRNA1 stated, Most of the time. There are times when R144 is upset or excited, it is hard to know what he needs. Interview on 07/24/2025 at 10:23 AM with Nurse Practitioner (NP) she stated she did not assess R144 initially on admission. The NP stated when a resident was admitted to the facility, the nurses would notify the therapy practitioner to implement concerns regarding speech. Then the speech therapist would come and evaluate the resident to determine if they qualified for services. Review of nursing progress notes dated 07/20/2025 at 11:34 AM entered by NP she stated R144's dysarthria (speech disorder characterized by difficulty in articulating words due to damage or dysfunction in the nerves and muscles that control speech) had significantly worsened an hour before at the previous living facility, before arriving to the Emergency Department (ED). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/24/2025 at 3:50 PM with LPN3, she stated she was one of two nurses who assisted in completing the 48-hour baseline care plan for R144. LPN1 stated she and another nurse were asking R144 questions, and the other was completing a skin assessment. LPN1 stated R144 did not do a lot of talking. During an interview on 07/24/2025 at 4:01 PM with LPN4, she stated R144's speech was pretty jumbled. LPN4 stated she could not recall if R144 could make his needs known at that time. LPN4 stated R144 was beginning to get upset about losing the ability to speak. LPN4 stated she could not remember if R144 was able to speak more than one word at a time. During an interview on 07/24/2025 at 10:40 AM with DON, she stated residents who are admitted to the facility have a 48-hour baseline care plan implemented upon arrival. The DON was asked if the 48-hour care plan instrument used adequately assessed residents who have dysphasia. The DON stated the nurses were able to communicate with R144. During an interview on 07/24/2025 at 3:01 PM with the Administrator, she stated she was familiar with R144. She stated nurses use the 48-hour care plan as a baseline for determining a resident's immediate needs. She stated once the baseline care plan was completed, the MDS nurse completed their assessment on R144. The Administrator stated the care plan did not address R144's dysphagia. The Administrator also provided a copy of a document titled, SRNA Care Plan Record, with R144's name, room number, and other significant information to dictate care for all SRNAs. Not documented under speech were three areas; Aphasic/Doesn't Talk, Clear, or Mumbles. None of the three items were marked indicating impaired speech. This document was reviewed and signed on 07/17/2025 by the DON. The Administrator state the document was not an accurate assessment of R144 because staff who did not know him would not be informed of his speech difficulties. The Administrator stated it was her expectation the 48-hour assessments and the SRNA care plan records would be completed accurately and meet the needs of the residents.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to develop and implement a comprehensive care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, Resident (R) 99.R99 had been discharged to the hospital and upon her return on 06/25/2025 her Baseline Care Plan (BCP) documented R99 was assessed as not verbalizing or exhibiting signs of pain but was at risk for pain. Review of R99's Comprehensive Care Plan (CCP) revealed no active care plan for pain had not been initiated until 07/23/2025, after State Survey Agency requested it. Review of R99's Medication Administration Record (MAR) dated 07/01/2025-07/24/2025 revealed she had been medicated with Tramadol for pain once on 7/17/2025, once on 07/18/2025, and once on 07/20/2025.The findings include:Review of the facility policy titled, Comprehensive Care Plans, (CCP) dated 02/09/2024 and as last reviewed on 01/31/2025 revealed the facility would develop and implement a comprehensive person-centered care plan for each resident the included measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment.Review of R99's Minimum Data Set (MDS) Assessment schedule revealed the facility admitted her on 04/13/2023, with diagnoses of cirrhosis (chronic liver damage), heart failure, atrial fibrillation (a rapid irregular heart rate), diabetes, anemia, neurogenic bladder (lack of bladder control). R99 was discharged to the hospital as a return anticipated on 06/19/2025 and readmitted to the facility on [DATE].Review of R99's MDS Quarterly assessment dated [DATE] for pain revealed R99 had been on a scheduled pain regimen, had received as needed pain medication and a pain assessment interview was conducted and R99 was assessed as pain being present occasionally, occasionally affecting her sleep, occasionally interfered with day-to-day activities and was a 04/10 on the pain scale indicating moderate pain.Review of R99's MDS Quarterly assessment dated [DATE] Brief Interview for Mental Status (BIMS) assessment revealed a score of 12 out of 15 indicating moderate cognitive impairment.Review of R99's 48-hour Baseline Care Plan (BCP) dated 06/25/2025 upon her return from the hospital revealed R99 was not verbalizing or exhibiting signs of pain but was at risk for pain.Review of R99's Clinical Orders, dated 06/26/2025 revealed she had an active order for Tramadol (a pain medication) 50mg tablet orally every 6 hours as needed.Review of R99's Medication Administration Record (MAR) dated 07/01/2025-07/25/2025 revealed she had received a dose of Tramadol for pain once on 7/17/2025, once on 07/18/2025, and once on 07/20/2025.Review of R99's CCP on 07/23/2025 revealed she did not have an active plan for pain.Review of R99's CCP on 07/24/2025 revealed plan for pain had been added with a start date of 07/23/2025.During an interview on 07/25/2025 at 11:04 AM with MDS Nurse1 (MDS1), she stated she had been at the facility for four months and the MDS nurses did not complete resident BCPs, the nurse that admitted the resident completed them. MDS1 also stated R99 had been at the hospital and had returned so a BCP would have been completed, but R99 would not trigger for MDS to complete a CCP until her next comprehensive assessment which would have been due 3 months after her previous assessment. R99's previous significant change of condition assessment dated [DATE] was her last one and her next comprehensive assessment would not be due until 10/03/2025 unless she had another change of condition or discharged from the facility and returned. MDS1 stated anything necessary to provide for the immediate care and needs of the resident should be documented on the BCP by the admitting nurse so the resident's needs would be met. Lastly, MDS1 stated R99 should have had a care plan for potential for pain initiated when she returned to the facility and was assessed as being at risk for pain, or a care plan for pain management when she required the Tramadol be given to her for complaints of pain.During an interview on 07/25/2025 at 10:15 AM with Licensed Practical Nurse (LPN) 5 he stated he had been at the facility since 10/2024 but had been a unit manager here prior to Covid, had left and had come back. LPN5 stated when completing a BCP for a resident, information received from the hospital during report would include how the resident transferred, took medications, diet and fluid consistency, toileting habits, how the resident communicated, possession of hearing aids/dentures/and glasses, pain medication last dose, use of oxygen and need for dialysis. The BCP checklist was completed from this information and the CNA Kardex (paper) was also generated so staff would know what the resident care needs were. He stated floor nurses did not complete the comprehensive care plan but had access to it and could add to/edit it. Stated staff used the BCP and the Resident Profile/admission assessment as a