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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49044 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure proper placement of a stability boot for one (1) of thirty-one (31) sampled residents, Resident #68. The findings include: A review of a facility policy titled, Medication and Treatment Order, revised in July 2016, revealed Orders for medications and treatments will be consistent with principles of safe and effective order writing. A review of Resident #68's Admission Record revealed the facility admitted the resident on 06/15/2022. The Admission Record revealed the resident had diagnoses to include a fracture of the right fibula, fracture of the lateral malleolus (bone on the outside of the ankle) of the right fibula, and displaced fracture of medial malleolus of the right tibia. A review of Resident #68's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/03/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) of 0, which indicated the resident had severe cognitive impairment. The MDS revealed the resident required extensive assistance with personal hygiene. A review of an emergency department Encounter Summary, dated 12/26/2023 at 7:50 PM, revealed Resident #68 was seen for right foot pain/swelling. The Encounter Summary revealed a boot was placed on the resident. A review of Resident #68 Order Summary Report for active Orders as of 02/01/2024, revealed an order dated 12/27/2023, to remove the resident's boot every shift and check skin integrity. During an observation on 02/01/2024 at 1:26 PM, Certified Nursing Assistant (CNA) #36 and CNA #37 took Resident #68 into his/her room and pulled the resident's privacy curtain. CNA #36 pulled the resident's blanket back which exposed the resident's legs. The resident had a stabilizing boot on his/her left foot and no boot on their right foot. CNA #37 immediately identified the resident's boot was on the wrong foot. Once the staff transferred the resident back to bed, they placed the boot on the resident's right foot. During an interview 02/02/24 12:07 PM, Nurse Practitioner (NP) #38 stated the resident had a fracture of his/her right lower ankle and always wore the boot. NP #38 stated that she was made aware that staff had placed the boot on the resident's left foot. NP #38 stated that staff should ensure the boot was on the correct foot. She stated that the boot was for stabilization. During an interview on 02/06/2024 at 11:13 AM, Licensed Practical Nurse (LPN) #23 stated the nurse on the hall was responsible to make sure durable medical equipment (DME) was applied appropriately. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2024 at 11:52 AM, LPN #42 stated she believed Resident #68's physician orders instructed staff to remove the boot to check for skin integrity and indicated that it was the nurses' responsibility, not CNAs. During an interview on 02/06/2024 at 3:43 PM, the Director of Nursing stated when a resident had DME that required an order, the nurse needed to check every shift at least for skin integrity and placement.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46863 Based on interviews, record review, and facility policy review, it was determined the facility failed to ensure one (Resident #463) of five (5) sampled residents reviewed for advance directors, with physician's orders that accurately reflected the resident's code status. The findings included: A review of the facility's policy titled, Do Not Resuscitate Order, revised in [DATE], revealed, Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. A review of Resident #463's Admission Record revealed the facility admitted the resident on [DATE], with diagnoses that included metabolic encephalopathy, cognitive communication deficit, and unspecified dementia. A review of Resident #463's Resuscitation Designation Form dated [DATE], revealed the resident had the code of do not resuscitate and wished for cardiopulmonary resuscitation (CPR) not to be initiated in the event they were found without a pulse or respiration. A review of Resident #463's Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order, dated [DATE] and discussed with Resident #463's Power of Attorney (POA) and witnessed by two (2) individuals, revealed the resident wished not to be resuscitated. A review of Resident #463's Order Summary Report, for the time period [DATE] to [DATE], revealed an order dated [DATE], for the resident to have full code status (if a person's heart stopped beating and/or they stopped breathing, CPR should be initiated). A review of Resident #463's care plan, initiated on [DATE], revealed the resident had full code status. During an interview on [DATE] at 11;34 AM, Resident #463's POA stated the resident's code status was DNR. During an interview on [DATE] at 2:00 PM, the Administrator stated he deferred all questions regarding a resident's code status to nursing. During an interview on [DATE] at 2:35 PM, the Director of Nursing (DON) stated there should not be a discrepancy in Resident #463's code status. Per the DON, the physician's order, care plan, and designation form should all indicate the same information. The DON stated it was important to not have a discrepancy as in the event of an emergency, staff needed to know how to honor the resident's wishes.