STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185486	A. Building B. Wing	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boonespring Transitional Care Center, LLC	10250 US Hwy 42 Union, KY 41091

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43694 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to develop and/or implement comprehensive care plans for five (5) of forty-eight (48) sampled residents, Resident #4, #89, #105, #106, and #229. 1. Resident #229's care plan had interventions to monitor the resident for altered cardiopulmonary status, complete respiratory evaluations as needed, notify the physician of significant changes, have the resident wear oxygen as ordered, and for staff to encourage the resident to refrain from smoking. However, the night of 02/04/2024 the resident experienced an untoward respiratory event which was not documented, and the physician was not notified. In addition, the resident was not wearing his/her oxygen. The resident was sent to the hospital on 02/05/2024 because of this. In addition, per interview with Family Member #1 and State tested Nurse Aide (STNA) #3 and #8, Resident #229 went outside to smoke and was assisted by staff members to do so. 2. Resident #4 had a gastric feeding tube which was dislodged on 12/08/2023. However, the resident's care plan did not have interventions developed as precautions for preventing dislodgement of the tube. 3. Resident #106 had a history of childhood abuse and trauma. However, the resident's care plan did not include any interventions related to Resident #106's distress during incontinence care. 4. Resident #87 was observed with cigarettes and a lighter in his/her possession. Resident #87 stated staff assisted residents outside to smoke, and he/she sometimes smoked at the top of the wheelchair ramp by the door because he/she could not make it all the way out to the staff smoking area. However, Resident #87's care plan was not developed for interventions to address the resident's behavior problem of noncompliance related to smoking, including interventions to reduce the resident's desire to smoke. 5. Resident #105, per interviews with State tested Nurse Aide (STNA) #8 and Resident #87, was assisted to go outside to smoke. However, Resident #105's care plan revealed staff were to encourage the resident to refrain from smoking (initiated on 01/09/2023). 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Care Planning, dated January 2019, revealed the policy was to provide resident/patient centered care aiming to provide individualized Comprehensive/Interdisciplinary Care Plans for each resident/patient. Continued review revealed a care plan was developed to identify strengths or possible barriers to guide the resident in reaching their maximum functional level while encompassing a holistic approach including medical, nursing, psycho-social, nutritional, activities, therapy, spiritual and education interventions. Further review revealed the ultimate objective was to assist the resident in meeting his/her personal goals, with an optimal functioning level and a more fulfilled/enhanced quality of life. Additional review revealed the care plans were updated as needed following the Resident Assessment Instrument (RAI) manual and according to the changing needs of the resident. Review of the facility's policy, Quality of Care-Care Planning, dated 10/2022, revealed the facility was to assess each resident for a history of trauma, including surviving physical and sexual abuse. Further review revealed the facility was to collaborate with the resident and his/her family to identify potential triggers and develop a resident-centered care plan to avoid re-traumatizing the resident. 1. Review of Resident #229's Face Sheet revealed the facility admitted the resident on 07/01/2021 with diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, emphysema, and acute respiratory failure. Review of Resident #229's Admission Assessment completed on 02/01/2024 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), signifying the resident was cognitively intact. The facility did not identify the resident with any behaviors or any upper/lower extremity impairments. It was noted Resident #229 used a walker with supervision and a wheelchair independently for ambulation. Per the assessment, the resident required supervision and/or touch assistance for all Activity of Daily Living (ADL) care. Review of Resident #229's Physician's Orders, dated 01/26/2024, revealed Resident #229 was on oxygen via nasal cannula with an oxygen flow of 2.5 liters (L) per minute. Review of Resident #229's Comprehensive Care Plan (CCP), revealed the facility failed to provide a copy of the care plan with all dates as requested and provided a care plan without any dates to show when focus areas and/or interventions were created or revised. Per the care plan, staff members were to monitor the resident for altered cardiopulmonary status related to COPD and shortness of breath, complete respiratory evaluations as needed, and notify the physician of significant changes. The only documentation on the care plan for oxygen was oxygen as ordered. The care plan also had an intervention for staff to encourage the resident to refrain from smoking. In an interview with Registered Nurse (RN) #1 on 02/09/2024 at 12:26 PM, she stated during report on 02/05/2024 at 7:00 AM, RN #2 informed her Resident #229 had an episode during the night in which the resident removed the oxygen cannula, and his/her oxygen saturations dropped to sixty (60) percent. RN #1 stated RN #2 did not document his findings or contact the physician. RN #1 stated at the start of her shift, she went to check on Resident #229 and found the resident slumped over in his/her bed, and the resident's oxygen flow had been moved up to four (4) liters (L) per minute, but RN #2 had not reported that. She stated Resident #229 was taken to the hospital. