STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185484	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Seasons at Alexandria	7341 E Alexandria Pike Alexandria, KY 41001

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46651 Based on observation, interview, record review, and review of the facility's policy, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs for five of five sampled residents, Resident (R) 4, R37, R38, R40, and R41. R4, who was left unsupervised outside in 90-degree weather for 30 to 45 minutes on 08/04/2024 required a transfer to the Emergency Department (ED) for evaluation of mental status changes and a temperature of 105 degrees Fahrenheit (F) and as of 08/07/2024, the resident had not yet returned to the facility. Review of R4's Comprehensive Care Plan (CCP) revealed no care plan interventions in place for supervision while he was outside. Additionally, it was reported by staff R4 went outside to the courtyard daily with R37, R38 and R40. R38, R40, and R41 were observed by the State Survey Agency (SSA) Surveyor outside the facility in the courtyard on 08/07/2024. However, review of CCPs for R37, R38, R40 and R41 revealed no interventions in place for supervision when outside. The facility's failure to have an effective system in place to ensure development and implementation of a comprehensive person-centered care plan is likely to cause serious injury, impairment, or death. Immediate Jeopardy (IJ) was identified on 08/09/2024 at 42 CFR 483.21 Develop and Implementation of a Comprehensive Person-Centered Care Plan (F656) with a Scope and Severity (S/S) of a J. The Immediate Jeopardy was determined to exist on 08/04/2024. The facility was notified of Immediate Jeopardy on 08/09/2024. An acceptable Immediate Jeopardy Removal Plan was received on 08/13/2024, which alleged removal of the Immediate Jeopardy on 08/14/2024. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 08/14/2024, prior to exit on 08/14/2024. Non-compliance remained in the areas of 42 CFR Comprehensive Care Planning (F656) at a Scope and Severity (S/S) of an E while the facility monitors the effectiveness of systemic changes and quality assurance activities. Refer to F689 The findings include: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Comprehensive Care Plans, copyright 2019 and dated as revised on 11/01/2023, revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. Further review of the policy defined person-centered care as the resident was the focus of control, and staff was to support the resident in making their own choices and having control over their daily lives. 1. Closed Record review of R4's Admission Record revealed the facility admitted R4 on 03/03/2022 with diagnoses of other sequelae following unspecified cerebrovascular disease. Further review revealed on 04/03/2024, muscle weakness and unsteadiness on feet were added, and on 06/05/2024, vascular dementia, mild, with mood disturbance was added. Review of R4's quarterly Minimum Data Set (MDS), Assessment Reference Date (ARD) of 06/20/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 11 of 15, indicating moderate cognitive impairment. Review of R4's CCP, initiated on 03/10/2023 for activities, revealed among other activities, R4 enjoyed the outdoors, and during his down time he enjoyed relaxing outdoors. Documented goals included active participation in at least three activity programs a week in one on one and/or group settings, and he would remain active with his daily routine by interacting with others, listening to music, reading, using the computer, drawing, painting, watching television, and watching movies throughout the week each week. Documented interventions included encourage family involvement, introduce to other residents with common interests, invite, remind, offer assist to and from group activities, offer materials and supplies for down time, praise for all positive responses, okay to participate in movement-based activity and work with staff to visit one on one engaging in activities of his interests. Further review of R4's CCP revealed no care plan for supervision when outdoors and no interventions in place for when R4 was outdoors. 2. Review of R37's Admission Record revealed the facility admitted R37 on 07/10/2023 with diagnoses of malignant neoplasm of the lung, chronic obstructive pulmonary disease (COPD), and atrial fibrillation. Review of R37's quarterly MDS, with an ARD of 07/06/2024, revealed the facility assessed R37 to have a BIMS score of 13 of 15, indicating R37 was cognitively intact. Review of R37's CCP, initiated on 07/14/2023 for activities, revealed among other activities, R37 enjoyed being outdoors. Documented goals included active participation in at least three group programs of interest a week and remaining active with her daily routine by interacting with others, watching television and movies, listening to music, and going outdoors throughout the week each week. Documented interventions included continue to encourage family involvement, introduce to others with common interests, invite, remind, and offer assist to and from group activities of interest every week, offer supplies and materials for down time, praise for all positive responses, and work with staff to assist with one-on-one visits engaging in activities of her interests. Further review of R37's CCP revealed no care plan for supervision when outdoors and no interventions in place for when R37 was outdoors. