STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185455	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valhalla Post Acute	300 Shelby Station Drive Louisville, KY 40245

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. 28193 Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to ensure Medication Aide (MA) #58 did not allow two (2) of three (3) residents (Resident #96 and Resident #18)observed during medication administration to self-administer their own medications. There were no physicians' orders and interdisciplinary team assessments to determine if the residents were able to safely do so. The findings include: A review of a facility policy titled Administering Medications, revised in April 2019, revealed, Medications are administered in a safe and timely manner, and as prescribed. The policy also specified, 27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. 1. Review of Resident #96's Admission Record revealed the facility admitted the resident on 10/07/2021. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and unspecified dementia. Review of Resident #96's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2023, revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 15. This score indicated the resident was cognitively intact. According to the MDS, the resident was independent with activities of daily living and had no range of motion impairments. A review of Resident #96's Order Summary Report, listing active orders as of 01/31/2024, revealed an order dated 01/20/2024 for Flonase allergy relief nasal suspension 50 micrograms per actuation (mcg/act), two sprays in each nostril one time a day for sinus congestions. The Order Summary Report did not reveal any orders for Resident #96 to self-administer their own medications. During medication administration observations on 01/31/2024 at 7:36 AM, MA #58 handed Resident #96 their Flonase nasal suspension, and the resident sprayed five sprays in their right nostril and four sprays in their left nostril. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/04/2024 at 12:35 PM, MA #58 reviewed Resident #96's physician's orders and verified there was no order for the resident to self-administer their Flonase nasal spray. MA #58 confirmed the resident administered five sprays in their right nostril and four sprays in their left nostril. 2. A review of Resident #18's Admission Record revealed the facility admitted the resident on 08/01/2017. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified dementia and chronic obstructive pulmonary disease (COPD). A review of Resident #18's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/12/2023, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 14. This score indicated the resident was cognitively intact. A review of Resident #18's Order Summary Report, listing active orders as of 01/31/2024, revealed an order dated 01/20/2024 for Incruse Ellipta Inhalation Aerosol Powder-Breath Activated 62.5 micrograms per actuation (mcg/act), inhale one puff one time a day for COPD. The Order Summary Report did not reveal any orders for Resident #18 to self-administer their own medications. During medication administration observations on 01/31/2024 at 7:45 AM, MA #58 handed Resident #18 their Incruse inhaler and Resident #18 self-administered one puff of the inhaler. During an interview on 02/04/2024 at 12:35 PM, MA #58 reviewed Resident #18's physician's orders and verified the resident did not have an order to self-administer their Incruse inhaler. During an interview on 02/06/2024 at 2:00 PM, the Administrator stated he expected nursing staff to follow the physician's orders and to follow the facility's policies. He stated for questions specific to medication administration, he would defer to the nursing department. During an interview on 02/06/2024 at 2:35 PM, the Director of Nursing stated she expected staff to administer medications per physician's orders. She further stated allowing Resident #96 and Resident #18 to self-administer their medications was an error.

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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. 49044 Based on record review, document reviews, video camera footage, interviews, and facility policy review, it was determined the facility failed to ensure (one) 1 of seven (7) sampled residents, Resident #311, reviewed for abuse was free from physical abuse. On 09/13/2022 at approximately 3:30 PM, Resident #311's Power of Attorney (POA) met with Administrator #77 and alleged Certified Nursing Assistant (CNA) #74 smacked at the resident's legs while care was being provided. The POA also alleged that another CNA ate food that was on the resident's meal tray and another CNA handled the resident roughly while care was being provided. Per the initial report, the three (3) staff identified were CNA #74, CNA #75, and CNA #76. The facility provided video coverage of the incident for State Survey Agency (SSA) Surveyor review. The findings include: A review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised in April 2021, revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. A review of Resident #311's Admission Record revealed the facility admitted the resident on 08/30/2019, with diagnoses to include major depressive disorder, need for assistance with personal care, unspecified dementia with behavioral disturbance, and anxiety disorder. A review of Resident #311's significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/05/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, out of a possible fifteen (15), which indicated the resident had severe cognitive impairment, and was not interviewable. Per the MDS, the resident required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. A review of Resident #311's comprehensive care plan, initiated on 09/11/2019, revealed the resident needed assistance with their (his/her) activities for daily living related to limited range of motion. Review of the facility's initial report, revealed on 09/13/2022 at approximately 3:30 PM, Resident #311's Power of Attorney (POA) met with Administrator #77 and alleged Certified Nursing Assistant (CNA) #74 smacked at the resident's legs while care was being provided. The POA also alleged that another CNA ate food that was on the resident's meal tray and another CNA handled the resident roughly while care was being provided. Per the initial report, the three (3) staff identified were CNA #74, CNA #75, and CNA #76. The initial report revealed an investigation was started, the appropriate agencies were notified, and the staff involved were placed on administrative leave. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility final report, dated 09/19/2022, revealed a nurse completed a full body assessment of the resident and found no areas of discoloration or any other concerns. Per the final report, Resident #311 was not able to be interviewed and psychosocial visits were conducted with the resident on 09/14/2022, 09/15/2022, and 09/16/2022 and the staff did not note any distress or concerns with the resident. The final report revealed, CNA #74 and CNA #75 were interviewed by way of telephone and denied any inappropriate interactions with the resident. Per the final report, CNA #76 did not respond to the facility's request for an interview. According to the final report, upon completion of the investigation, the facility terminated the employment of CNA #74 and CNA #75, and since CNA #76 failed to respond to multiple interview attempts, their employment with the facility was terminated. On 01/31/2024 at 6:06 PM, the surveyor attempted a telephone interview with CNA #74, but there was no answer, and the surveyor was unable to leave a message. On 02/01/2024 at 7:40 PM, the surveyor attempted a telephone interview with CNA #74; a female answered and stated she was not CNA #74 and told the surveyor to not call the telephone number again. On 01/31/2024 at 6:09 PM and 02/01/2024 at 7:42 PM, the surveyor attempted a telephone interview with CNA #75; the telephone recording indicated the mailbox was invalid. During a telephone interview on 02/04/2024 at 8:27 PM, Administrator #77 stated he did remember the incident which involved Resident #311 but not a lot of specifics. Per Administrator #77, the resident's family member (FM) came to him with some concerns and he and either the Director of Nursing (DON) or the Assistant DON listened to the FM's concerns, watched the videos to determine the staff involved, removed the staff from resident care, and contacted the Regional [NAME] President of Operations (RVPO) and the Regional Director of Clinical Services (RDCS) for guidance, who then took over the investigation. During the survey, the facility provided the surveyor video camera footage of the incidents. In one (1) 30-second, undated and untimed video, a male staff member was noted to forcefully roll Resident #311 to their right side to the point the resident's right leg hung off the edge of the bed, all while the resident yelled quit and nurse repeatedly and a female staff member, who was also in the room, laughed. In another 30-second undated and untimed video, a female staff member entered Resident #311's room. The staff member greeted the resident by saying, good morning then pulled back the cover on the resident's bed and asked the resident if he/she was wet. Per the video, when the resident resisted, the staff member used their left hand and smacked the resident on their (his/her) right leg 3 times. In a telephone interview on 02/05/2024 at 8:21 PM, the RVPO stated he did remember the incident that involved Resident #311. Per the RVPO, Administrator #77 contacted him after a meeting with the resident's family, where concerns were voiced. The RVPO stated he informed Administrator #77 to start an investigation and report the allegation to the state. The RVPO stated he believed a pretty thorough investigation into the allegations was done. The RVPO acknowledged the staff members were suspended pending the investigation and once the investigation was concluded, the staff members were terminated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 02/06/2024 at 1:21 PM, CNA #76 stated she did nothing wrong and for the surveyor to stop calling. The surveyor had previously attempted to interview CNA #76 on 01/31/2024 at 6:15 PM and 02/01/2024 at 7:44 PM; there was no answer, and a voicemail message was left each time. During an interview on 02/06/2024 at 1:43 PM, the RDCS stated she received a call from Administrator #77 on the day the resident's family sent the concern to Administrator #77. The RDCS stated she immediately ensured the staff members were suspended pending the investigation, the resident was safe, and a skin assessment was completed. The RDCS stated when she was in the facility the next day, and she helped with the investigation. Per the RDCS, two (2) staff were terminated for failure to meet the expectation in the facility's code of conduct and one (1) staff was terminated due to failure to participate in the investigation. During an interview on 02/06/2024 at 2:45 PM, the Administrator stated he did not tolerate abuse and did not want it to occur in the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43017 Based on interviews, record reviews, and facility document and policy review, it was determined that the facility failed to provide supervision to prevent accidents related to elopement for one (1) of three (3) sampled residents, (Resident #112). Specifically, Resident #112, whom the facility assessed to have moderately impaired cognition and developed a care plan that directed staff to supervise as needed, left the facility without notifying staff on 05/09/2021. The facility failed to notify the police that the Resident was missing until approximately 18 hours after Resident #112 left the facility. On 05/10/2021 at approximately 10:00 AM, Resident #112 was found on the side of a highway, and the resident, who reported walking around all night, was transported by local Emergency Medical Services (EMS) to a local hospital for cold exposure. It was determined the provider's non-compliance with one or more requirements of participation had caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified at 483.25, Free of Accidents Hazards and Supervision, F689. Additional IJ deficiencies were identified at 483.70 Administration, F835 and F837. The IJ began on 05/09/2021 at approximately 6:00 PM when Resident #112 exited the facility without the staff's knowledge. The facility was notified of the IJ and provided a copy of the IJ template on 02/02/2024 at 5:12 PM. An acceptable IJ Removal Plan was received on 02/05/2024. The IJ was determined to be to past, effective 01/01/2022. 1. A review of an undated facility policy titled, Emergency Procedure - Missing Resident, revealed, Resident elopement resulting in a missing resident is considered a facility emergency. The policy revealed, 2. Staff will implement the protocol for a missing resident upon discovering that a resident cannot be located. Further review of the policy revealed when a resident was missing 1. Announce a Code Pink with the resident's room/unit number. 2. Note the time that the resident was discovered missing. 3. Report to the nursing station to see if the resident was signed out. 4. Notify the Administrator, Director of Maintenance, and Director of Nursing if not on the premises. 5. Report to the resident's unit for briefing and instruction. 