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #229's Emergency Department (ED) provider note, dated 02/05/2024, revealed the resident's daughter informed the ED the resident was found down around 8:00 AM, no oxygen, and it was unknown how long the resident had been down. The note also stated Resident #229 had wheezing present, decreased airflow, and scattered wheezes. The ED report noted the ED Clinical Impression was delirium (primary encounter diagnosis), elevated troponin, and COPD. In an interview with Licensed Practical Nurse (LPN) #1 on 02/09/2024 at 3:05 PM, she stated she looked at the care plan if she thought something changed in the resident's care. She said the purpose of the care plan was for staff to know how to provide care for the resident. She stated if the care plan was not followed a resident could get hurt and things could be missed. She stated if Resident #229 removed his/her oxygen, it should have been documented. She also stated that might have been added to the care plan. She stated documentation was important because it informed other staff of what took place. In an interview with Registered Nurse (RN) #3 on 02/09/2024 at 8:20 PM, she stated if she was not sure something needed to be care planned she would double check with the Director of Nursing, (DON). She stated the care plan explained how to care for residents and needed to be specialized for each resident. She stated if a resident had specific oxygen needs that should have been care planned. In an interview with Minimum Data Set (MDS) Coordinator #1 on 02/12/2024 at 6:10 PM, she stated if a resident had a history which required him/her to wear oxygen that should be care planned. She stated if a resident refused to keep his/her oxygen on, that should be care planned. In an interview with Family Member #1 of Resident #229 on 02/16/2024 at 2:00 PM, she stated she knew the resident smoked on facility property. She also said the resident told her staff helped him/her get out to smoke and assisted residents who needed help. In an interview with STNA # 3 on 02/13/2024: 1:25 PM, she stated Resident #229 was a smoker and went outside the facility during the day and during the evening to smoke. She stated she never intervened to stop the resident because it was her understanding it was okay for residents to smoke. In an interview with STNA #8 on 02/12/2024 at 6:20 PM, she stated Resident #229 went outside to smoke, and staff assisted the resident getting out to smoke (she was unable to name staff members). She stated Resident #229 always had his/her oxygen when he/she was outside smoking. 2. Review of Resident #4's Face Sheet revealed the facility admitted the resident on 01/22/2021 with diagnoses including dysphagia (difficulty swallowing), hemiplegia (paralysis of one side of the body), and anxiety. Review of Resident #4's Annual Minimum Data Set (MDS) Assessment, dated 12/28/2023, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fourteen (14) of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as requiring a feeding tube for more than half of his/her caloric intake during the look-back period. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's Care Plan, dated 01/22/2021, revealed the facility assessed the resident as requiring tube feedings due to dysphagia (swallowing difficulty). Further review revealed the facility included interventions for tube feeding care such as verification of placement before feedings and monitoring for dislodgement. However, the care plan did not specify precautions for preventing dislodgement of the tube. In an interview on 02/15/2024 at 8:09 AM, Registered Nurse (RN) #5 stated that early in the morning of 12/08/2023, STNA #9 came and told her that Resident #4's tube fell out during a briefs change. However, RN #5 stated the tube could not have fallen out because the tube was in correct placement when she assessed it earlier in the shift. RN #5 further stated when she assessed the gastric tube after the aide's report, she found the tube in the floor with the balloon anchoring device still inflated. RN #5 stated she was not sure without looking at it, but she would expect relevant precautions for feeding tube care to be included on the care plan. Interviews were attempted with STNA #9 on 02/15/2024 at 8:26 AM and at 9:04 PM and on 02/16/2024 at 5:57 PM with messages left. However, no attempts were successful. In an interview on 02/15/2024 at 1:55 PM, State tested Nurse Aide (STNA) #14 stated communication regarding the resident's needs was inconsistent at the facility. She further stated there was nothing on Resident #4's aide Kardex (care plan) about precautions to take with his/her feeding tube. STNA #14 stated she had seen Resident #4's feeding tube become tangled in his/her blankets, and it could have become dislodged if she had not been paying attention. Additionally, STNA #14 stated she did not know if Resident #4's care plan described interventions for prevention of tube dislodgement. 