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/07/2024 at 3:25 PM with R37, she stated she thought staff checked on her and other residents every 30 minutes or so, when they were outside. 3. Review of R38's Admission Record revealed the facility admitted R38 on 06/10/2022 with diagnoses of type 2 diabetes with kidney complication, depression, and hypertension. Review of R38's quarterly MDS, with an ARD of 07/08/2024, revealed the facility assessed R38 to have a BIMS score of 13 of 15, indicating R38 was cognitively intact. Review of R38's CCP, initiated on 06/24/2022 for activities, revealed among other activities, R38 enjoyed going outdoors. Documented goals included active participation in at least three activity programs a week in a one-on-one setting and/or group programs, and remaining active with her daily routine by interacting with others, listening to music, going outdoors, watching television and movies throughout the week each week. Documented interventions included continue to encourage family involvement, introduce to others with common interests, invite, remind and offer assist to and from group programs, offer supplies and materials for down time, offer out of room for one-on-one visits, okay to participate in movement-based activity, praise for all positive responses, and work with staff to visit one-on-one engaging in activities of her interests. Further review of R38's CCP revealed no care plan for supervision when outdoors and no interventions in place for when R38 was outdoors. Observation on 08/07/2024 at 4:10 PM, revealed R38 was outside in the courtyard with R40 and R41. No staff was observed outside with the residents, and no staff was observed in the dining area near the windows that faced out into the courtyard. 4. Review of R40's Admission Record revealed the facility admitted R40 on 04/02/2019 with diagnoses of chronic kidney disease, heart failure, and peripheral vascular disease. Review of R40's annual MDS, with an ARD of 06/21/2024, revealed the facility assessed R40 to have a BIMS score of nine of 15, indicating R40 had moderately impaired cognition. Review of R40's CCP, initiated on 04/10/2019 for activities, revealed among other activities, R40 enjoyed sunbathing. Documented goals included remaining active with her daily routine by interacting with others and watching television throughout the week each week. Documented interventions included introduce to other residents with common interests, invite, remind, offer to assist to and from group programs of interest, offer materials, supplies for down time such as reading and listening materials, okay to participate in movement-based activity, praise for all positive responses, and work with staff to visit one-on-one engaging in activities of her interest once a week. Further review of R40's CCP revealed no care plan for supervision when outdoors and no interventions in place for when R40 was outdoors. 5. Review of R41's Admission Record revealed the facility admitted R41 on 11/09/2023 with diagnoses of Alzheimer's disease, dementia, and anxiety. Review of R41's quarterly MDS, with an ARD of 06/20/2024, revealed the facility assessed R41 to have a BIMS score of 12 of 15, indicating R41 had moderately impaired cognition. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R41's CCP, initiated 11/30/2023 for activities, revealed R41 enjoyed being outdoors and relaxing outdoors. Documented goals included remaining active with her daily routine by interacting with others, watching television, movies, reading, listening to music, throughout the week each week, and accepting and actively participating in at least three group programs of her interest a week. Documented interventions included continue to encourage family involvement, introduce to other residents with common interest, invite, remind, offer assist to and from group programs of her interest once a week, offer materials, supplies for down time, praise for all positive responses, and work with staff to assist with one-on-one visits engaging in activities of her interests. Further review of R41's CCP revealed no care plan for supervision when outdoors and no interventions in place for when R41 was outdoors. During an interview on 08/07/2024 at 3:33 PM with R40 and R41, both stated they were unsure of how often staff checked on them while they were outside in the courtyard. During an interview on 08/07/2024 at 3:10 PM with STNA40, she stated she had been at the facility since 04/2023. STNA40 stated instructions for resident care and resident tasks to be completed were on the nurse aide Kardex (care plan), which was where she