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28193 Based on observations, interviews, record reviews, and facility policy review, it was determined the facility failed to ensure proper respiratory care was provided to three (3) of five (5) sampled residents (Residents #62, #127, and #57) reviewed for respiratory care. The findings include: 1. A review of a facility policy titled Tracheostomy Care, revised in October 2023, revealed, The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. The policy further revealed, A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. The policy revealed the Procedure Guidelines for Preparation and Assessment included Check the physician order. The policy revealed it did not specifically address the proper storage of respiratory equipment, to include a suction machine. A review of Resident #62's Admission Record revealed the facility admitted the resident on 09/24/2018, with diagnoses that included tracheostomy (trach) status, atelectasis (complete or partial collapse of a lung), and severe morbid obesity with alveolar hypoventilation. A review of Resident #62's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/09/2024, revealed a Brief Interview for Mental Status (BIMS) of fifteen (15), which indicated the resident was cognitively intact. In addition, the MDS assessment revealed Resident #62 received tracheostomy care. A review of Resident #62's care plan revealed a Focus area, revised on 05/31/2024, that indicated Resident #62 had a tracheostomy related to chronic obstructive pulmonary disease (COPD), atelectasis, obstructive sleep apnea (OSA), simple chronic bronchitis, a history of pulmonary embolism, and indicated the resident had a #8 [NAME] Trach (a stainless-steel tracheostomy tube). A review of Resident #62's physician orders revealed an Active order for Trach Size, with a revision date of 04/21/2021. The order revealed there was no size specified in the order. Further review of Resident #62's physician orders revealed an Active order for an Ambu bag, supplemental oxygen, suction canister, and catheters to be in the resident's room at all times, with a start date of 07/18/2023. The orders also included an Active order to suction the trach as needed every six (6) hours, with a start date of 07/18/2023. Further review revealed an Active order for humidified oxygen at twenty-eight (28) percent (%) to trach, as needed, with a start date of 10/01/2021. On 01/31/2024 at 9:48 AM, an observation was made in Resident #62's room, which revealed one (1) extra tracheostomy tube taped to a wall. During an interview on 01/31/2024 at 2:01 PM with Licensed Practical Nurse (LPN) #45, she stated Resident #62 had an additional tracheostomy tube hanging on the wall by the resident's bed in case the current one came out, and additional tracheostomy supplies were in a central supply room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/31/2024 at 2:06 PM, the Central Supply (CS)/Certified Medication Technician (CMT) was asked to provide the additional tracheostomy tube used for a backup supply. The CS/CMT was observed looking around, and after approximately 60 seconds, the CS/CMT asked LPN #45 what size the tracheostomy tube was. LPN #45 stated that she was not sure and started helping the CS/CMT look at the supplies that were available. The CS/CMT stated she had ordered some supplies for Resident #62, but the resident had their tracheostomy tube changed recently, and the staff had used up the available supplies that she had. The CS/CMT stated that the only extra tracheostomy tube for Resident #62 that the facility had was the one that was taped to Resident #62's room wall. The CS/CMT stated she had ordered more. A copy of the invoice was requested but not received prior to exit. During an observation and interview on 02/02/2024 at 8:20 AM, in Resident #62's room, LPN #45 stated the suction machine should be covered up with plastic, and it was not; she stated that it was covered in a lot of dust, and she did not see the tubing for it. LPN #45 stated she was not