3. Review of Resident #106's Face Sheet revealed the facility admitted the resident on 01/16/2023 with diagnoses including unspecified dementia, insomnia, and unspecified disorientation. Review of Resident #106's Annual Minimum Data Set (MDS) Assessment, dated 12/14/2023, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident was not able to complete the interview. Further review revealed the resident had disorganized thinking, irrelevant conversation, and illogical flow of ideas. Continued review revealed the facility assessed the resident as always incontinent and dependent on staff for toileting, showering, and personal hygiene. Review of Resident #106's Care Plan, dated 02/13/2024, revealed the facility failed to identify the resident as having a childhood history of abuse with the potential to affect his/her care in the facility. Further review revealed the facility assessed the resident as having a behavior problem related to dementia and disorientation but failed to include resident-centered interventions that addressed the cause of Resident #106's agitation. Continued review revealed the facility failed to include any interventions related to Resident #106's distress during incontinence care prior to the State Survey Agency (SSA) team's entrance on 02/12/2024. Review of the facility's document Social Service Assessment and History, dated 01/23/2024, revealed no questions about a history of trauma nor any information about triggers that could re-traumatize the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/13/2024 at 1:08 PM, Resident #106's resident representative stated the resident had experienced sexual abuse as a child, which caused him/her to become combative and anxious when staff performed incontinence care. Resident #106's resident representative stated he had told some aides about the resident's history of trauma, but he did not believe the aides communicated this to be included in the care plan because new staff members were never aware of Resident #106's history when he told them. In an interview on 02/15/2024 at 9:25 AM, State tested Nurse Aide (STNA) #14 stated she had no way of knowing if Resident #106 had a history of trauma or if that affected the resident's reactions to caregiving activities. STNA #14 stated Resident #106 would become agitated during incontinence care, and the only intervention she had found to help was to tell the resident they needed to take care of the water. Per interview, STNA #14 did not know what interventions were described in Resident #106's care plan. In an interview on 02/16/2024 at 8:19 AM, Registered Nurse (RN) #12 stated Resident #106 became highly anxious during incontinence care, and she had wondered if the resident had been abused in his/her past but did not believe the facility had documented trauma history or a specific care plan related to trauma for Resident #106. RN #12 further stated that she worked mostly night shift and did not have the opportunity to visit with families to learn about residents' histories, so she had to rely on word of mouth, the care plan, and the documented assessments for information. In an interview on 02/16/2024 at 4:23 PM, the Director of Nursing (DON) stated her expectations for care planning for a resident with a history of trauma would depend on the resident's triggers. Per the interview, the DON stated the facility would ask the family about how to address the resident's triggers if the resident was cognitively impaired. In an interview on 02/16/2024 at 5:27 PM, the Administrator stated her expectations were for staff to ask residents and their families upon admission about a history of trauma so the facility could develop a care plan to address the resident's individual needs and make referrals to outside resources as needed. The Administrator further stated she was not aware of Resident #106 having any history of traumatic events. 4. Review of Resident #87's Face Sheet revealed the facility admitted the resident on 11/28/2021. Review of Resident #87's Comprehensive Care Plan revealed the resident had the following diagnoses: chronic obstructive pulmonary disease (COPD), history of nicotine dependence, nicotine dependent, anxiety and major depressive disorder. Review of Resident #87 Quarterly Minimum Data Set (MDS) Assessment, dated 12/29/2023, revealed the facility assessed the resident with a BIMS score of fifteen (15) of fifteen (15), signifying the resident was cognitively intact. The facility identified the resident for activities of daily living (ADL) for hygiene as set up only. The resident was identified as requiring supervision and touch for all mobility; however, he/she was identified as independent in his/her wheelchair. The assessment revealed the resident was not known to have any behaviors present. Further review of Resident #87's Comprehensive Care Plan (CCP) revealed the facility developed a focus area for the resident's behavior problem of noncompliance related to smoking on 02/13/2024, after State Survey Agency (SSA) Surveyors identified smoking concerns for other residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 02/13/2024 at 5:45 PM, she stated she had previous knowledge of Resident #87 smoking and recently had been informed the resident was caught vaping (smoking an electronic cigarette that used a liquid that produced a vapor). Further review of Resident #87's Comprehensive Care Plan, revealed nothing care planned to assist in reducing the resident's desire to smoke until 02/14/2024, even though the facility reported Resident #87 had previously been caught trying to smoke and vape. 5. Review of Resident #105's Face Sheet revealed the facility initially admitted the resident on 12/19/2022 and last admitted the resident on 01/31/2024 with diagnoses of cerebral infarction, aphasia, and dysphagia. Review of Resident #105's Annual MDS Assessment, dated 01/12/2024, revealed the facility assessed Resident #105 