did her charting. STNA40 stated staff knew to check on R4 and any other residents outside in the courtyard, but it was not documented anywhere. During an interview on 08/07/2024 at 3:37 PM with Licensed Practical Nurse 4 (LPN4), she stated when she started to work at the facility, she asked about a policy for supervision of residents in the courtyard and/or any temperature restrictions for allowing residents outside and was told nothing was set in stone. During an interview on 08/09/2024 at 1:34 PM with the MDS Nurse, she stated she had worked for the facility for three months and had been doing MDS for five years. The MDS Nurse stated the admitting nurse, clinical coordinators or the MDS Nurse usually initiated the baseline care plan, and then it was reviewed by the Interdisciplinary Team (IDT) and was in place within 48 hours of admission. She stated the CCP was due within 28 days of admission but was usually completed within 14 days when the MDS admission assessment was due. She stated care plans should be person-centered and specific to the resident. She further stated if there were cognitive or mobility changes for a resident, then the care plan might need to be updated for increased supervision but that would be communicated between on-coming and off-going shift staff. She stated, if it was determined a resident needed increased checks, then the resident's care plan would need to be revamped. For outdoor supervision, the MDS Nurse stated she had no concrete regulatory answer for that, it would be individually based, and taking care of humans was unpredictable, and they had a choice. She stated the facility was the residents' home, they had rights, and were allowed to make bad decisions. However, she stated she would take each patient [resident] day by day and if a resident was outside, she would communicate that to staff to ensure the resident was being monitored every 15 to 20 minutes. She stated, if she felt like the resident was not safe, she would increase monitoring and that would be reflected on the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 08/08/2024 at 10:50 AM and an in-person interview on 08/09/2024 at 10:35 AM with Clinical Coordinator 1 (CC1), he stated there was no official care plan for supervision policy for residents in general or in the courtyard, but staff should lay eyes on residents in the courtyard every 15 minutes, so they could immediately respond to any distress. CC1 further stated there were only two patients he knew of that liked to go out in the courtyard, and they both had to be able to self-propel in the wheelchair. He stated those residents were R4 and R40. During an interview on 08/08/2024 at 8:51 PM with the DON he stated there was no facility policy for supervision of residents or care planning for the supervision of residents in the courtyard/outside or for the rounding on residents in general. He stated it was the facility's practice to have eyes on all residents throughout the shift. The DON further stated the practice for the courtyard was if a resident wanted to go outside, they were reminded to take a drink with them, and if it was hot, it was discussed with them, and an agreement was come to about how long they would stay out. The DON stated, at this point, the incident with R4 was viewed as a one-time occurrence, but the facility was discussing practice changes for the future. During an interview on 08/09/2024 at 11:15 AM with the Administrator, she stated residents were not specifically planned for independent activities, but activities that required an assist would be documented in the Activities of Daily Living (ADL) care plan and would be triggered to carry over to a STNA task on the resident's Kardex. The Administrator stated there was no specific care plan for being outdoors. She then stated she would possibly expect a care plan could be developed for every resident who was outside, but signing off for every 15 minute checks would be unrealistic. The Administrator stated residents that were outside needed to be supervised, and the facility processes needed to be reviewed and then implemented and would be going forward.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 46651 Based on observation, interview, record review, review of the website localconditions.com, review of the website my.clevelandclinic.org, and review of the facility's policy, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of five sampled residents, Resident (R) 4. On 08/04/2024, R4 was assisted outside in his wheelchair by State Trained Nurse Assistant (STNA) 40 and was left unattended in 90 degree Fahrenheit (F) weather for 30 to 45 minutes. R4 required transfer to the Emergency Department (ED) for evaluation of mental status changes, a temperature of 105 degrees F, and as of 08/07/2024, the resident had not yet returned to the facility. The facility's failure to have an effective system in place to ensure residents received adequate supervision to prevent accidents is likely to cause serious injury, impairment, or death if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 08/09/2024 at 42 CFR 483.25 Accidents and Supervision (F689) with a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Accidents and Supervision (F689). The Immediate Jeopardy was determined to exist on 08/04/2024. The facility was notified of Immediate Jeopardy on 08/09/2024. An acceptable Immediate Jeopardy Removal Plan was received on 08/13/2024, which alleged removal of the Immediate Jeopardy on 08/14/2024. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 08/14/2024, prior to exit on 08/14/2024. Non-compliance remained in the areas of 42 CFR 483. 25 Accidents and Supervision (F689) at a Scope and Severity (S/S) of a D, while the facility monitors the effectiveness of systemic changes and quality assurance activities. Refer to F656 The findings include: Review of the facility's policy titled, Accidents and Supervision, implementation date 10/07/2020, revealed the residents' environment would remain as free of accidents and hazards as was possible; and each resident received adequate supervision and assistive devices to prevent accidents which included identifying hazards and risks, evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness, and modifying interventions when necessary. Closed record review of R4's Admission Record, revealed the facility admitted the resident on 03/03/2022 with diagnoses of other sequelae following unspecified cerebrovascular disease. Further review revealed on 04/03/2024, muscle weakness and unsteadiness on feet were added, and on 06/05/2024, vascular dementia, mild, with mood disturbance was added. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/20/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 11 of 15, indicating moderate cognitive impairment. Review of R4's Comprehensive Care Plan (CCP), initiated on 03/10/2023, for activities, revealed among other activities, R4 enjoyed the outdoors, and during his down time he enjoyed relaxing outdoors. However, further review of R4's CCP revealed no care plan for supervision when outdoors and no interventions in place for when R4 was outdoors. Review of R4's Progress Note, dated 08/04/2024 at 3:55 PM by Licensed Practical Nurse (LPN) 4, revealed that afternoon R4 had requested to be taken outside to sit with peers and was outside approximately 30-45 minutes. Staff went to check on R4 because he was no longer under the shaded area, and he was noted to be non-verbal and was unable to be aroused with stimuli. Per the note, R4 was taken into the facility, and he had an axillary temperature of 105.0 degrees F. The note stated ice packs were immediately placed under R4's arms, groin, and neck, and R4 was assisted to bed. Per the note, R4's blood pressure (B/P) was 122/76; pulse (P) was 115 beats per minute (BPM), (normal 60 to 100 BPM), oxygen saturation was 92 percent (normal 95 to 100 on room air) and respirations (R) were 16. The note stated LPN4 continued to attempt to stimulate R4 via sternal rub with minimal response, and an oral temp of 102.0 degrees F was obtained. Per the note, a call was placed to R4's provider to advise and request orders to transfer him to the ED for evaluation related to his status; orders were obtained; and 911 was called at 3:40 PM. Further review of R4's Progress Note, dated 08/04/2024 at 3:55 PM by LPN4, revealed she then returned to R4's bedside with a nursing assistant (not specified). Per the note, R4 had started to arouse, with his eyes opened, and he verbally responded to voice commands. The note stated R4 was then advised that he was going to be transported to the hospital for evaluation. At 3:50 PM, per the note, EMS arrived for transport, and EMS staff was made aware R4's provider had advised that he be transported to the ED. The note stated LPN4 would be calling R4's son and the hospital to give report on R4. Review of the website localconditions.com for the weather conditions at the facility, on 08/04/2024 at 2:00 PM-4:00 PM (the timeframe R4 was alleged to have been outside), revealed the temperature ranged from 89. 6 degrees F to 91.4 degrees F with an Ultraviolet Light (the light from the sun which could cause sunburn) Index of moderate to high. Review of the website my.clevelandclinic.org, information last reviewed 09/13/2021, revealed heatstroke was defined as a life-threatening condition when body temperature rose above 104 degrees F. Symptoms could include confusion, seizures, or loss of consciousness. If left untreated, heatstroke could cause organ failure, coma, or death. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R4's Emergency Medical Service (EMS) Ambulance Run document titled, [NAME] Fire Rescue Patient Care Record, Incident #2400001422, dated 08/04/2024, revealed EMS arrived on the scene at 3:46 PM. Per the document, R4's chief complaint was described as lethargic, the primary impression was generalized weakness, and the secondary impression was dehydration. R4's signs and symptoms were drowsiness, dehydration, stupor or semicoma, weakness, and his acuity was emergent. Further review revealed at 3:56 PM, R4 was alert with a B/P of 110/71, P of 95, R of 18, oxygen saturation of 93 percent, and a blood glucose level of 102 (normal 70-110). R4's Glasgow Coma Scale (GCS) Score was 12 of 15 (the Glascow Coma Scale was used to rate a patient's level of consciousness by evaluating their eyes, speech, and motor skills. Scores could range from 3 to 15 with 3 being the lowest and 15 being the highest, and were used to determine the severity of a traumatic brain injury. A score of 9 to 12 could indicate the possibility of moderate traumatic brain injury). Further review revealed R4 arrived at the ED at 4:10 PM. Review of R4's ED Flowsheet revealed his temperature at 4:20 PM was 99.4 degrees F. Review of R4's Emergency Department-Hospital Admission/ED Provider Note (EDHAPN), dated 08/04/2024, by Emergency Department Physician 1 (P1), revealed the reason for R4's visit was altered mental status. The note stated, per report from the facility, R4 had been taken outside at 2:30 PM, was at his baseline, which included some confusion, and was outside for approximately 45 minutes. Per the note, the facility had also reported when R4 was checked on, he was unresponsive and noted to have a temperature of 102.7 degrees F. Upon the arrival of EMS, R4 was responsive, appropriate, and blood glucose level was 102. Further review revealed given the concern for syncope with recovering heatstroke, R4 would be admitted to the hospital for further evaluation and management with a diagnosis of altered mental status. Additional review of R4's EDHAPN, under the History and Physical Notes, dated 08/04/2024 and written by Physician 2 (P2) revealed R4's chief complaint was altered mental status. The EDHAPN also revealed R4 had an active hospital problem of acute metabolic encephalopathy (a serious medical condition that occurred when the body lacked oxygen, glucose, or vitamins) and suspected heatstroke. The EDHAPN revealed R4's Computed Tomography (CT) scan of the head, CT of the cervical spine, and Chest Xray were reviewed with a notation to check magnetic resonance imaging (MRI) of the brain, serum creatine kinase (CK), urinalysis (UA), with gentle infusion of intravenous fluids (IVF), and monitor temperature. Review of the facility's Investigation Report, dated 08/05/2024 and attached to the Long-Term Care Self-Reported Incident form, revealed, on 08/04/2024, R4 requested to go outside into the secured courtyard to visit with friends. Staff interviews revealed it was evident R4 routinely spent time in the secured courtyard, and his care plan indicated relaxing outside was part of R4's daily routine. Per the report, STNA40 assisted R4 to the courtyard awning as he requested. The report stated, in interviews with STNA40 and LPN4, on 08/05/2024, they stated R4 was outside for around 45 minutes on 08/04/2024, and he routinely visited residents from neighboring units in the courtyard and was able to self-propel his wheelchair and signal to staff when he was prepared to come back inside. Further review revealed STNA40 and LPN4 stated they were able to see R4 while they were at the nurse's station and while in the dining room. Per the report, LPN4 stated at one point she looked outside and saw R4 propelling his wheelchair toward the unit doors, and he got caught on a grassy patch. LPN4 then requested STNA40 go and make sure R4 could continue to self-propel on the grass. STNA40 reported she went to R4, and he told her, Its hot out here. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the facility's investigation, dated 08/05/2024, revealed STNA40 stated she asked R4 to lift his feet so she could propel him back into the building, and R4 became unresponsive. STNA40 summoned LPN4, and they brought him back into the building, and his temperature was elevated. Per the report, LPN4 placed cool packs on R4's groin, axilla, and head; assisted him to bed; and called the Nurse Practitioner (NP) who advised LPN4 to send R4 to the ED for further evaluation. Additional review revealed R4 arrived at the hospital with a temperature of 98.2 degrees F, and he was admitted with a diagnoses of mental status change. Per the report, review of R4's hospital notes on 08/04/2024, revealed R4's son requested an Adult Protective Services (APS) referral citing the facility's neglect of R4. Further review of R4's EDHAPN's Provider Progress Note, dated 08/06/2024 by Physician 3 (P3), revealed R4 was awaiting transfer to a different nursing facility at the request of his son. During an interview on 08/07/2024 at 3:10 PM with STNA40, she stated she was not taking care of R4 on 08/04/2024, but at approximately 2:00 PM, she walked past R4, and he asked to be taken outside. She then stated she wheeled R4 out into the courtyard in his wheelchair and positioned him under an awning. STNA40 stated R4 went outside nearly every day as long as it was not cold or raining, was usually fine on his own, and would wave at staff or knock on the door when he wanted to come back inside. She also stated she did not tell any other staff she had