6. Initiate a thorough search by staff members to locate the resident. 7. If the search is unsuccessful after a period of ten (10) minutes, call the police to report the resident missing. The policy revealed, 11. Complete an incident report and follow the facility's incident reporting process. 12. Document the incident and events objectively in the resident record, including: a. Circumstances and precipitating factors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an undated facility policy titled Discharging a Resident without a Physician's Approval revealed, A physician's order is obtained for discharges, unless a resident or representative is discharging himself or herself against medical advice. The policy revealed, 3. If the resident or representative (sponsor) requests discharge or leaves the facility on their own accord without the approval of the attending physician, the resident and/or representative (sponsor) will be asked to sign a release of responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members. 4. If a resident wishes to be discharged to a setting that does not appear to meet his/her post-discharge needs, or appears unsafe, the facility will treat this situation similarly to refusal of care, and will: a. discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location; b. document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed; c. document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings; and d. determine if a referral to Adult Protective Services or other State entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge. A review of Resident #112's Admission Record indicated the facility admitted the resident on 04/01/2021 with diagnoses that included acute kidney failure, stage 3 chronic kidney failure, cerebral infarction (stroke), muscle weakness, type 2 diabetes mellitus, cognitive communication deficit, major depressive disorder, varicose veins of the left lower extremity with an ulcer to the lower leg, essential hypertension, and heart failure. The Admission Record revealed the facility discharged Resident #112 on 05/09/2021 at 6:00 PM. The discharged to, Signature, and Personal Effects Sent With, sections of the form were not completed. A review of Resident #112's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/06/2021, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident required extensive assistance of one (1)staff member with dressing, toilet use, and personal hygiene; and required extensive assistance of two (2) or more staff members with transfers. The MDS revealed that Resident #112 required limited assistance (staff provide guided maneuvering of limbs or other non-weight bearing assistance) with locomotion off the unit. Further review revealed Resident #112's balance was not steady. The MDS revealed the resident was not steady and only able to stabilize with staff assistance when transferring from surface to surface. The MDS revealed the resident utilized a walker or wheelchair for mobility. Continued review of the MDS revealed the resident's overall expectation was to remain at the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #112's Care Plan revealed a Focus area initiated on 04/12/2021 that indicated the resident had cognitive impairment related to cognitive communication deficit. The facility developed interventions that directed staff to cue, re-orient, and supervise the resident as needed. Further review of Resident #112's Care Plan revealed a Focus area initiated on 04/02/2021 that indicated the resident needed assistance with activities of daily living (ADL) related to weakness. The facility developed interventions that directed staff to assist the resident with ambulation, locomotion, toileting, and transfers. The Care Plan revealed Focus areas initiated on 04/02/2021 related to pain; a wound to the left lower extremity that was at risk for developing infection and/or deterioration; risk for falls related to weakness; diagnosis of diabetes and risk of complications; risk for bleeding and bruising related to Plavix (a blood thinner) medication use; and risk for cardiac issues related to heart failure, hyperlipidemia, and hypertension. A review of Resident #112's Care Plan revealed no documented evidence the facility planned for the resident to leave the facility nor go to a local store without staff supervision. A review of Resident #112's Progress Notes dated 05/09/2021 at 6:36 PM, electronically signed by Licensed Practical Nurse (LPN) #2 (a charge nurse), revealed Resident #112 walked past LPN #2 in the hallway heading back to their room, LPN #2 called out the resident's name, and LPN #2 witnessed the resident leave through double doors. The note revealed LPN #2 called the receptionist at the front desk and asked if Resident #112 left the building. The note revealed the receptionist reported she saw a resident leave the building. The note revealed LPN #2 notified the weekend supervisor, Registered Nurse (RN) #3 and checked the parking lot for the resident. The note revealed LPN #2 then walked to the grocery store next door to the facility to check for the resident. The note revealed LPN #2 witnessed Resident #112 checking out with the cashier at the grocery store and encouraged the resident to return to the facility. Continued review revealed the resident looked at LPN #2 but did not respond. LPN #2 walked out to the front of the store while on the phone with Resident #112's Responsible Party (RP) and another family member, and the resident was following behind. The note revealed LPN #2 turned around to check on the resident, and the resident was missing. According to the note, LPN #2 re-checked the grocery store and parking lot and could not locate Resident #112. The note revealed the nurse returned to the facility to look for the resident and met RN #3 at the front door. RN #3 asked about the resident, and LPN #2 explained what she had witnessed. The note revealed RN #3 went to check the grocery store. Further review of the note revealed LPN #2 was on the phone with the resident's family during the entire search. The note revealed the resident's family had also attempted to reach the resident on a cellular phone, but they were unable to reach the resident. The note also revealed RN #3, the Director of Nursing (DON), and the Administrator were notified. A review of Resident #112's Progress Notes dated 05/09/2021 at 7:47 PM revealed DON #27, a previous DON, documented that the family notified the facility that Resident #112 had discharged AMA (against medical advice), which the family expected. The note revealed the family was in the process of locating the resident by calling the resident's friends. DON #27's documentation revealed a discharge form would be given to a family member. According to the note, the resident's physician was notified of the discharge. A review of Resident #112's Progress Notes dated 05/10/2021 at 10:31 AM, titled Interdisciplinary Note, revealed Administrator #54, a previous Administrator, documented that Nurse Practitioner (NP) #38 was present during a discussion of Resident #112's AMA discharge the day before. According to the note, NP #38 stated she was not surprised by the resident's discharge because the resident told her the resident had been homeless in the past and was used to going out on their own. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an undated facility document titled Initial revealed Adult Protective Services (APS) was at the facility on 05/11/2021 (two days after the resident left the facility without staff knowledge) related to Resident #112's AMA discharge over the past weekend. The report revealed the facility notified APS that, per the resident's family, this was normal behavior for the resident and that the resident used to live on the streets. According to the document, the resident was alert and oriented and was their own responsible party with BIMS of 10. The document revealed the resident was readmitted to the facility on [DATE], and a family member was working to get power of attorney. Continued review revealed the facility placed the resident on 15-minute checks to make sure the resident settled back into the facility. The document revealed a care plan conference would be set up with the resident and their family member to discuss not leaving AMA in the future. A review of an undated facility document titled 5-Day revealed the resident's elopement risk assessment indicated the resident was at low risk for elopement (score of 2 of 23) and a Wanderguard bracelet (a bracelet placed on a resident that alerts staff when a resident exits a door equipped with a Wanderguard system) was not placed because the resident's cognition was intact. The document revealed on 05/09/2021, Resident #112 went to a store and bought snacks at approximately 5:45 PM; when the resident did not immediately return, the weekend supervisor (RN #3) went to check on the resident. The report revealed that when RN #3 did not find the resident at the store, she notified the DON, who called the Administrator at approximately 6:04 PM. The document revealed that the Administrator drove along the road looking for the resident but did not find the resident. The facility document revealed the facility contacted the resident's family and notified them the resident had left. The document revealed the Administrator verified with the store's video footage that Resident #112 entered the store at approximately 5:45 PM and left at approximately 5:56 PM with a bag of groceries. The document revealed the resident was wearing a baseball cap and a jacket. According to the document, the resident's family member did not want to file a police report as they considered this normal resident behavior. The document revealed that on 05/10/2021 at 11:24 AM, approximately 18 hours after Resident #112 left the facility, the police were called, and a missing person report was filed. The document revealed that at 12:02 PM on 05/10/2021, the resident's family arrived at the facility and notified them that the resident had been found and was in the emergency room (ER). The document revealed that the facility concluded that Resident #112 went to a store and decided to go visit a friend who lived nearby. The document revealed the resident stated they had always come and gone as they pleased and didn't have to tell anyone what they were doing or where they were going. The document revealed the resident stated they did not tell anyone where they were going because they did not want to, and they had originally planned to come back to the facility after buying snacks. There was no documented evidence the facility followed their Emergency Procedure - Missing Resident protocol that required staff to Initiate a thorough search for the resident and contact the police if the resident was not found within ten minutes. A review of Google Maps revealed the store was a four-minute walk, or 0.2 miles from the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an untitled and undated facility document revealed DON (Director of Nursing) #27, the previous DON, signed a statement that LPN (Licensed Practical Nurse) #2 reported Resident #112 told them that they were going to the store. However, according to the statement, LPN #2 also called the receptionist about the resident, and the receptionist stated the resident went out the door as a visitor was entering the facility. The statement indicated the nurse followed the resident who was at a store across the street; the resident was getting items at the store and agreed to return to the facility when they were finished. The statement revealed that DON #27 verified with the nurse that the resident was alert, oriented, and able to make their own decisions. Further review revealed the resident was also their own responsible party. DON #27's statement revealed that when the resident did not return, LPN #2 went back to the store, and the resident had left. The nurse notified Resident #112's RP, who stated they were expecting this. A review of an untitled facility document dated 05/12/2021 revealed Administrator #54, a previous Administrator, signed a statement that revealed LPN #2 reported that on 05/09/2021, Resident #112 left the facility to go to the store. However, the statement also revealed LPN #2 observed the resident walk past the front part of the unit, which prompted her to call the receptionist. Further review revealed LPN #2 stated the receptionist informed her that while she was talking with a family member at the desk, Resident #112 had went through the front doors. The statement revealed that LPN #2 walked to the store, made contact with the resident, and waited by the side door for the resident to exit. The resident did not exit the store, so LPN #2 entered the store and observed that the resident had left. The statement indicated LPN #2 contacted the resident's family. A review of another untitled facility document dated 05/12/2021 revealed Administrator #54, a previous Administrator, signed a statement that revealed RN #3, the weekend supervisor, went to the store after LPN #2 returned without the resident. After several minutes at the store, RN #3 was unsuccessful at determining where the resident went and notified the DON. A review of Resident #112's AMA Release Form revealed two (2) forms dated 05/09/2021 that were electronically signed by DON #27, the former DON. One of the AMA forms was dated 05/09/2021 at 8:13 PM and revealed Resident #112's RP's name was typed in the section of the form for the Resident/Responsible Party Signature and dated 05/09/2021. The second AMA form for Resident #112 was dated 05/09/2021 at 8:42 PM and revealed an N was documented for the Resident/Responsible Party Signature and for witness one's and two's signatures sections of the form. A statement on the AMA Release Forms revealed 1. This document serves to certify that the above named resident at the above named facility, am leaving against the advice of the attending physician. I acknowledge that I have been informed of the risks involved and hereby release the attending physician and the facility from all responsibility from all ill effects which may result from such discharge. A review of Resident #112's Emergency Department Encounter note dated 05/10/2021 at 11:18 AM, revealed the resident presented to the Emergency Department (ED) via EMS with cold exposure. The note revealed the resident left the facility the night before at approximately 7:30 PM to go to the store without informing staff. The resident got lost when trying to get back and ended up on the expressway. The note revealed EMS found the resident that morning and stated the resident was out in the cold all night. Continued review revealed the first documented body temperature for Resident #112 was taken on 05/10/2021 at 2:45 PM, and the resident's body temperature was 99.2 degrees Fahrenheit (F). The ED record revealed the resident's diagnoses were chronic confusion, medically noncompliant, and non-intractable vomiting with nausea. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #112's ED Laboratory Results report dated 05/10/2021 revealed the resident's blood glucose level was 250 milligrams per deciliter (mg/dL) and was documented as high. The report reference range for blood glucose was 74-99 mg/dL. A review of Resident #112's hospital Discharge Plan Update dated 05/10/2021 at 12:50 PM revealed the hospital Social Worker documented Resident #112 had confusion, and the Social Worker spoke with the resident's family about discharge from the hospital. A review of The Weather Channel's weather history for the area where the facility was located revealed the lowest temperature from 5:56 PM on 05/09/2021 through 11:56 AM on 05/10/2021 was 43 degrees F with no precipitation. During a telephone interview on 01/31/2024 at 12:04 PM, LPN #2, the Charge Nurse stated Resident #112 was due for blood glucose testing at 6:00 PM on 05/09/2021; however, the resident was not in their room. She stated the resident was ambulatory and went throughout the facility, visiting with residents and staff. LPN #2 stated when she could not find the resident, she went to the receptionist at the front desk. LPN #2 stated the regular/routine receptionist was not at the front desk; there was a new person at the desk. She stated she described the resident to the new receptionist, and the receptionist remembered pushing the button to open the front doors for the resident to exit the facility. LPN #2 stated the receptionist told her she thought the resident was a visitor. LPN #2 stated she walked out the front door to see if Resident #112 was in the parking lot. She stated she did not see the resident, so she notified her supervisor, RN #3 because she was not sure what she should do. LPN #2 stated RN #3 told her to return to her duties on the floor. LPN #2 stated that RN #3 stated she would walk to the store to see if the resident was there. LPN #2 stated RN #3 returned to the facility and stated the resident was not in the store, and she had notified Administrator #54, who stated they were to create a report that indicated the resident had notified the staff the resident was going to the store. LPN #2 stated the resident had not told her they were going to the store; she did not know where the resident had gone. She stated the facility did not ask her to write a statement. She stated she had spoken to the family when she noticed the resident was missing. She stated the family attempted to call the resident on their cell phone, and the resident did not answer. The LPN stated she wrote a lengthy progress note describing the elopement and told the family the resident had eloped. She stated she considered it an elopement because no one knew where Resident #112 was located. LPN #2 stated she had never known Resident #112 to leave the facility unattended before. During a follow-up interview by phone on 02/01/2024 at 5:43 PM, LPN #2 stated the Progress Notes dated 05/09/2021 at 6:36 PM, with her electronic signature, were inaccurate. She stated the resident did not notify her that they were going to the store, as documented in the note. She stated she would have told the resident not to go. She stated she also did not see the resident leave through the double doors; again, she would have tried to stop the resident. LPN #2 also stated she did not go to the store looking for the resident. She stated she would not have left the residents on her unit without a nurse. LPN #2 stated she did not speak to the resident at the store because she was not there. The LPN stated if she had been at the store and the resident was behind her, the resident could not have disappeared quickly, as stated in the Progress Notes. She explained the resident was ambulatory, but the resident walked very slowly because both of his/her lower legs were wrapped with dressings. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/29/2024 at 11:56 AM, Resident #112 stated prior to admission to the facility, the resident had a stroke and had mini-strokes. Resident #112 stated he/she walked to the gas station, and when he/she exited the store, he/she went the wrong way. Resident #112 stated he/she thought he/she knew the area and where their friend lived, but they could not find the friend's house. Resident #112 stated they did not remember telling anyone they were going to the store. Resident #112 stated they did not plan on leaving the facility permanently. Resident #112 stated they did not sleep anywhere that night; they just walked around. Resident #112 stated the next morning, someone found him/her on the side of the highway. Resident #112 stated they had never gone to the store before and would never do that again. Resident #112 stated a supervisor from the facility was at the store, and they were sure she saw them, but she did not say anything to them. During an interview on 02/01/2024 at 12:00 PM, Resident #112 stated the weather was okay, and they were okay during the night of 05/09/2021. Resident #112 stated they were found on the road by the highway. During a telephone interview on 02/01/2024 at 3:28 PM, Resident #112's RP stated the former Administrator (Administrator #54) called them and reported the resident had gone to the store and had not returned. Resident #112's RP stated Administrator #54 asked them to call the police. Resident #112's RP stated they told Administrator #54 that the facility should call the police, but the Administrator refused. Resident #112's RP stated they ended up calling the police; however, they lived in another state, and due to jurisdiction issues, the police told them they needed to go to the facility/facility area to make the report. Resident #112's RP stated that before they arrived at the facility on the morning of 05/10/2021, the police found the resident. Resident #112's RP stated Administrator #54 had tried to get them to sign a waiver indicating the resident had left the facility AMA; however, they refused to sign the form and told Administrator #54 the resident was confused and was not capable of making a decision to leave AMA. Resident #112's RP stated the resident's mind was not right, and the resident did not understand what was going on. During a follow-up interview on 02/01/2024 at 6:25 PM, Resident #112's RP stated they thought the police notified them at approximately 9:00 AM or 10:00 AM on 05/10/2021 that EMS had found the resident beside the highway and transported the resident to the hospital. Resident #112's RP was unable to provide an additional timeline. Resident #112's RP stated Administrator #54, asked them to come to the facility before going to the hospital to see the resident on 05/10/2021 because he wanted the RP to sign some papers. Resident #112's RP stated when they arrived at the facility, Administrator #54 was not there. Resident #112's RP added they thought Administrator #54 was at the hospital with the RP's relative at that time. Resident #112's RP stated someone at the facility handed them some papers and asked them to sign them. Resident #112's RP stated the form indicated the resident had left AMA. Resident #112's RP stated they refused to sign the form and informed the facility that the resident did not leave AMA. Resident #112's RP stated the facility had allowed the confused resident to leave the facility, and the resident had wandered off. Resident #112's RP stated the facility was trying to cover themselves. Resident #112's RP stated that when they arrived at the hospital, Resident #112 was very upset and wanted to know why Administrator #54 had been there asking a lot of questions. Resident #112's RP stated the resident was in a bad way and was very confused and delirious. Unsuccessful attempts to contact Receptionist #4, the former receptionist who was working when Resident #112 left the faciity on [DATE], were made on 02/01/2024 at 9:41 AM, 12:38 PM, and 4:00 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempts were made to interview RN #3, the Weekend Supervisor, on 01/31/2024 at 12:03 PM, 01/31/2024 at 12:03 PM, 02/01/2024 at 12:25 PM, and 02/02/2024 at 7:45 PM and were unsuccessful. During an interview on 02/02/2024 at 11:27 AM, NP #38 stated Administrator #54 misquoted her in the Progress Notes dated 05/10/2021, which indicated she was not surprised that the resident had left AMA. She stated she had notified Administrator #54 that she did not make the statement and told him to remove that note from the Progress Notes. She stated she did not see Resident #112 on 05/09/2021, 05/10/2021, or 05/11/2021. She stated she saw the resident on 05/06/2021, prior to the resident leaving the facility, and the resident did not voice anything about leaving the facility. NP #38 stated usually, when a resident left AMA, the resident voiced that they were leaving and not coming back. She stated she thought DON #27, the former DON, notified her that Resident #112 had left AMA, but later, she was told the resident had eloped. NP #38 stated someone told her the resident went out the store's side door and became confused, but she had not spoken to the resident about the incident. She stated she would have called the family and police and would have looked for the resident. She stated the facility should have done more. NP #38 stated the resident could have been seriously injured and was in danger. During an interview on 02/01/2024 at 1:00 PM, DON #27, the former DON, stated she did not remember much about the incident because it was a long time ago. She stated she recalled being notified Resident #112 had gone to the store and had not returned. She stated she was not concerned because the resident had told LPN #2, they were going to the store. She stated she believed the resident had previously gone to the store and returned without difficulty. She stated the resident was responsible for themselves (did not have a power of attorney [POA]) and was alert and oriented, so the resident was capable of going to the store. She stated that residents who were alert and oriented and their own POA were allowed to go to the store. DON #27 stated back then residents did not have to sign out when they left the facility. DON #27 stated when the resident had not returned, someone went to the store to look for the resident. She was not sure whether anyone had seen the resident. She stated Administrator #54 had spoken with the family, and she thought the family told the Administrator that prior to admission to the facility, the resident would often leave without providing notice. DON #27 stated she never had a conversation with the resident about the incident. She stated she was never involved in the investigation or decision-making. DON #27 stated the incident was not investigated as an elopement because Administrator #54 determined that the resident left AMA. During a telephone interview on 02/01/2024 at 1:48 PM, Administrator #54, the former Administrator stated he did not remember much about the incident. He stated he was notified Resident #112 had told a nurse that they were going to the store, and the resident had not returned. He stated the resident was alert, oriented, and their own POA and was allowed to leave. According to Administrator #54, the facility was not a prison. He stated he notified the family, who stated that before entering the facility, the resident would leave without telling anyone. He stated the resident's family notified him the next day that the resident was in the hospital. He stated he visited the resident in the hospital, and the resident stated they had wanted to visit with friends. Administrator #54 stated he did not know whether Resident #112 had a habit of going to the store. He stated he also did not know whether the facility had assessed the resident's ability to go to the store because [the resident] left AMA. Administrator #54 further stated he did not remember whether the facility had a policy related to determining whether a resident was capable of going to the store. He stated if the resident was alert and oriented and their own POA, they had the right to go, we cannot stop them. He added he did not remember anything else. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Regional [NAME] President of Operations (RVPO) on 01/30/2024 at 11:56 AM, the RVPO stated they did not consider the 05/09/2021 incident as an elopement because Resident #112 was their own POA and was alert and oriented. He stated Resident #112 walked to a store located near the facility. The RVPO stated if a resident was alert, oriented, and responsible for themselves, they were allowed to go to the store unsupervised. The RVPO stated when it was observed the resident was not in the facility, a staff member walked to the store to escort Resident #112 back to the facility; however, the resident refused to return to the facility. The RVPO stated the staff member waited at the door of the store for the resident, but the resident exited the store through a different door and left the grounds. The RVPO stated that since the resident had refused to return to the facility, they considered the resident to have left AMA. The RVPO stated they immediately notified the family and reported to the state agency on 05/11/2021 or 05/12/2021, after an APS visit on 05/11/2021, that the resident had left AMA. During a follow-up interview on 02/02/2024 at 5:18 PM, the RVPO stated Resident #112 had a right to leave and stated the facility even went to the store to check on the resident. The RVPO stated they did not check on every resident who went to the store. The RVPO shook his head and stated he did not know why they checked on Resident #112. During an interview on 02/06/2024 at 9:42 PM, the DON stated she was not there when the incident with Resident #112 occurred and could not address the incident. She stated if the resident eloped, it should have been fully investigated and reported, and the policy for elopement should have been followed. During an interview on 02/01/2024 at 2:45 PM, the current Administrator stated he confirmed with Administrator #54 that he determined Resident #112 left AMA. The current Administrator stated he was notified that the facility knew the resident was going to the store but did not know the resident was going to leave the store. The Administrator stated that Administrator #54 told him the resident was considered to have left AMA because the resident had left the store without notifying the facility. During a f [TRUNCATED]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 28193 Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to ensure staff administered tube feeding formula at the rate prescribed by the physician. The facility also failed to accurately and consistently monitor the amount of tube feeding formula infused each shift to ensure one (Resident #135) of two (2) sampled residents reviewed for tube feedings consistently received the amount of tube feeding formula recommended by the Registered Dietitian (RD) and as ordered by the physician. The findings included: A review of the facility's policy titled Enteral Nutrition, revised in November 2018, revealed, Adequate nutritional support through enteral nutrition is provided to residents as ordered. Policy Interpretation and Implementation 1. The interdisciplinary team, including the dietitian, conducts a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings. The policy further indicated, 3. The dietitian, with input from the provider and nurse: a. Estimates calorie, protein, nutrient and fluid needs; b. Determines whether the resident's current intake is adequate to meet his or her nutritional needs; c. Recommends special food formulations; and d. Calculates fluids to be provided (beyond free fluids in formula). 4. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. The policy also specified, 9. The nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition. A review of Resident #135's Admission Record revealed the facility admitted Resident #135 on 08/18/2022 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, dysphagia (difficulty swallowing) following unspecified cerebrovascular disease, and gastrostomy (a surgically placed opening into the stomach from the abdominal wall) status. Review of Resident #135's Care Plan revealed a Focus area, initiated on 08/19/2022 and revised on 09/12/2023, that indicated the resident had a feeding tube to meet all nutritional needs and was at risk for complications. Interventions dated 08/19/2022 indicated the resident was to receive nothing by mouth (nil per os; NPO) and directed staff to provide tube feeding and water flushes per physician's orders. Another intervention dated 08/19/2022 indicated the RD would evaluate the resident at least quarterly and as needed to monitor caloric intake, estimate caloric needs, and make recommendations for changes in tube feedings as needed. A review of Resident #135's Order Summary Report, listing active orders as of 01/31/2024, revealed an order dated 08/18/2022 for the resident to be NPO and an order dated 09/05/2022 for Jevity 1.2 at 70 milliliters per hour (ml/hr) continuously. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #135's Dietary Note dated 11/29/2023 at 8:26 AM revealed a Quarterly Nutrition Assessment that indicated Jevity 1.2 at 70 ml/hr continuously, 150 ml water flushes every six hours, and 200 ml water flushes with medication pass three times a day provided Resident #135 with 1848 calories, 85 grams of protein, and 2,647 ml of fluids every 24 hours. Resident #135's nutritional needs were recorded as 1600 to 1900 calories, 64 to 76 grams of protein, and 1600 to 1900 milliliters of fluids every 24 hours. A review of the manufacturer's information for Jevity 1.2 revealed the resident's ordered tube feeding formula provided 1.2 calories for every ml infused, indicating that in order for Resident #135 to receive the amount of daily calories recommended by the RD, the resident would need to receive between 1,333 ml and 1,583 ml of tube feeding formula per day. A review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/02/2023, revealed a Staff Assessment for Mental Status (SAMS) determined Resident #135 had severely impaired cognitive skills for daily decision making. According to the MDS, the resident weighed 166 pounds at the time of the assessment, had not experienced a weight loss or gain of 5 percent (%) or more in the last month or 10 % or more in the last six months, and had a feeding tube while a resident of the facility. The MDS indicated Resident #135 received 51% or more of their total calories through parenteral or tube feeding and an average fluid intake of 501 cubic centimeters (cc) or more per day intravenously or by tube feeding. A review of Resident #135's Order Summary Report, listing active orders as of 01/31/2024, revealed an order dated 12/04/2023 that directed staff to monitor the resident's tube feeding twice a day by documenting the total amount of formula infused at the end of each shift, then clearing the volume on the tube feeding pump. A review of Resident #135's December 2023 and January 2024 Medication Administration Record (MAR) revealed documentation of tube feeding monitoring, including recording the total amount of formula infused each shift and clearing the tube feeding pump, was initiated on 12/04/2023 at 6:00 PM. However, the MAR revealed that staff did not begin recording the amount of tube feeding formula infused each shift on the MAR until 6:00 PM on 12/28/2023. The MAR revealed that prior to 12/28/2023, staff only initialed the MAR to indicate they completed the order or initialed and referred to the resident's progress notes. Staff documentation on the MAR revealed that the resident did not receive at least 1,333 ml of tube feeding formula daily to meet the amount of daily calories recommended by the RD on the following dates: 01/01/2024, 01/03/2024, 01/06/2024, 01/07/2024, 01/11/2024, 01/12/2024, 01/14/2024, 01/18/2024, 01/20/2024, 01/26/2024, and 01/27/2024. A review of Resident #135's Progress Notes for the timeframe from 12/04/2023 to 12/28/2023, for which the MAR referenced the Progress Notes, revealed the following: - A Nurse's Note dated 12/06/2023 at 6:40 AM that reflected the resident had received 244 ml of tube feeding formula on 12/05/2023 at 8:00 PM and 925 ml of tube feeding formula on 12/06/2023 at 6:35 AM; - A Nurse's Note dated 12/07/2023 at 6:02 AM that indicated the resident had received 0 ml of tube feeding formula on 12/06/2023 at 8:45 PM and 626 ml of tube feeding formula on 12/07/2023 at 6:00 AM; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A Nurse's Note dated 12/08/2023 at 6:26 AM that indicated the resident had received 618 ml of tube feeding formula on 12/08/2023 at 6:15 AM, and the pump was cleared to 0 ml for the oncoming nurse; - A Medication Administration Note dated 12/13/2023 at 5:27 PM that reflected the resident had received a total of 901 ml of tube feeding formula during the shift; - A Medication Administration Note dated 12/14/2023 at 5:27 PM that indicated the resident had received a total of 686 ml of tube feeding formula during the shift, and the tube feeding pump was cleared; - A Medication Administration Note dated 12/20/2023 at 5:47 PM that indicated the resident had received a total of 741 ml tube feeding formula during the shift, and the tube feeding pump was cleared; - An EMAR [electronic medication administration record]- Orders Administration Note dated 12/22/2023 at 5:54 PM that indicated the resident had received 684 ml of tube feeding formula during the shift; and - A Medication Administration Note dated 12/26/2023 at 5:43 PM that indicated the resident had received a total of 867 ml tube feeding formula during the shift, and the tube feeding pump was cleared. There were no other documented entries during this timeframe reflecting that staff were consistently monitoring and recording the amount of tube feeding formula the resident received each shift to ensure the resident was receiving the amounts recommended by the RD and as ordered by the physician. During an interview on 01/31/2024 at 8:26 AM, Licensed Practical Nurse (LPN) #16 stated Resident #135's tube feeding was hung on 01/31/2023 at 6:00 AM and was infusing at a rate of 70 ml/hr. However, LPN #16 said the tube feeding pump reflected the resident had received 981 ml of tube feeding formula because the night shift did not clear the pump. LPN #16 said when recording the amount of tube feeding formula the resident received each shift, she based it on a rate of 70 ml/hr but said it was just a guestimate. During an observation on 02/04/2024 at 10:35 AM, Resident #135's Jevity 1.2 was labeled as being hung on 02/04/2024 at 6:00 AM, and a water flush bag was labeled as being hung on 02/04/2024 at 8:00 AM. The tube feeding formula was infusing at a rate of 80 ml/hr. The tube feeding pump reflected that 150 ml of water flush and 1094 ml of the tube feeding formula had been infused since the pump was last cleared. On 02/04/2024 at 10:40 AM, LPN #16 accompanied the surveyor to Resident #135's room to observe the tube feeding pump. LPN #16 confirmed the resident's tube feeding formula was infusing at a rate of 80 ml/hr and said the pump reflected the resident had received 150 ml water flush and 1097 ml of tube feeding formula. After reviewing Resident #135's orders, LPN #16 said the resident's Jevity 1.2 should be administered at a rate of 70 ml/hr, and nursing staff should be recording the amount of tube feeding formula infused each shift, then clearing out the tube feeding pump. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/2024 at 3:11 PM, the RD stated he felt the information documented regarding the amount of tube feeding formula received by Resident #135 was a clerical error because the resident had not lost any weight. The RD said this was likely due to staff not clearing out the tube feeding pump each shift so that they could determine an accurate amount of tube feeding formula infused. During an interview on 02/06/2024 at 12:04 PM, Nurse Practitioner (NP) #38 stated if nursing staff were not monitoring the amount of tube feeding formula infused and clearing the pump each shift, they were not obtaining accurate information. NP #38 stated this could eventually lead to a negative outcome for the resident, such as significant weight loss, wounds, or low protein levels. During an interview on 02/06/2024 at 2:00 PM, the Administrator stated he was going to defer questions about tube feedings to nursing staff; however, he stated he expected staff to follow the facility's policies and physician's orders. During an interview on 02/06/2024 at 2:35 PM, the Director of Nursing stated she expected nurses to infuse tube feeding formula per the physician's orders because if they did not, it could result in weight loss or the development of wounds.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valhalla Post Acute	300 Shelby Station Drive Louisville, KY 40245