with a BIMS score of five (5) of fifteen (15), signifying severe cognitive impairment. The facility assessed the resident required partial to moderate assistance with oral hygiene, showering, upper body dressing, and personal hygiene. Additionally, the facility assessed the resident for partial to moderate assistance of staff with sitting to standing, chair to bed to chair transfer, and toileting transfers. The facility assessed the resident required substantial to maximum assistance with toileting hygiene and lower body dressing and was fully dependent on staff putting on footwear. Resident #105 was also assessed as being fully dependent (helper did all) for wheelchair movement more than one hundred fifty (150) feet. Review of Resident #105's Comprehensive Care Plan (CCP) revealed staff were to encourage the resident to refrain from smoking (initiated on 01/09/2023). In an interview with State tested Nurse Aide (STNA) #8 on 02/09/2024 at 4:00 PM, she explained she witnessed Resident #105 being assisted outside to smoke. STNA #8 stated she also knew of a few other residents who were assisted by staff outside to smoke. She stated she never reported it because management was seen taking the residents out to smoke, and staff smoked on the facility's property so she did not think it was wrong. In an interview with Registered Nurse (RN) #2 on 02/11/2024 at 2:32 PM, he identified Resident #105 as a resident who was assisted outside to smoke. In continued interview with Registered Nurse (RN) #2 on 02/11/2024 at 2:32 PM, he stated coming on shift, he got report from the nurse going off shift, and he had access to all of the care plans. He stated usually anything that came up as new information or if he had any questions, he looked at the care plan. RN #2 explained the purpose of the care plan was to make sure staff followed the doctor's orders and provided care each resident needed. He stated if the care plan was not followed there could be bad outcomes, and there were a million different scenarios of what could happen. RN #2 stated for example, if thickened liquids were given to the wrong resident, it could result in aspiration. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Minimum Data Set (MDS) Coordinator #1 on 02/12/2024 at 6:10 PM, she stated she reviewed and updated care plans quarterly based on the quarterly assessments, but the Unit Manager updated the care plan with new orders, and floor nurses updated the care plan when there was a change in condition for the resident. She stated new interventions would be added to the care plan by the Unit Manager. MDS #1 stated she did not attend the clinical meetings. MDS #1 stated all staff were trained on care plans when they first started working at the facility. She stated the purpose of the care plan was it provided a whole picture of what was going on with the resident and what needed to be done and how to do it for each resident. She stated each department did their part in the care plan. She stated an important part of care planning was keeping it up to date and making changes on it. She stated she did not meet as part of the team, but she looked at medications that had been discontinued and closed that out on the care plan. MDS #1 stated staff members were expected to follow the care plan, and if the care plan was not followed the residents would not receive the specialized care meant for them, which could result in the resident and/or staff being harmed. In an interview on 02/16/2024 at 5:27 PM, the Administrator stated it was important for the facility to develop and follow resident-centered care plans because the care plan described the individualized care each resident needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 43694 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to properly assess a resident when the resident had a change of condition for one (1) of forty-eight (48) sampled residents, Resident #229. Review of Resident #229's electronic medical record (EMR) revealed no documented evidence Registered Nurse (RN) #2 assessed the resident or contacted the doctor on 02/04/2024 after he/she experienced an episode with decreased oxygen saturation levels. Cross reference: F656 and F689 The findings include: Review of the facility's policy, Change of Condition, last revised 06/2015, revealed staff would document and report a significant change in the resident's status. Per the policy, the resident's physician and responsible party would be notified of the resident's change of condition. The policy also revealed a resident's significant change in condition or event was to be reported to the nursing supervisor. Review of the facility's policy, Oxygen Administration, dated 03/2020, revealed oxygen therapy was administered to prevent or treat hypoxia (below normal oxygen level) and/or to improve tissue oxygenation. Per the policy, staff was to notify the physician of an abnormal assessment and interventions upon resident stabilization or transfer. The policy also revealed oxygen would be administered per the physician's order. Review of Resident #229's Face Sheet revealed the facility admitted the resident on 01/26/2024 with diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and heart failure. Review of Resident #229's Admission Assessment completed on 02/01/2024 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), signifying the resident was cognitively intact. Review of Resident #29's Physician's Orders, dated 01/26/2024, revealed Resident #229 was on an oxygen flow of 2.5 liters (L), delivered via nasal cannula. In an interview with Kentucky Medication