sure how it was supposed to work. She stated she was not sure how long it had been in the resident's room or exactly why it was in there. She also verified there was no supplemental oxygen available in the room and had not been for quite some time. During an interview on 02/02/2024 at 8:27 AM, LPN #83 stated that when she worked with Resident #62, she only cleaned the inner cannula and around the opening and had never changed out the outer cannula. She stated that if the tracheostomy tube came out, she would call for help and have her supervisor come and do it because the outside was not supposed to come out. She stated an extra tracheostomy tube was hanging by the resident's bed. She further stated she had tracheostomy training during orientation but did not remember if she had to do a return demonstration. During an interview on 02/02/2024 at 11:55 AM, Nurse Practitioner (NP) #38 stated she was unfamiliar with tracheostomy care and could not say what supplies should have been kept at Resident #62's bedside. She stated suction equipment should be present but was unsure of the facility policy. NP #38 further stated that in an emergency, the staff would use the extra tracheostomy tube hanging on the resident's room wall. She stated that she was unsure how staff could order supplies without the tracheostomy tube size in the physician's order. NP #38 stated without the tracheostomy tube size in the order, if there was not an extra one at the bedside, Resident #62 could potentially die without the correct supplies. During the interview, NP #38 called Respiratory Therapist (RT) #26, who had come to the facility to care for Resident #62. During the phone interview, RT #26 stated Resident #62 started with a Shiley tracheostomy tube, then changed to a [NAME] tracheostomy tube, which was metal and caused the resident discomfort, so he had changed it to the current one, which had been in place for the last couple of years. RT #26 stated that Resident #26's outer cannula did not have to be replaced due to the age of the resident's tracheostomy. RT #26 stated the inner cannula had to be changed, and it should have been changed at least daily. RT #26 stated the suction machine in the resident's room should have been kept clean and ready to be used at all times. During an interview on 02/06/2024 at 2:35 PM, the Director of Nursing stated she noticed for Resident #62 that there was no size in the physician order. She stated she did not know how the size of the tracheostomy tube was not on the order for so long, and they did not catch it. She stated that she wanted the nurses to clean the suction machine, cover it when not in use, and keep the supplies accessible at the resident's bedside. She also stated they were lucky Resident #62's tracheostomy was stable, and they had not had any problems thus far, because no one, including herself, knew what size the resident's tracheostomy tube was. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/02/2024 at 2:00 PM, with the Administrator, he stated he would defer to nursing staff for respiratory care; however, he would expect them to follow their policies and physician's orders. 45555 2. A review of a facility policy titled CPAP [continuous positive airway pressure]/BiPAP [bilevel positive airway pressure] Support, revised in March 2015, revealed General Guidelines for Cleaning included 4. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. 5. Humidifier (if used): a. Use clean, distilled water only in the humidifier chamber. b. Clean humidifier weekly and air dry. 6. Filter cleaning; [sic] a. Rinse washable filter under running water once a week to remove dust and debris. Replace this filter at least once a year. 7. Mask, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. 8. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. A review of a facility policy titled Administering Medications through a Small Volume (Handheld) Nebulizer, revised in October 2010, revealed, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The policy revealed it did not include the proper cleaning or storing of nebulizer equipment. A review of Resident #127's Admission Record revealed the facility admitted the resident on 06/13/2022 with diagnoses that included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea (OSA) (disruption of breathing during sleep). A review of Resident #127's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/02/2023, revealed Resident #127 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had diagnoses including COPD and OSA. The MDS revealed the resident received respiratory treatments, including oxygen therapy and a non-invasive mechanical ventilator. A review of Resident #127's care plan revealed a Focus area initiated on 06/14/2022, that indicated the resident was at risk for respiratory complications related to COPD, sleep apnea, and a cough. The care plan revealed interventions included instructions for staff to use a CPAP machine (a type of non-invasive mechanical ventilator) as ordered, see a nurse for supplemental oxygen, use ear protectors on oxygen tubing, check placement of oxygen tubing every shift, elevate the head of the bed to decrease difficulty breathing and administer medication per physician orders. Further review revealed interventions included instructions for staff to observe, document, and report symptoms of respiratory distress and monitor, document, and report any signs and symptoms of respiratory infection to the physician as needed. A review of Resident #127's Order Summary Report for Active Orders As Of: 02/05/2024 revealed an order with a start date of 06/10/2023 for supplemental oxygen at four (4) liters per minute (LPM) via a nasal cannula continuous per concentrator/tank; and indicated that the resident may wear ear protectors if the resident preferred. Further review of the report revealed an order, dated 03/23/2023, that directed staff to change and date all respiratory supplies and tubing weekly on Sunday; if the oxygen concentrator is present, clean the filter every Sunday during the night shift. (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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #127's Order Details revealed an order dated 06/16/2022 that directed staff to clean the resident's CPAP/BiPAP mask with a moist wipe every day shift. A review of Resident #127's Order Details revealed an order dated 08/03/2022 that directed staff to clean the resident's CPAP/BiPAP with one-part white vinegar and three parts distilled water. The order directed staff to clean all parts, tubing, mask parts, the shell, pillows, and swivels, soak for 15 minutes, and rinse after disinfection. The order specified that the CPAP/BiPAP cleaning was to be completed every day shift starting on the 10th and ending on the 11th of every month. A review of Resident #127's Order Details revealed an order dated 06/16/2022 that instructed staff to fill the resident's CPAP/BiPAP with distilled water every Sunday on the night shift. A review of Resident #127's treatment administration record (TAR) for 01/01/2024 through 01/31/2024 revealed a transcription of an order for the use of a CPAP/BiPAP machine every night shift for sleep apnea. The TAR revealed staff documented that the CPAP/BiPAP machine was used all but one night (01/25/2024). The TAR revealed staff documented that they cleaned the CPAP/BiPAP on 01/10/2024 and 01/11/2024. The TAR revealed staff documented that the CPAP/BiPAP machine was filled with distilled water on 01/07/2024, 01/14/2024, 01/21/2024, and 01/28/2024. The TAR revealed staff documented that the CPAP/BiPAP mask was cleaned with a moist wipe all but one day (01/24/2024). Further review of the TAR revealed staff documented that all respiratory supplies and tubing were changed and dated on 01/07/2024, 01/14/2024, 01/21/2024, and 01/28/2024. A review of Resident #127's TAR for 02/01/2024 through 02/03/2024 revealed that staff documented that the resident's CPAP/BiPAP mask was cleaned with a moist wipe daily. The TAR revealed that staff documented the resident used their CPAP/BiPAP machine on the night shift on 02/01/2024 and 02/03/2024. The TAR revealed that staff documented that the resident received supplemental oxygen at 4 Liters Per Minute (LPM) via a nasal cannula continuous per concentrator/tank daily. An observation on 02/02/2024 at 1:39 PM revealed Resident #127 was lying in bed receiving supplemental oxygen; the concentrator was set at 2.5 LPM. The oxygen tubing was not dated. During an observation and interview on 02/03/2024 at 2:49 PM with Certified Nursing Assistant (CNA) #12, she confirmed that the resident's oxygen concentrator was set at 2.5 LPM. She stated she did not adjust the oxygen setting; she only applied the nasal cannula when needed. She stated she did not do anything with the resident's nebulizer machine and confirmed that the date on the tubing was 07/30/2023. CNA #12 stated she did not know how often the tubing should be changed. During an observation and interview on 02/03/2024 at 2:56 PM, LPN #39 confirmed that Resident #127's oxygen concentrator was set at 2.5 LPM. She stated she was unsure what it was supposed to be set at without looking at the physician's orders. LPN #39 confirmed the date on the nebulizer tubing was dated 07/30/2023. She stated the tubing and masks were supposed to be changed out weekly. During an observation on 02/04/2024 at 11:44 AM, Medication Aide (MA) #58 entered Resident #127's room to look for the resident's CPAP/BiPAP machine. MA #58 searched through all the nightstand drawers and found several CPAP/BiPAP masks but no tubing or the machine. MA #58 found the CPAP/BiPAP machine in the bottom of the resident's closet, with the tubing and mask still attached and covered in a thick layer of dust. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/04/2024 at 11:49 PM, LPN #39 stated she was not aware Resident #127 had a CPAP/BiPAP machine and stated that she thought it might have been discontinued or the resident was refusing it. After observing the condition of the machine, covered in dust, she stated it was not acceptable. She confirmed that the use of the CPAP/BiPAP machine and other orders related to the CPAP/BiPAP were being documented as though it was being used. During an interview on 02/06/2024 at 11:45 AM, the Director of Nursing (DON) stated nebulizer equipment should be wiped down and covered per the manufacturer's instructions; the mouthpiece should be rinsed, air-dried, and stored in a bag. She stated the equipment should be changed weekly. She stated that when a CPAP/BiPAP machine was not in use, the machine should be covered, and the mask should be wiped down and stored in a bag. The DON stated that Resident #127's CPAP/BiPAP had obviously not been in use. She stated, after speaking with the nurse, the CPAP/BiPAP should have been discontinued since the resident was not wearing it. During an interview on 02/06/2024 at 2:01 PM, the DON indicated that she expected staff to follow physician orders and check oxygen concentrator settings every shift. During an interview on 02/06/2024 at 12:15 PM, the Administrator stated he expected the staff to follow the facility's policy and procedures regarding respiratory care. He stated that staff should not be documenting that they were doing something if they were not. During a follow-up interview on 02/06/2024 at 12:50 PM, the Administrator indicated that he expected staff to follow physician orders. 3. A review of Resident #57's Admission Record revealed the facility admitted the resident on 11/15/2022, with diagnoses that included acute respiratory failure with hypoxia (lack of oxygen), chronic obstructive pulmonary disease (COPD) with acute exacerbation (sudden worsening of symptoms), and obstructive sleep apnea (OSA). A review of Resident #57's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/16/2023, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident's diagnoses included COPD and respiratory failure. The MDS revealed no respiratory treatments were performed during the assessment period. A review of Resident #57's care plan revealed a Focus area, with a revision date of 01/24/2023, that revealed the resident was at risk for respiratory complications related to COPD, sleep apnea, and shortness of air (SOA). The care plan revealed interventions included instructions for staff to elevate the head of the resident's bed to decrease difficulty breathing, administer medication per orders, observe, document, and report symptoms of respiratory distress, and monitor, document, and report to the physician any signs or symptoms of respiratory infection. A review of Resident #57's Order Details revealed an order dated 11/22/2022 for ipratropium-albuterol solution 0.5-2.5 (3) milligrams (mg) per 3 milliliters (ml), inhale 3 ml orally four (4) times a day for COPD. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/29/2024 at 12:29 PM revealed a nebulizer machine on Resident #57's nightstand with a nebulizer mask lying on top of the nightstand, and a plastic storage bag was lying next to it. An observation on 01/30/2024 at 10:47 AM revealed the nebulizer machine was on the nightstand with the mask lying on top of the storage bag. Dried debris was inside the mask, and fluid was observed in the medication chamber. An observation on 01/31/2024 at 9:26 AM revealed the resident's nebulizer machine was on the nightstand with the mask lying on top of the storage bag. Dried debris was in the mask, and fluid was in the medication chamber. An observation on 02/01/2024 at 10:24 AM revealed the resident's nebulizer machine was on the nightstand with the mask lying on top of the plastic storage bag. There was debris observed in the mask, and fluid was in the medication chamber. An observation on 02/02/2024 at 1:39 PM revealed the nebulizer machine was on the nightstand and the mask was lying on top of the plastic storage bag. Fluid was observed in the mask's medication chamber, debris was observed in the mask, and the tubing was not dated. During an observation and interview