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683 Based on observations, interviews, and facility policy review it was determined that the facility failed to ensure staff stored, prepared, and served foods for 152 of 152 residents in a sanitary manner. Kitchen staff failed to implement proper hand hygiene practices during meal service to prevent potential contamination. Staff failed to ensure food items were not contaminated during food preparation when staff used a knife while handling raw meat, then without sanitizing, used the same knife to slice cooked meatloaf. In addition, staff should ensure that personal jewelry should not touch resident's food. Furthermore, staff should ensure that all food stored in the nourishment room refrigerators are properly labeled and dated and discarded if expired. The findings include: 1. Review of the facility's policy titled, Food Preparation and Service, revised in [DATE], revealed 7. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. On [DATE] at 12:22 PM, Dietary Aide #8 was observed serving residents' meal trays. During meal service, Dietary Aide #8 touched her forehead with her gloved right hand, then continued serving trays without changing gloves or washing her hands. During an interview on [DATE] at 1:47 PM, Dietary Aide #8 stated she had worked at the facility for eight (8) months and had been trained on food preparation and hygiene practices. Dietary Aide #8 stated she was expected to change gloves and wash her hands between every task. During an interview on [DATE] at 11:45 AM, the Dietary Director stated he expected staff to change gloves and wash their hands after they touched parts of their body. During an interview on [DATE] at 12:56 PM, Cook #24 stated she had been the Assistant Dietary Manager for a year. Cook #24 stated staff were expected to change gloves and wash their hands after every task and after they touched parts of their body to avoid cross contamination. 2. Review of the facility's policy titled, Food Preparation and Service, revised in [DATE], revealed the section titled Food Preparation Area specified, 4. Appropriate measures are used to prevent cross contamination. These include: a. storing raw meat separately and in drip-proof containers, and in a manner that prevents cross-contamination from other foods in the refrigerator; b. preparing potentially hazardous foods away from other foods; c. sanitizing towels and cloths used for wiping surfaces in containers filled with approved sanitizing solution; and d. cleaning and sanitizing work surfaces (including cutting boards) and food-contact equipment between uses, following food code guidelines. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:30 AM, Cook #7 was observed with a knife that was not cleaned nor sanitized, with particles of raw meat on it, begun to slice prepared meatloaf on the holding steam table. During an interview on [DATE] at 2:44 PM, Cook #7 stated she was expected to sanitize equipment before use. During an interview on [DATE] at 11:45 AM, the Dietary Director stated he expected staff to sanitize equipment after handling raw meat. During an interview on [DATE] at 12:56 PM, Cook #24 stated she had been the Assistant Dietary Manager for one (1) year. She further stated she expected staff to sanitize equipment after use. 3. Review of the facility's policy titled, Food Preparation and Service, revised in [DATE], revealed 9. Food and nutrition services staff keep fingernails trimmed and clean. Jewelry is worn minimally and hand jewelry is covered with gloves. On [DATE] at 10:31 AM, Cook #7 was observed handling prepared meatloaf with a bracelet on her left wrist. The bracelet came into contact with the meatloaf as she sliced it into individual servings. During an interview on [DATE] at 2:44 PM, Cook #7 stated she should not have worn a bracelet while preparing food, because it could lead to cross-contamination. During an interview on [DATE] at 12:56 PM, Cook #24/the Assistant Dietary Manager stated dietary staff were not permitted to wear jewelry, other than a wedding ring. Cook #24 further stated if a staff member's bracelet came into contact with meatloaf as they were preparing it, it risked cross-contamination. During an interview on [DATE] at 12:10 PM, the Dietary Director stated dietary staff should not wear jewelry while preparing food because it could result in cross-contamination. 4. Review of the facility's policy titled, Food Preparation and Service, revised in [DATE], revealed, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. On [DATE] at 1:57 PM, observation of the nourishment room refrigerator revealed one (1) container of opened thickened water with no date and one (1) an undated pitcher of orange juice. On [DATE] at 2:12 PM, observation of the nourishment room refrigerator in the English Oak Terrace revealed an opened containers of zero calorie sweet tea, nectar thickened tea, nectar thickened apple juice, and nectar thickened lemon water. These opened containers were not dated. In addition, the refrigerator contained an opened carton of tomato soup and a sandwich wrapped in plastic wrap labeled as extra that were not dated. On [DATE] at 2:26 PM, observation of the nourishment room refrigerator in the Chestnut Oak Garden hall revealed an opened tub of cottage cheese, a pitcher of orange juice, and an opened container of honey thickened lemon water. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:11 AM, observation of the Chestnut Oak Terrace nourishment room refrigerator revealed a sign that specified, When using thickened liquid containers, label the day you opened the bottle. On [DATE] at 11:43 AM, observation of Chestnut Oak Garden Hall nourishment room refrigerator contained three (3) expired half-and-half packets. In addition, there was one (1) undated, opened tub of cottage cheese and one (1) undated pitcher of orange juice in the refrigerator. On [DATE] at 9:52 AM, observation on English Oak Terrace nourishment room refrigerator contained two (2) undated, opened containers of nectar thickened tea, two (2) undated, opened containers of nectar thickened orange juice, and undated, opened containers of honey thickened orange juice. were observed in the English Oak Terrace nourishment room refrigerator. In addition, the refrigerator also contained an opened container of smoked ham, labeled with a date of ,d+[DATE], and one (1) undated, opened box of creamy tomato soup. During an interview on [DATE] at 1:47 PM, Dietary Aide #8 stated the dietary department was expected to maintain the nourishment rooms on each unit, including discarding unlabeled and undated food items. During an interview on [DATE] at 11:45 AM, the Dietary Director stated he expected dietary staff to maintain the nourishment rooms, including discarding any expired, undated, or unlabeled food items daily. During an interview on [DATE] at 11:56 PM, Cook #24/the Assistant Dietary Manager stated dietary staff should check the nourishment room refrigerators to make sure food items were in date and nothing was stored beyond three (3) days. During an interview on [DATE] at 1:31 PM, the Director of Nursing (DON) stated any opened and undated items in the nourishment rooms should be discarded. The DON further stated thickened liquids should be labeled when they were opened, and then discarded after three (3) days.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 43017 Based on interviews, record reviews, and facility document and policy review, it was determined the facility failed to ensure that the Administrator of the facility took proper measures to ensure the safety of a resident for 1 (Resident #112) of three (3) sampled residents reviewed for elopement. Specifically, Resident #112, whom the facility assessed to have moderately impaired cognition and developed a care plan that directed staff to supervise the resident as needed, left the facility without notifying staff on 05/09/2021. The facility failed to notify the police that the resident was missing until approximately 18 hours after the resident left the facility. On 05/10/2021 at approximately 10:00 AM, Resident #112 was found on the side of a highway. It was reported that Resident #112, who had been walking around all night, was transported by local Emergency Medical Services (EMS) to a local hospital for cold exposure. It was determined the provider's non-compliance with one or more requirements of participation had caused or was likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25(d) Accidents, at a scope and severity of J. The IJ began on 05/09/2021 at approximately 6:00 PM when Resident #112 exited the facility without the staff's knowledge. The facility was notified of the IJ and provided a copy of the IJ template on 02/02/2024 at 5:12 PM. An acceptable IJ Removal Plan was received on 02/05/2024. The IJ was determined to be to past, effective 01/01/2022. The findings included: A review of the facility's policy titled Administrator, dated March 2021, revealed, A licensed Administrator is responsible for the day-to-day functions of the facility. The policy revealed, The Administrator is responsible for, but not limited to: d. implementing established resident care policies, personnel policies, safety and security policies and other operational policies and procedures necessary to remain in compliance with current laws, regulations, and guidelines governing long term care facilities; and e. serving as liaison to the governing to the governing board, medical staff, and other professional and supervisory staff. A review of an undated facility policy titled, Emergency Procedure - Missing Resident revealed, Resident elopement resulting in a missing resident is considered a facility emergency. The policy revealed, 2. Staff will implement the protocol for missing resident upon discovering that a resident cannot be located. The policy revealed, 6. Initiate a thorough search by staff members to locate the resident. 7. If the search is unsuccessful after a period of ten minutes, call the police to report the resident missing. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #112's Admission Record indicated the facility admitted the resident on 04/01/2021 with diagnoses that included acute kidney failure, stage 3 chronic kidney failure, cerebral infarction (stroke), muscle weakness, type 2 diabetes mellitus, cognitive communication deficit, major depressive disorder, varicose veins of the left lower extremity with an ulcer to the lower leg, essential hypertension, and heart failure. The Admission Record revealed the facility discharged Resident #112 on 05/09/2021 at 6:00 PM. The discharged to, Signature, and Personal Effects Sent With, sections of the form were not completed. A review of Resident #112's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/06/2021, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident required extensive assistance of two or more staff members with transfers. Resident #112's balance was not steady, but was able to stabilize when walking or turning around. Resident #112 utilized a walker or wheelchair for mobility. Review of the MDS revealed the resident's overall expectation was to remain at the facility. A review of Resident #112's Care Plan revealed a Focus area initiated on 04/12/2021 that indicated the resident had cognitive impairment related to cognitive communication deficit. The facility developed interventions that directed staff to cue, re-orient, and supervise the resident as needed. Further review of Resident #112's Care Plan revealed a Focus area initiated on 04/02/2021 that indicated the resident needed assistance with activities of daily living (ADL) related to weakness. The facility developed interventions that directed staff to assist the resident with ambulation, locomotion, toileting, and transfers. A review of Resident #112's Care Plan revealed no documented evidence the facility planned for the resident to leave the facility or go to a local store without staff supervision. A review of Resident #112's Progress Notes dated 05/09/2021 at 6:36 PM, electronically signed by Licensed Practical Nurse (LPN) #2 (a charge nurse), revealed Resident #112 walked past LPN #2 in the hallway heading back to their room. The note revealed the receptionist reported she saw a resident leave the building. Continued review revealed LPN #2 notified the weekend supervisor (Registered Nurse (RN) #3) and checked the parking lot for the resident. The note also revealed RN #3, the Director of Nursing (DON), and the Administrator were notified. A review of Resident #112's Progress Notes dated 05/09/2021 at 7:47 PM revealed DON #27, a previous DON, documented that the family notified the facility that Resident #112 had discharged AMA (against medical advice), which the family expected. DON #27's documentation revealed a discharge form would be given to a family member. According to the note, the resident's physician was notified of the discharge. A review of Resident #112's Progress Notes dated 05/10/2021 at 10:31 AM, titled Interdisciplinary Note, revealed Administrator #54, a previous Administrator, documented that Nurse Practitioner (NP) #38 was present during a discussion of Resident #112's AMA discharge the day before. According to the note, NP #38 stated she was not surprised by the resident's discharge because the resident told her the resident had been homeless in the past and was used to going out on their own. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	However, during an interview on 02/02/2024 at 11:27 AM, NP #38 stated Administrator #54 misquoted her in the Progress Notes dated 05/10/2021, which indicated she was not surprised that the resident had left AMA. She stated she had notified Administrator #54 that she did not make the statement and told him to remove that note from the Progress Notes. She stated she did not see Resident #112 on 05/09/2021, 05/10/2021, or 05/11/2021. She stated she saw the resident on 05/06/2021, prior to the resident leaving the facility, and the resident did not voice anything about leaving the facility. NP #38 stated usually, when a resident left AMA, the resident voiced that they were leaving and not coming back. She stated she thought DON #27, the former DON, notified her that Resident #112 had left AMA, but later, she was told the resident had eloped. She stated she would have called the family and police and would have looked for the resident. She stated the facility should have done more. NP #38 stated the resident could have been seriously injured and was in danger. A review of an undated facility document titled Initial revealed Adult Protective Services (APS) was at the facility on 05/11/2021 (two days after the resident left the facility without staff knowledge) related to Resident #112's AMA discharge over the past weekend. A review of an undated facility document titled 5-Day revealed on 05/09/2021, Resident #112 went to a store and bought snacks at approximately 5:45 PM. However, the resident did not immediately return. The facility document revealed the facility contacted the resident's family and notified them the resident had left. The document revealed the Administrator verified with the store's video footage that Resident #112 entered the store at approximately 5:45 PM and left at approximately 5:56 PM with a bag of groceries. However, further review revealed that not until 05/10/2021 at 11:24 AM, approximately 18 hours after Resident #112 left the facility, was the police called, and a missing person report was filed. The document revealed that at 12:02 PM on 05/10/2021, the resident's family arrived at the facility and notified them that the resident had been found and was in the emergency room (ER). There was no documented evidence the facility followed their Emergency Procedure - Missing Resident protocol that required staff to Initiate a thorough search for the resident and contact the police if the resident was not found within ten minutes. A review of Resident #112's Emergency Department Encounter note dated 05/10/2021 at 11:18 AM revealed the resident presented to the Emergency Department (ED) via EMS with cold exposure. The note revealed the resident got lost when trying to get back and ended up on the expressway. The note revealed EMS found the resident that morning and stated the resident was out in the cold all night.with nausea. A review of The Weather Channel's weather history for the area where the facility was located revealed the lowest temperature from 5:56 PM on 05/09/2021 through 11:56 AM on 05/10/2021 was 43 degrees F with no precipitation. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 01/31/2024 at 12:04 PM, LPN #2, the Charge Nurse stated Resident #112 was due for blood glucose testing at 6:00 PM on 05/09/2021; however, the resident was not in their room. She did not see the resident, so she notified her supervisor (RN #3) because she was not sure what she should do. LPN #2 stated RN #3 returned from the store and stated the resident was not in the store, and she had notified Administrator #54, who stated they were to create a report that indicated the resident had notified the staff the resident was going to the store. LPN #2 stated the resident had not told her they were going to the store; she did not know where the resident had gone. She stated she wrote a lengthy progress note describing the elopement and told the family the resident had eloped. She stated she considered it an elopement because no one knew where Resident #112 was located. LPN #2 stated she had never known Resident #112 to leave the facility unattended before. During a follow-up interview by phone on 02/01/2024 at 5:43 PM, LPN #2 stated the Progress Notes dated 05/09/2021 at 6:36 PM, with her electronic signature, were inaccurate. She stated the resident did not notify her that they were going to the store, as documented in the note. She stated she would have told the resident not to go. She stated she also did not see the resident leave through the double doors; again, she would have tried to stop the resident. LPN #2 also stated she did not go to the store looking for the resident. She stated she would not have left the residents on her unit without a nurse. LPN #2 stated she did not speak to the resident at the store because she was not there. She stated if she had been at the store and the resident was behind her, the resident could not have disappeared quickly, as stated in the Progress Notes. She explained the resident was ambulatory, but the resident walked very slowly because both of the lower legs were wrapped with dressings. During an interview on 01/29/2024 at 11:56 AM, Resident #112 stated prior to admission to the facility, the resident had a stroke and had mini-strokes. Resident #112 stated they walked to the gas station, and when they exited the store, the resident went the wrong way. Resident #112 stated they thought they knew the area and where their friend lived, but they could not find the friend's house. Resident #112 stated they did not plan on leaving the facility permanently. Resident #112 stated they did not sleep anywhere that night; they just walked around. Resident #112 stated the next morning, someone found them on the side of the highway. Resident #112 stated they had never gone to the store before and would never do that again. During a telephone interview on 02/01/2024 at 3:28 PM, Resident #112's RP stated the former Administrator (Administrator #54) called them and reported the resident had gone to the store and had not returned. Resident #112's RP stated Administrator #54 asked them to call the police. Resident #112's RP stated they told Administrator #54 that the facility should call the police, but the Administrator refused. Resident #112's RP stated they ended up calling the police; however, they lived in another state, and due to jurisdiction issues, the police told them they needed to go to the facility/facility area to make the report. Resident #112's RP stated that before they arrived at the facility on the morning of 05/10/2021, the police found the resident. Resident #112's RP stated Administrator #54 had tried to get them to sign a waiver indicating the resident had left the facility AMA; however, they refused to sign the form and told Administrator #54 the resident was confused and was not capable of making a decision to leave AMA. Resident #112's RP stated the resident's mind was not right, and the resident did not understand what was going on. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 02/01/2024 at 1:48 PM, Administrator #54, the former Administrator stated the resident was alert, oriented, and their own POA and was allowed to leave. According to Administrator #54, the facility was not a prison. He stated he notified the family, who stated that before entering the facility, the resident would leave without telling anyone. He stated the resident's family notified him the next day that the resident was in the hospital. He stated he visited the resident in the hospital, and the resident stated they had wanted to visit with friends. He stated he also did not know whether the facility had assessed the resident's ability to go to the store because [the resident] left AMA. Administrator #54 further stated he did not remember whether the facility had a policy related to determining whether a resident was capable of going to the store. He stated if the resident was alert and oriented and their own POA, they had the right to go, we cannot stop them. He added he did not remember anything else. During an interview on 02/06/2024 at 9:46 PM, the Administrator stated he was not at the facility when the incident occurred and did not know what happened; however, he stated the incident with Resident #112 should have been investigated if the resident eloped. The Administrator stated the facility's policy should have been followed, and it should have been investigated a long time ago. The facility alleged removal of the immediacy of the IJ on 01/01/2022 as follows: 1. On 05/10/2021, Resident #112 was assessed using the Elopement Risk Assessment by Licensed Practical Nurse (LPN) #9. The resident was placed on 15-minute checks until he/she went to the hospital on 05/11/2021. The resident ' s care plan was updated. The resident has not had further elopements since 05/09/2021. 2. On 05/09/2021, the facility reviewed the State Operations Manual (SOM) and again on 02/03/2023, to go over the definition of elopement. The Interdisciplinary team (IDT), Administrator, Assistant Director of Nursing, Nurse Mangers, and Social Services reviewed the Wander Risk Assessment. Residents that were assessed to require a Wander-guard bracelet were placed in the binder located at each nursing station and front desk. Further, the residents assessed to be an elopement risk, care plans were updated. 3. On 05/10/2021, education began with all the facility staff. The Director of Nursing (DON) provided the education, and it was ongoing. Further, education was provided during all staff meetings on 09/2021 through 11/2021 after the Assistant Regional Director of Services identified potential issues and/or concerns during onsite visits through resident medical record audits and observations. Education that was included was on the Elopement Policy, Wandering, resident/resident representative expectations of signing out prior to resident leaving the facility, and missing resident protocol by the Administrator, DON, Nurse Managers, Social Workers, Admissions Staff, and Supervisors. 4. On 07/02/2021 through 07/27/2021, the Assistant Regional Director of Clinical Services assigned the Director of Clinical Services assigned the DON, Nurse Managers, Charge Nurses, and nurse supervisors, after completion of an onsite audit, to conduct an audit on wandering risk assessments. All residents were verified to have an updated risk assessment in their medical record. 5. On 07/02/2021, the Assistant Director of Clinical Services re-educated the DON and Administrator regarding their roles and responsibilities for following the facility's policies which included but was not limited to discharging against medical advice, elopement, and wandering oversight and supervision, QA process and QAPI Program. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. On 07/29/2021 and 09/24/2021, the Quality Assurance and Performance Improvement meeting was held to review the facility's protocol and policy for elopement. The attendees included the Administrator, Medical Director, Director of Nursing, Assistant Regional Director of Clinical Services, Medical Records, Assistant Director of Nursing, Therapy, Housekeeping, and Activity Director. 7. On 07/29/2021 and 09/24/2021, the facility assessment was reviewed in the Quality Assurance Performance Improvement Committee to review the results of the audits and no changes were needed. Further, the QAPI committee reviewed any discharges or unplanned dischargers from 06/2021 through 12/2021, no concerns were identified. 8. On 08/01/2021, the DON, Nurse Manager, Supervisor or Charge Nurse evaluated all new admissions/re-admissions residents on admission to determine if a resident was triggered to be an elopement risk. The residents who triggered to be at risk for elopement would have a comprehensive person-centered care plan developed and implemented by the Minimum Data Set (MDS) nurse and IDT team, that included the resident's risk for elopement. If concerns were identified, it was discussed in the daily Interdisciplinary Plan of Care Meeting and the DON would report the concerns to the QAPI committee. 9. During the month of August of 2021, the Assistant Regional Director of Clinical Services assigned the Director of Nursing and Administrator to conduct elopement drills. A total of 2 element drills were completed. All elopement drills were reviewed with the Assistant Director of Clinical Services, the Director of Nursing and Administrator. The Emergency Plan for locating a missing resident was reviewed by the Assistant Regional Director of Nursing and the Administrator on 09/24/2021, with no changes indicated. 10. On 11/17/2021, the Governing Body (Regional [NAME] President) received verbal education per the Regional Director of Clinical Services regarding expectations of self-reportable incidents including but not limited to elopements and elopement versus against medical advice. The Assistant Regional Director of Clinical Services and Assistant Regional Director of Clinical Services increased onsite facility visits to 2-3 days per week to ensure that facility Administration and staff were following the Elopement Policy and Procedures. 11. On 12/01/2021 through 12/31/2021, annual competencies were completed, which included but was not limited to elopements. All the new staff received Elopement training upon hire, during new hire orientation, by the staff development coordinator. Staff who had not received the training, to include the agency staff, prior to 12/31/2021 received training prior to the start of their shift by the nursing scheduler, staff development coordinator, nurse management team, or supervisor prior to the start of their shift. Further, self-reportable incidents was reviewed by the Regional Director of Clinical Services and/or Assistant Regional Director of Clinical services on site no later than 72 hours following the incident. The Assistant Regional Director of Clinical Services kept a log of all the self-reportable incidents and was reviewed monthly by the Administrator and the Regional [NAME] President. The State Agency validated the IJ Removal Plan as follows: (continued on next page)