Aide (KMA) #1 on 02/12/2024 at 10:00 AM, she stated on 02/04/2024 during the night medication administration at approximately 9:30 PM, she found Resident #229 lethargic and slurring his/her words. She stated she immediately alerted Registered Nurse (RN) #2 of her findings because such behavior was not normal for Resident #229. KMA #1 stated she went on with her job duties finishing medication administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Registered Nurse (RN) #1 on 02/09/2024 at 12:26, she explained on 02/05/2024 at 7:00 AM shift change, RN #2 told her Resident #229 had an episode during the night and was found without his/her nasal cannula on, with oxygen saturations of sixty (60) percent. RN #1 stated she also noticed the resident's oxygen flow had been turned up to four (4) liters (L), but RN #2 had not reported that. RN #1 stated RN #2 had not documented anything in the resident's medical record. RN #1 stated she reported this information to the Director of Nursing (DON). RN #1 stated right after her shift started, she went to talk to Resident #229 and found the resident slumped over in his/her bed. She stated the resident's feet were on the ground, his/her body bent over on the bed, and his/her eyes were closed. RN #1 stated she had to physically sit Resident #229 up in the bed to do vitals, and once she finished the vitals, she laid the resident back down. RN #1 stated the resident's vitals were all within normal limits; however, the resident was still lethargic and not acting like himself/herself. RN #1 stated she called 911, and the resident was transported to the Emergency Department. In an interview with Registered Nurse (RN) #2 on 02/12/2024 at 2:32 PM, he stated he provided care for Resident #229 on 02/04/2024, and KMA #1 informed him Resident #229 was lethargic. However, he stated, Unless it was something crazy, I would not be concerned. RN #2 stated he could not recall what happened with the resident on 02/04/2024. He stated he remembered the resident could be lethargic at times so that was nothing new. He stated he could not recall telling the morning nurse on 02/05/2024 that the resident's oxygen saturation levels were sixty (60) percent. He stated if a resident was found with oxygen saturations at sixty (60) percent, he would have checked the equipment and rechecked the oxygen. He stated, if the oxygen tubing was off, he would have put it back on the resident and then called the doctor. He stated whatever he did would have been documented in the resident's Electronic Medical Record (EMR). He stated the only thing he remembered was KMA #1 telling him that Resident #229 was lethargic. Review of Resident #229's Emergency Department Provider Notes, dated 02/05/2024 at 8:25 AM, revealed the facility reported the resident was slurring his/her words, and the oxygen flow was increased from 2 L to 4 L. Per the notes, the facility also reported the resident was found with an altered mental status this morning, and the facility told the Emergency Department they did not know the last time the resident was observed. The Emergency Department physician's clinical impression was delirium, elevated troponin, and chronic obstructive pulmonary disease (COPD). Per the notes, the physician admitted the resident. Additional hospital records after admission were requested but were never received. Further, the facility nor the hospital were able to identify who gave report to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #229's facility Primary Care Physician (PCP) on 02/13/2024 at 2:50 PM, she stated Resident #229's oxygen flow was four (4) L at his/her baseline at home, but at the facility she had lowered it to 2.5 L per minute because his/her oxygen saturations were stable in the upper ninety (90) percent. She stated staff was expected to check the resident's oxygen saturations six (6) times per day and document and report any changes or concerns. The PCP stated when the resident discharged home, she wanted the oxygen flow to be turned back up to 4 L per minute. She stated she was not on call on 02/04/2024, and it would have been the on-call service who would have been contacted if staff called about a change in condition. She stated she rounded on 02/04/2024 around lunch time, and the resident was doing okay. The PCP stated the resident was due to discharge that afternoon, but she was told there was a transportation issue. The PCP stated if a nurse found a resident whose oxygen level was at sixty (60) percent, she would expect a rapid response to the resident's condition: staff should check the resident's vitals, send the resident to the hospital, and inform the physician of the change in condition. In an interview with the Director of Nursing (DON) on 02/09/2024 at 12:10 PM, she stated RN #1 did not immediately report the information about RN #2 not documenting a change in condition for Resident #229; she did not report it until later in the afternoon. She stated if a nurse told the oncoming staff he found a resident with a sixty (60) percent oxygen saturation level, he should have documented it in the resident's EMR. The DON stated this case sounded like a bunch of he said, she said, and if it was not documented, It did not happen. The DON also stated if someone changed the resident's oxygen flow from 2 L to 4 L that should had been documented as well. She stated the physician should have been notified when this incident happened and been informed the oxygen was bumped up to 4 L. The DON stated if RN #1 said the oxygen was at 4 L that too should have been documented. The DON stated again, If it was not documented, it did not happen. The DON stated she could not explain why the resident had an order for 2.5 L of oxygen, but the hospital was told he/she had been on 2 L of oxygen which was bumped up to 4 L. The DON stated Resident #229 had previously been on 4 L of oxygen during his/her previous stays at the facility. In an interview with the Administrator on 02/16/2024 at 5:00 PM, she stated she expected staff to follow the policies and procedures of the facility. She stated she also expected staff members to follow the physician's orders, and if they had concerns about orders, they were to be brought to the nursing team.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boonespring Transitional Care Center, LLC	10250 US Hwy 42 Union, KY 41091