taken R4 outside, returned to caring for her assigned residents, and did not check on R4 again. STNA40 stated about 45 minutes later, LPN4 asked her to go bring R4 inside because it appeared his wheelchair was off the concrete path. STNA40 stated R4 said to her damn, it's hot when she went to get him. She stated, after she brought R4 inside, he would not move his legs when she asked him to, and he then became unresponsive. She then stated LPN4 took R4's temperature, and it was 105 degrees F under his arm (axillary). STNA40 stated she and LPN4 put R4 in his bed, placed gloves packed with ice on him and a baggie with ice behind his neck, and his temperature went down to 103 degrees F. She stated EMS arrived, and about five to 10 minutes after that, R4 woke up. STNA40 stated staff knew to check on R4 and any other residents outside in the courtyard, but it was not documented anywhere. During an interview on 08/07/2024 at 3:37 PM with LPN4, she stated if she was the staff to let a resident outside, she set her watch alarm for every 15 minutes to monitor the resident. She stated she would only leave a resident unattended if they were able to self-propel their wheelchair or ambulate independently. She also stated most residents in a wheelchair could wheel themselves to the door and knock when they needed something. LPN4 stated that was what usually happened with R4, but on the day of the incident, she did not know R4 had been taken outside until she looked out the window and saw what appeared to be the wheel of his wheelchair caught in between the grass and the concrete, and R4 attempting to use his left arm to move the wheelchair wheel. LPN4 then stated she asked STNA40 to go check on R4 because she feared the wheel of the wheelchair had gotten caught on the grass and would cause him to tip over. LPN4 then stated STNA40 brought R4 in and came to get her for help with R4, stating R4 would not move his legs. LPN4 then stated upon R4's being brought inside, he was unresponsive to verbal and painful stimuli, his temperature was assessed to be 105 degrees F, and R4 was sent to the ED for evaluation. LPN4 stated she asked about a policy for supervision of residents in the courtyard and/or any temperature restrictions for allowing residents outside and was told nothing was set in stone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185484	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Seasons at Alexandria	7341 E Alexandria Pike Alexandria, KY 41001

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 08/08/2024 at 10:50 AM and an in-person interview on 08/09/2024 at 10:35 AM with Clinical Coordinator 1 (CC1), he stated he had been at the facility for [AGE] years. He stated he was contacted by LPN4 on 08/04/2024 informing him that R4 was being sent to the hospital for mental status changes, but CC1 was not sure what time that was. CC1 stated he was not in the facility at the time and was not made aware of the specifics of the incident until the next day when he received an e-mail from the Director of Nursing (DON). CC1 stated there was no official supervision or care plan policy for residents in the courtyard, but staff should lay eyes on residents in the courtyard every 15 minutes so they could immediately respond to any distress. During an interview on 08/08/2024 at 8:51 PM with the DON, he stated he became aware R4 had been transferred to the ED for a medical condition on 08/05/2024 via a text message from CC1. The DON stated weekend staff on call was on a rotation, and he was not generally made aware of medical events but was made aware of falls with an injury and abuse allegations. The DON then stated there was no facility policy for supervision of residents or care planning for the supervision of residents in the courtyard/outside or for the rounding on residents in general. The DON stated it was facility practice to have eyes on all residents throughout the shift. The DON further stated the practice for the courtyard was if a resident wanted to go outside, they were reminded to take a drink with them, and if it was hot, it was discussed with them, and an agreement was made about how long they would stay out. The DON stated at this point, the incident with R4 was viewed as a one-time occurrence, but the facility was discussing practice changes for the future, but no policy changes had been implemented yet. During an interview on 08/07/2024 at 2:52 PM with the Administrator, she stated staff visually checked on residents that were outside, and R4 would usually take a soda or a popsicle out with him. She stated there was no formal policy on the practice of a resident going out in the courtyard/outside, but it was common practice for staff to do visual 15 minute checks on residents and offer drinks or popsicles when they were outside, but this was not documented. During an additional interview on 08/09/2024 at 11:15 AM with the Administrator, she stated residents that were outside needed to be supervised, and the facility processes needed to be reviewed and then implemented.