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	185455	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valhalla Post Acute	300 Shelby Station Drive Louisville, KY 40245

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of Resident #112 Admission/Readmission Assessment revealed the resident was accompanied by the paramedics, by ambulance on 05/10/2021. Further review revealed the resident refused to be checked by staff for a skin assessment. Review of the resident's Baseline care plan revealed the resident's care plan was revised to include 15-minute checks and the care plan included the resident was at risk for elopement. 2. Review of the SOM documentation, dated 2021, revealed the facility reviewed the definition of elopement. Review of the elopement binder revealed the facility had placed all residents to be an elopement risk in the binder. 3. Review of the facilities education, provided by the facility revealed education was provided to all staff from 05/2021 to 11/2021. Education provided included Abuse, Wandering Residents, Behaviors, Customer Service, and Infection Control. Review of the facility's Wandering and Elopement policy, revised on 05/17/2020, revealed the facility defined elopement as an unsafe wandering and the facility strived to prevent harm while maintaining at the least restrictive environment for the residents. 4. Review of the QA Audit-Wander guard Tool, dated 07/02/2021, revealed the residents were audited to ensure the residents that were assessed as an elopement risk had an MD order, Wander guard Bracelet, updated care plan, TAR, and were in the elopement book/binder. No concerns were identified. Review of the Care Planning Audit Tool, dated 07/27/2021, revealed the residents who were assessed as an elopement risk care plan was assessed to include the following: Had the comprehensive care plan been developed; Did the residents care plan identify and include areas that pertain to the residents diagnosis; Did the care plan match the resident ' s needs; Were assistive devices in place per the residents plan of care; Was there evidence that the care plan reflected an interdisciplinary approach to the development of the care plan; Did the care plan identify the residents individualized goals, preferences and choices; Did the care plan clearly show a description of the action to be taken and by whom; Did the care plan contain some evidence of supporting or encouraging the individual to self-care/manage their well-being; Was there evidence that the care plan had been reviewed; Did the care and services provided reflect the residents current functioning status; Did the Kardex reflect the resident specific assistance needed to ensure care and services were provided? Continued review of the Audit tool revealed it was signed off and reviewed on 07/29/2021. 5. Review of facility's document, dated 07/02/2021, revealed the ARDCS went over the roles and responsibilities with the Administrator and DON. Further, the ARDCS went over the facility's goals, leadership, and management expectations. The QA Process and QAPI Program and audits were discussed. Continued review revealed the Administrator, DON, and ARDCS, signed the document on 07/02/2021. 6. Review of the Quality Assurance Committee Meeting Minutes, dated 07/29/2021 and 09/24/2021, revealed the committee reviewed elopement drills with no concerns identified. Review of the sign-in sheet revealed the Administrator, DON, Medical Director, ADON, Social Service, Dietary manager, Dietitian, Therapy, Maintenance, Environmental Services, Activities, Admissions, and MDS attended the meeting. 7. Review of the Facility Assessment revealed the QA Committee revealed the results of the audits. There were no changes on concerns identified. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Review of the New Admission worksheet revealed the residents were assessed to be an elopement risk and was care planned based on assessment. No concerns were identified. 9. Review of the Emergency Plan and Elopement Drills, dated 07/29/2021 and 09/24/2021, revealed no concerns identified. 10. Review of the document, dated 11/17/2021, revealed the Regional Director of Clinical Services met with the Regional [NAME] President to review the self-reportable incidents from the region. The Regional Director of Clinical Services advised that the DON and Administrator was expected to report any allegations to the Regional Director of Clinical and the Regional [NAME] President to meet regulations related to reporting. Further review of the document revealed the Regional [NAME] President and Regional Director of Clinical Services signed off on the document on 11/17/2021. 11 Review of the annual competencies form revealed the facility checked the competency of each staff in areas which included: resident rights, abuse, skin/wound care, medication management, and disaster planning. Continued review revealed staff were checked prior to the start of their shift. During an interview with the ARDCS, on 02/05/2024 at approximately 6:30 PM, she stated she reviewed the incident related to Resident #112's elopement and determined the facility needed additional training on the definition of elopement. She stated she retrained the Administrator, who left in November of 2021, and the DON. Further, she stated she put a Plan of Correction in place to address the concerns, with auditing the residents for changes in behaviors, assessing the residents to be an elopement risk, and updated the resident's care plans. Per the interview, she stated she audited the concern until the end of December. She further stated she had not had concerns with Resident #112 leaving the facility without staff supervision since 2021.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 43017 Based on interviews, record reviews, and facility document and policy review, it was determined the facility's governing body failed to ensure policies regarding the management and operation of the facility were implemented. The governing body was aware that on 05/09/2021, at approximately 6:00 PM, a resident whom the facility assessed to have moderate cognitive impairment left the facility and was missing. The facility failed to implement its missing resident protocol and notify the police of the missing resident. The governing body was aware that the facility concluded Resident #112 left against medical advice (AMA) and took no further action to find the resident. The police found Resident #112 along a highway (unknown location) on 05/10/2021 at approximately 10:00 AM, approximately eighteen (18) hours after the resident left the facility. Emergency Medical Services (EMS) transported Resident #112 to a local hospital for cold exposure. It was determined the provider's non-compliance with one or more requirements of participation had caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care were identified at 483.25, Free of Accidents Hazards and Supervision/F689. Additional IJ deficiencies were identified at 483.70 Administration; F835 and F837. The IJ began on 05/09/2021 at approximately 6:00 PM when Resident #112 exited the facility without the staff's knowledge. The facility was notified of the IJ and provided a copy of the IJ template on 02/02/2024 at 5:12 PM. A Removal Plan was requested. The findings include: A review of the facility's policy titled, Administrative Management (Governing Board), dated October 2017, revealed The governing board shall be responsible for the management and operation of the facility. 1. The facility's governing board is the supreme authority and has full legal authority and responsibility for the management and operation of our facility. The policy revealed, 3. The governing board is responsible for, but not limited to: a. Oversight of facility care and services in accordance with professional standards of practice and principles; and d. Establishment and ongoing review of all administrative programs governing facility management and operations, including: (3) Quality Assurance and Performance Improvement; and j. Establishment of a system whereby the Administrator reports to the governing body, including: (5) How the Administrator will be held accountable for facility management and operations. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of an undated facility policy titled Emergency Procedure - Missing Resident, revealed, Resident elopement resulting in a missing resident is considered a facility emergency. The policy revealed, 2. Staff will implement the protocol for missing resident upon discovering that a resident cannot be located. Further review of the policy revealed when a resident was missing 6. Initiate a thorough search by staff members to locate the resident. 7. If the search is unsuccessful after a period of ten (10) minutes, call the police to report the resident missing. The policy revealed, 11. Complete an incident report and follow the facility's incident reporting process. 12. Document the incident and events objectively in the resident record, including: a. Circumstances and precipitating factors. A review of Resident #112's Admission Record indicated the facility admitted the resident on 04/01/2021 with diagnoses that included acute kidney failure, stage 3 chronic kidney failure, cerebral infarction (stroke), muscle weakness, type 2 diabetes mellitus, cognitive communication deficit, major depressive disorder, varicose veins of the left lower extremity with an ulcer to the lower leg, essential hypertension, and heart failure. The Admission Record revealed the facility discharged Resident #112 on 05/09/2021 at 6:00 PM. The discharged to, Signature, and Personal Effects Sent With, sections of the form were not completed. A review of Resident #112's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/06/2021, revealed the resident had a Brief Interview for Mental Status (BIMS) score of ten (10), which indicated the resident had moderate cognitive impairment. The MDS revealed the resident required extensive assistance of one (1) staff member with dressing, toilet use, and personal hygiene; and required extensive assistance of two (2) or more staff members with transfers. The MDS revealed the resident was not steady and only able to stabilize with staff assistance when transferring from surface to surface and moving on and off the toilet. The MDS revealed the resident utilized a walker or wheelchair for mobility. A continued review of the MDS revealed the resident's overall expectation was to remain at the facility. A review of Resident #112's Care Plan revealed a Focus area initiated on 04/12/2021 that indicated the resident had cognitive impairment related to cognitive communication deficit. The facility developed interventions that directed staff to cue, re-orient, and supervise the resident as needed. Further review of Resident #112's Care Plan revealed a Focus area initiated on 04/02/2021 that indicated the resident needed assistance with activities of daily living (ADL) related to weakness. The facility developed interventions that directed staff to assist the resident with ambulation, locomotion, toileting, and transfers. A review of Resident #112's Care Plan revealed no documented evidence the facility planned for the resident to leave the facility or go to a local store without staff supervision. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of an undated facility document titled 5-Day revealed on 05/09/2021, Resident #112 went to a store and bought snacks at approximately 5:45 PM; when the resident did not immediately return, the weekend supervisor Registered Nurse (RN) #3 went to check on the resident. The report revealed that when RN #3 did not find the resident at the store, she notified the DON, who called the Administrator at approximately 6:04 PM. The facility document revealed the facility contacted the resident's family and notified them the resident had left. The document revealed the Administrator verified with the store's video footage that Resident #112 entered the store at approximately 5:45 PM and left at approximately 5:56 PM with a bag of groceries. According to the document, the resident's family member did not want to file a police report as they considered this normal resident behavior. The document revealed that on 05/10/2021 at 11:24 AM, approximately 18 hours after Resident #112 left the facility, the police were called, and a missing person report was filed. The document revealed that on 05/10/2021 at 12:02 PM, the resident's family arrived at the facility and notified them that the resident had been found and was in the emergency room (ER). There was no documented evidence the facility followed their Emergency Procedure - Missing Resident protocol that required staff to Initiate a thorough search for the resident and contact the police if the resident was not found within 10 minutes. A review of Resident #112's Emergency Department Encounter note dated 05/10/2021 at 11:18 AM revealed the resident presented to the Emergency Department (ED) via EMS with cold exposure. The note revealed the resident left the facility the night before at approximately 7:30 PM to go to the store without informing staff. The note revealed the resident got lost when trying to get back and ended up on the expressway. Continued review of the note revealed EMS found the resident that morning and stated the resident was out in the cold all night. The note revealed the first documented body temperature for Resident #112 was taken on 05/10/2021 at 2:45 PM, and the resident's body temperature was 99.2 degrees Fahrenheit (F). The ED record revealed the resident's diagnoses were chronic confusion, medically noncompliant, and non-intractable vomiting with nausea. A review of Resident #112's ED Laboratory Results report dated 05/10/2021 revealed the resident's blood glucose level was 250 milligrams per deciliter (mg/dL) and was documented as high. The report reference range for blood glucose was 74-99 mg/dL. During an interview with the Regional [NAME] President of Operations (RVPO) on 01/30/2024 at 11:56 AM, the RVPO stated they did not consider the 05/09/2021 incident as an elopement because Resident #112 was their own POA and was alert and oriented. He stated Resident #112 walked to a store located near the facility. The RVPO stated if a resident was alert, oriented, and responsible for themselves they were allowed to go to the store unsupervised. The RVPO stated when it was observed the resident was not in the facility, a staff member walked to the store to escort Resident #112 back to the facility; however, the resident refused to return to the facility. The RVPO stated the staff member waited at the door of the store for the resident, but the resident exited the store through a different door and left the grounds. The RVPO stated that since the resident had refused to return to the facility, they considered the resident to have left AMA. The RVPO stated they immediately notified the family and reported to the state agency on 05/11/2021 or 05/12/2021 that the resident left AMA, after an Adult Protective Services (APS) visit on 05/11/2021. During a follow-up interview on 02/02/2024 at 5:18 PM, the RVPO stated Resident #112 had a right to leave and stated the facility even went to the store to check on the resident. The RVPO stated they did not check on every resident who went to the store. The RVPO shook his head and stated he did not know why they checked on Resident #112. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility alleged removal of the immediacy of the IJ on 01/01/2022 as follows: 1. On 05/10/2021, Resident #112 was assessed using the Elopement Risk Assessment by Licensed Practical Nurse (LPN) #9. The resident was placed on 15-minute checks until he/she went to the hospital on 05/11/2021. The resident ' s care plan was updated. The resident has not had further elopements since 05/09/2021. 2. On 05/09/2021, the facility reviewed the State Operations Manual (SOM) and again on 02/03/2023, to go over the definition of elopement. The Interdisciplinary team (IDT), Administrator, Assistant Director of Nursing, Nurse Mangers, and Social Services reviewed the Wander Risk Assessment. Residents that were assessed to require a Wander-guard bracelet were placed in the binder located at each nursing station and front desk. Further, the residents assessed to be an elopement risk, care plans were updated. 3. On 05/10/2021, education began with all the facility staff. The Director of Nursing (DON) provided the education, and it was ongoing. Further, education was provided during all staff meetings on 09/2021 through 11/2021 after the Assistant Regional Director of Services identified potential issues and/or concerns during onsite visits through resident medical record audits and observations. Education that was included was on the Elopement Policy, Wandering, resident/resident representative expectations of signing out prior to resident leaving the facility, and missing resident protocol by the Administrator, DON, Nurse Managers, Social Workers, Admissions Staff, and Supervisors. 4. On 07/02/2021 through 07/27/2021, the Assistant Regional Director of Clinical Services assigned the Director of Clinical Services assigned the DON, Nurse Managers, Charge Nurses, and nurse supervisors, after completion of an onsite audit, to conduct an audit on wandering risk assessments. All residents were verified to have an updated risk assessment in their medical record. 5. On 07/02/2021, the Assistant Director of Clinical Services re-educated the DON and Administrator regarding their roles and responsibilities for following the facility's policies which included but was not limited to discharging against medical advice, elopement, and wandering oversight and supervision, QA process and QAPI Program. 6. On 07/29/2021 and 09/24/2021, the Quality Assurance and Performance Improvement meeting was held to review the facility's protocol and policy for elopement. The attendees included the Administrator, Medical Director, Director of Nursing, Assistant Regional Director of Clinical Services, Medical Records, Assistant Director of Nursing, Therapy, Housekeeping, and Activity Director. 7. On 07/29/2021 and 09/24/2021, the facility assessment was reviewed in the Quality Assurance Performance Improvement Committee to review the results of the audits and no changes were needed. Further, the QAPI committee reviewed any discharges or unplanned dischargers from 06/2021 through 12/2021, no concerns were identified. 8. On 08/01/2021, the DON, Nurse Manager, Supervisor or Charge Nurse evaluated all new admissions/re-admissions residents on admission to determine if a resident was triggered to be an elopement risk. The residents who triggered to be at risk for elopement would have a comprehensive person-centered care plan developed and implemented by the Minimum Data Set (MDS) nurse and IDT team, that included the resident's risk for elopement. If concerns were identified, it was discussed in the daily Interdisciplinary Plan of Care Meeting and the DON would report the concerns to the QAPI committee. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. During the month of August of 2021, the Assistant Regional Director of Clinical Services assigned the Director of Nursing and Administrator to conduct elopement drills. A total of 2 element drills were completed. All elopement drills were reviewed with the Assistant Director of Clinical Services, the Director of Nursing and Administrator. The Emergency Plan for locating a missing resident was reviewed by the Assistant Regional Director of Nursing and the Administrator on 09/24/2021, with no changes indicated. 10. On 11/17/2021, the Governing Body (Regional [NAME] President) received verbal education per the Regional Director of Clinical Services regarding expectations of self-reportable incidents including but not limited to elopements and elopement versus against medical advice. The Assistant Regional Director of Clinical Services and Assistant Regional Director of Clinical Services increased onsite facility visits to 2-3 days per week to ensure that facility Administration and staff were following the Elopement Policy and Procedures. 11. On 12/01/2021 through 12/31/2021, annual competencies were completed, which included but was not limited to elopements. All the new staff received Elopement training upon hire, during new hire orientation, by the staff development coordinator. Staff who had not received the training, to include the agency staff, prior to 12/31/2021 received training prior to the start of their shift by the nursing scheduler, staff development coordinator, nurse management team, or supervisor prior to the start of their shift. Further, self-reportable incidents was reviewed by the Regional Director of Clinical Services and/or Assistant Regional Director of Clinical services on site no later than 72 hours following the incident. The Assistant Regional Director of Clinical Services kept a log of all the self-reportable incidents and was reviewed monthly by the Administrator and the Regional [NAME] President. The State Agency validated the IJ Removal Plan as follows: 1. Review of Resident #112 Admission/Readmission Assessment revealed the resident was accompanied by the paramedics, by ambulance on 05/10/2021. Further review revealed the resident refused to be checked by staff for a skin assessment. Review of the resident's Baseline care plan revealed the resident's care plan was revised to include 15-minute checks and the care plan included the resident was at risk for elopement. 2. Review of the SOM documentation, dated 2021, revealed the facility reviewed the definition of elopement. Review of the elopement binder revealed the facility had placed all residents to be an elopement risk in the binder. 3. Review of the facilities education, provided by the facility revealed education was provided to all staff from 05/2021 to 11/2021. Education provided included Abuse, Wandering Residents, Behaviors, Customer Service, and Infection Control. Review of the facility's Wandering and Elopement policy, revised on 05/17/2020, revealed the facility defined elopement as an unsafe wandering and the facility strived to prevent harm while maintaining at the least restrictive environment for the residents. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of the QA Audit-Wander guard Tool, dated 07/02/2021, revealed the residents were audited to ensure the residents that were assessed as an elopement risk had an MD order, Wander guard Bracelet, updated care plan, TAR, and were in the elopement book/binder. No concerns were identified. Review of the Care Planning Audit Tool, dated 07/27/2021, revealed the residents who were assessed as an elopement risk care plan was assessed to include the following: Had the comprehensive care plan been developed; Did the residents care plan identify and include areas that pertain to the residents diagnosis; Did the care plan match the resident ' s needs; Were assistive devices in place per the residents plan of care; Was there evidence that the care plan reflected an interdisciplinary approach to the development of the care plan; Did the care plan identify the residents individualized goals, preferences and choices; Did the care plan clearly show a description of the action to be taken and by whom; Did the care plan contain some evidence of supporting or encouraging the individual to self-care/manage their well-being; Was there evidence that the care plan had been reviewed; Did the care and services provided reflect the residents current functioning status; Did the Kardex reflect the resident specific assistance needed to ensure care and services were provided? Continued review of the Audit tool revealed it was signed off and reviewed on 07/29/2021. 5. Review of facility's document, dated 07/02/2021, revealed the ARDCS went over the roles and responsibilities with the Administrator and DON. Further, the ARDCS went over the facility's goals, leadership, and management expectations. The QA Process and QAPI Program and audits were discussed. Continued review revealed the Administrator, DON, and ARDCS, signed the document on 07/02/2021. 6. Review of the Quality Assurance Committee Meeting Minutes, dated 07/29/2021 and 09/24/2021, revealed the committee reviewed elopement drills with no concerns identified. Review of the sign-in sheet revealed the Administrator, DON, Medical Director, ADON, Social Service, Dietary manager, Dietitian, Therapy, Maintenance, Environmental Services, Activities, Admissions, and MDS attended the meeting. 7. Review of the Facility Assessment revealed the QA Committee revealed the results of the audits. There were no changes on concerns identified. 8. Review of the New Admission worksheet revealed the residents were assessed to be an elopement risk and was care planned based on assessment. No concerns were identified. 9. Review of the Emergency Plan and Elopement Drills, dated 07/29/2021 and 09/24/2021, revealed no concerns identified. 10. Review of the document, dated 11/17/2021, revealed the Regional Director of Clinical Services met with the Regional [NAME] President to review the self-reportable incidents from the region. The Regional Director of Clinical Services advised that the DON and Administrator was expected to report any allegations to the Regional Director of Clinical and the Regional [NAME] President to meet regulations related to reporting. Further review of the document revealed the Regional [NAME] President and Regional Director of Clinical Services signed off on the document on 11/17/2021. 11 Review of the annual competencies form revealed the facility checked the competency of each staff in areas which included: resident rights, abuse, skin/wound care, medication management, and disaster planning. Continued review revealed staff were checked prior to the start of their shift. (continued on next page)

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the ARDCS, on 02/05/2024 at approximately 6:30 PM, she stated she reviewed the incident related to Resident #112's elopement and determined the facility needed additional training on the definition of elopement. She stated she retrained the Administrator, who left in November of 2021, and the DON. Further, she stated she put a Plan of Correction in place to address the concerns, with auditing the residents for changes in behaviors, assessing the residents to be an elopement risk, and updated the resident's care plans. Per the interview, she stated she audited the concern until the end of December. She further stated she had not had concerns with Resident #112 leaving the facility without staff supervision since 2021.