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 43694 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure residents were provided a safe and homelike environment, with reduced hazards, by allowing residents to smoke on the facility's campus for three (3) out of forty-eight (48) sampled residents, Resident #87, #105, and #229. The findings include: Review of facility's policy, Federal Resident Rights and Facility Responsibilities, undated, revealed residents had the right to a safe, clean, comfortable, and homelike environment. Review of the facility's policy, Resident Rights-Self Determination-Resident Smoking, dated 01/2019, revealed the facility would maintain a smoke free environment in a manner that was respectful and beneficial to residents, family members, and visitors. The non-smoking policy would be reviewed with residents upon admission. Per the policy, the use of electronic cigarettes also was not permitted on campus. The policy revealed no resident was permitted to smoke on the facility's campus. The policy stated residents would be offered physician approved smoking cessation devices, such as nicotine patches. Per the policy, the social worker would follow up with residents to ensure their compliance and understanding of the policy. Staff members were to monitor residents' belongings and report any smoking concerns to management. The policy stated residents failure to comply with the non-smoking policy could result in discharge from the facility. 1. Review of Resident #229's Face Sheet revealed the facility last admitted the resident on 01/26/2024 for rehabilitation services. Previously the resident had been admitted to the facility on [DATE] and had been in and out of the facility since. The facility admitted the resident with diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, emphysema, and acute respiratory failure. Review of Resident #229's Admission Assessment completed on 02/01/2024 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), signifying the resident was cognitively intact. The facility did not identify the resident with any behaviors or any upper/lower extremity impairments. It was noted Resident #229 used a walker with supervision and a wheelchair independently for ambulation. The resident required supervision and/or touch assistance for all Activity of Daily Living (ADL) care. The resident used a catheter and a colostomy bag. Review of Resident #229's Comprehensive Care Plan (CCP) revealed the facility failed to provide a care plan with all dates, revisions, canceled, and resolved interventions as was requested by the State Survey Agency (SSA) Surveyor. Therefore a true assessment of the care plan could not be completed. The care plan did not have dates on the focus area when it was initiated and did not have dates on the interventions and when they were initiated. There was nothing care planned for the resident's history of smoking or the resident's continued desire to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #229's History and Physical completed by his/her Primary Care Physician (PCP), dated 01/28/2024, revealed the resident was admitted to the facility after hospitalization for COPD exacerbation, sepsis, and chronic respiratory failure. The facility admitted the resident for physical therapy and rehabilitation due to weakness and for management of multiple medical comorbidities which required intensive monitoring. In an interview with Resident #87 on 02/13/2024 at 3:35 PM, the resident stated Resident #229 smoked outside in the front of the building, especially during bad weather, so he/she could stay under the awning and because it was too hard for him/her to get up and down the ramp at the back of the facility. In an interview with Resident #229's Family Member #1, on 02/16/2024 at 2:00 PM, she stated she knew Resident #229 smoked outside the facility. She stated she could always hear the resident light the cigarette and then taking puffs from it. She stated the family felt the resident always wanted to return to this facility because he/she was allowed to smoke. Family Member #1 stated it was hard for people who smoked a pack a day for forty (40) years to just stop smoking. She stated the facility was non-smoking but did not do enough to help prevent the residents from smoking. She stated what was a resident to do who wanted to smoke, and the staff allowed them to do it. She stated what smoker would not smoke if staff allowed it. Family Member #1 stated when the resident went out to smoke, he/she took his/her oxygen tank out also. She stated she heard the resident moving the oxygen tubing off his/her face. She also stated the resident told her that staff helped him/her get out to smoke and assisted residents who needed help. In an interview with State tested Nurse Aide (STNA) #3 on 02/13/2024 at 1:25 PM, she stated Resident #229 was wheelchair bound but got around on his/her own very well. She stated the resident took himself/herself to the bathroom and around the facility on his/her own. She stated Resident #229 was a smoker and went outside the facility during the day and during the evening to smoke. STNA #3 stated residents were allowed to smoke at the facility, and they smoked outside the front of the facility by the statue. STNA #3 stated her shift started at 7:00 PM, and she often passed Resident #229 going outside. She also stated the resident had his/her oxygen tank with him/her as he/she went out to smoke. She said she never intervened to stop the resident because it was her understanding it was okay for residents to smoke. In an interview with STNA #2 on 02/13/2024 at 3:00 PM, she stated Resident #229 was independent in day-to-day functioning, and he/she took himself/herself outside to smoke and to the vending machine. She stated Resident #229 got to the restroom alone and hung out in the hallway often. STNA #2 stated Resident #229 told staff when he/she went out to smoke. She said staff would tell the resident to leave his/her oxygen inside because they did not want to get blown up. STNA #2 stated sometimes the resident would leave his/her oxygen and other times he/she did not. She stated if the resident took the oxygen tank outside, he/she turned it off to smoke. She stated the resident went out in the evening prior to the doors locking down, but he/she always told the staff. She stated staff who smoked, smoked outside in the back of the facility. In an interview with STNA #8 on 02/12/2024 at 6:20 PM, she stated Resident #229 always had his/her oxygen outside when the residents were outside smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Registered Nurse (RN) #2 on 02/12/2024 at 2:32 PM, he stated Resident #229 went out to smoke every now and then. RN #2 stated there was a smoking area outside and residents were allowed to go out and smoke. He stated he did not know if smoking should have been care planned or not. 2. Review of Resident #87's Face Sheet revealed the facility admitted the resident on 11/28/2021. Review of Resident #87's Comprehensive Care Plan (last page) revealed the resident had the following diagnoses: chronic obstructive pulmonary disease (COPD), history of nicotine dependence, nicotine dependence, anxiety, and major depressive disorder. Review of Resident #87's Quarterly Minimum Data Set (MDS) Assessment, dated 12/29/2023, revealed the facility assessed the resident to have a BIMS score of fifteen (15) of fifteen (15), signifying the resident was cognitively intact. The facility identified the resident required a set-up only for hygiene activities of daily living. The resident was identified as requiring supervision and touch for all mobility; however, he/she was identified as independent in his/her wheelchair. The assessment revealed the resident was not known to have any behaviors present. Review of Resident #87's Comprehensive Care Plan, revealed nothing care planned to assist in reducing the resident's desire to smoke until 02/14/2024, even though the facility reported Resident #87 had previously been caught trying to smoke and vape (use of an electronic cigarette which simulated tobacco smoking; instead of smoke, it produced a vapor). In an interview with Resident #87 on 02/13/2024 at 3:35 PM, the resident stated he/she went out to smoke every day two (2) to three (3) times per day, usually close to mealtime. The resident stated sometimes he/she walked out to the picnic tables and other times he/she stood at the top of the ramp and smoked next to the building door. Resident #87 stated there were two (2) other residents who smoked, and there were regular staff who took them out to smoke. Also, the resident stated staff bought him/her cigarettes when he/she ran out. Resident #87 stated residents were only allowed to go out and smoke when staff was there. Resident #87 stated he/she currently had cigarettes and a lighter in his/her room. Observation on 02/13/2024 at 3:45 PM by two (2) State Survey Agency (SSA) Surveyors revealed Resident #87 produced three (3) packs of cigarettes and one (1) lighter. The lighter had a white base and blue and white on it with the design of an American flag. The cigarettes were in red, shiny cigarette boxes. The resident had two (2) packs of cigarettes under the seat of his/her walker and a pack in the pocket of a big, puffy, green, winter coat. The lighter was also in the coat pocket. In an interview with the Social Service Director on 02/16/2024 at 2:00 PM, she stated she had not been to check on Resident #87 since his/her cigarette and lighter had been taken away by management. She explained she just found out about it because the facility only had meetings on Tuesday and Thursday. She stated it would be important to get that information at the time it occurred to be able to meet with the resident timely to ensure their psychosocial well-being was being met. On 02/13/2024 at 5:45 PM, the Director of Nursing (DON) was present in the room while the Administrator was interviewed. The DON stated she did not know if the smoking incidents with Resident #87 were documented in the resident's file. She also stated there was a smoking [NAME] in the back of the facility for staff members, and they were allowed to smoke out there on their break. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 02/13/2024 at 5:45 PM, she stated she only knew of one (1) resident who had incidents of smoking and that was Resident #87. She stated Resident #87 had a smoking incident when he/she was first admitted to the facility. The Administrator stated she had been informed by staff Resident #87 was caught vaping. 