on 02/03/2024 at 2:49 PM, in Resident #57's room, CNA #12 confirmed that Resident #57's nebulizer equipment was not stored in a plastic bag. During an observation and interview on 02/03/2024, in Resident #57's room, LPN #39 stated that nebulizer equipment was supposed to be changed weekly, dated, and stored in a plastic bag when not in use. She confirmed that Resident #57's mask was not stored in a plastic bag. During an interview on 02/06/2024 at 11:45 AM, the Director of Nursing stated that a nebulizer machine should be wiped down and covered per the manufacturer. She indicated that nebulizer equipment should be rinsed, air-dried, and stored in a bag. She stated the equipment should be changed weekly. During an interview on 02/06/2024 at 12:15 PM, the Administrator stated he expected the staff to follow the facility's policy and procedures regarding respiratory care.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 37683 Based on observations, interviews, and review of the United States (U.S.) Food and Drug Administration (FDA) 2022 Food Code it was determined the facility failed to ensure 3 of 3 dumpsters were closed and the area around them was free of trash, and the elimination of debris prevented the potential for vermin and pest attraction. This had the potential to affect all 155 of 155 residents who resided in the facility. The facility failed to provide dumpters. The findings included: Review of Chapter 5. Water, Plumbing, and Waste, section 5-5 Refuse, Recyclables, and Returnables of the U.S. FDA 2022 Food Code, dated 01/18/2023, revealed, 5-501.15 Outside Receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. (B) Receptacles and waste handling units for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit. On 01/31/2024 at 1:36 PM, observation of the facility's dumpsters revealed there were three (3) dumpsters. The left dumpster was opened on both sides. This dumpster was identified as cardboard only, but it had a bag of rubbish that hung from the left side. The right dumpster was opened on both sides, as well as the lid. The rear dumpster was also opened on both sides. Additionally, there was debris and rubbish littered about the dumpster area, to include gloves, cigarette butts, one bottle of clinical cleanser, pieces of wood, pieces of cardboard, and pieces of plastic. On 02/01/2024 at 11:27 AM, observation of the facility's dumpsters revealed the left dumpster's lid was opened and although labeled cardboard only, contained trash. The right dumpster's lid was also opened, and the door on the left side was partially opened. The rear dumpster's left door was opened, and two (2) gloves were on the ground by the dumpsters. On 02/05/2024 at 11:00 AM, observation of the facility's dumpsters revealed the left dumpster's right door and lid were opened. The right dumpster's left door and lid were opened. The rear dumpster's left door was opened. The back dumpster lid was closed, but a bag of rubbish hung from the top of the dumpster, wedged between the dumpster and its lid. Additionally, there was rubbish littered around the dumpsters, including three (3) gloves, a soda can, a creamer packet, jam and peanut butter packets, and a plastic bag. During an interview on 02/05/2024 at 12:56 PM, Cook #24/Assistant Dietary Manager stated dietary staff were responsible for maintaining the dumpsters. Cook #24 stated trash should not be on the ground around the dumpsters, and the dumpster doors should be closed to prevent vermin from getting into the rubbish. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/06/2024 at 12:10 PM, the Dietary Director stated the dumpsters were the responsibility of the dietary department, but the Maintenance Director usually handled that responsibility. The Dietary Director confirmed the dumpster area should be clean from rubbish, and the dumpsters should be closed so as not to attract vermin. During an interview on 02/06/2024 at 12:36 PM, the Maintenance Director confirmed the dietary department was responsible for maintaining the dumpsters, but he thought it should be a responsibility of the maintenance department. During an interview on 02/06/2024 at 1:31 PM, the Director of Nursing (DON) stated that she did not know who was responsible for maintaining the dumpsters. The DON stated that opened dumpsters carried the risk of attracting animals. During an interview on 02/06/2024 at 3:38 PM, the Administrator stated the maintenance of the dumpsters was a responsibility of the dietary department, but maintenance and housekeeping staff were also at the dumpsters frequently. The Administrator stated the primary concern if the dumpsters were left opened was that they could attract animals.