3. Review of Resident #105's Face Sheet revealed the facility initially admitted the resident on 12/19/2022 and last admitted the resident on 01/31/2024 with diagnoses of cerebral infarction, aphasia, and dysphagia. Review of Resident #105's Annual MDS Assessment, dated 01/12/2024, revealed the facility assessed Resident #105 to have a BIMS score of five (5) of fifteen (15), signifying severe cognitive impairment. The facility assessed the resident required partial to moderate assistance with oral hygiene, showering, upper body dressing, and personal hygiene. Additionally, the facility assessed the resident for partial to moderate assistance of staff with sitting to standing, chair to bed to chair transfer, and toileting transfers. The facility assessed the resident required substantial to maximum assistance with toileting hygiene and lower body dressing and was fully dependent on staff putting on footwear. Resident #105 was also assessed as being fully dependent (helper did all) for wheelchair movement more than one hundred fifty (150) feet. Review of Resident #105's Comprehensive Care Plan, revealed a focus area of altered cardiovascular/circulatory status related to Atrial Fibrillation, Pacemaker, and Smoking initiated on 01/09/2023 with an intervention for staff to encourage to refrain from smoking on 01/09/2023. In an interview with Resident #87 on 02/13/2024 at 3:35 PM, the resident stated Resident #105 smoked on the facility's grounds. Resident #87 stated staff lit the cigarette for Resident #105 and then handed it to him/her. In an interview with STNA #2 on 02/13/2024 at 3:00 PM, STNA #2 stated she knew Resident #105 was a smoker, and staff helped Resident #105 by lighting his/her cigarette and handing it to him/her. In an interview with STNA #8 on 02/12/2024 at 6:20 PM, she stated Resident #105 would return from smoking and would have a cigarette in his/her pocket and pull it out and show it to her. In an interview with Registered Nurse (RN) #2 on 02/12/2024 at 2:32 PM, he stated Resident #105 went out of the facility and onto the grounds to smoke. In an interview with the Regional [NAME] President of Operations (VPO) on 02/16/2024 at 5:15 PM, she explained Resident #105 was a family member. She stated she often met with Resident #105, and they visited outside in the front of the facility when the weather was nice. She stated she never allowed Resident #105 to smoke on the property, but when Resident #105 wanted to smoke she drove him/her somewhere off the property to smoke. The Regional VPO stated she had no knowledge of residents smoking on the property and had no knowledge of staff helping any resident with smoking on the property. She stated the expectation was residents were not permitted to smoke anywhere on the property. In continued interview with Resident #87 on 02/13/2024 at 3:35 PM, he/she stated residents had not been assessed for smoking safety, no clothes protectors were present, and no fire extinguisher was present while they smoked outside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with State Trained Nurse Aide (STNA) #22 on 02/12/2024 at 6:00 PM, she stated the residents at the facility were not permitted to smoke. She stated the facility was a non-smoking facility. In an interview with STNA #8 on 02/12/2024 at 6:20 PM, she stated there were three (3) residents who regularly went outside to smoke, and she identified them as Resident #87, #105, and #229. STNA #8 stated staff assisted the residents get out to smoke (she was unable to name staff members). She explained residents smoked at the front and back of the building. In an interview with Registered Nurse (RN) #2 on 02/12/2024 at 2:32 PM, he stated there was a smoking area outside, and residents were allowed to go out and smoke. In an interview with RN #4 on 02/12/2024 at 5:50 PM, he explained the facility was a non-smoking facility and that meant no smoking outside either. He stated as far as he knew, residents were not permitted to smoke. RN #4 explained it would be very dangerous for a resident to smoke with an oxygen tank on or near himself/herself when the resident smoked. RN #4 stated the keypads locked down at 7:00 PM and that meant residents and staff could only enter and exit through the front door which would also be locked. He stated for anyone to get in or out of the building a staff member would have to buzz the door open. In an interview with the Activity Director on 02/12/2024 at 6:10 PM, she stated the facility was a non-smoking facility and that meant inside and outside of the facility. She stated there was a designated smoking area but that was for staff only. She stated she did not go out during her shift, so she would not be able to provide information about residents who smoked, if there were any. In an interview with the Social Services Director on 02/16/2024 at 2:00 PM, she stated she had not done much in reference to helping residents who previously smoked to adapt to the non-smoking environment of the facility. She stated she had not thought about organizing any smoking cessation classes or groups but that would be something worth looking into. In an interview with the Director of Nursing (DON) on 02/16/2024 at 4:24 PM, she stated all residents were able to exit the facility and go outside at any time. She stated residents who had a Brief Interview for Mental Status (BIMS) score below eight (8) had to be supervised by staff when they were outside. She also stated the residents did not have to sign out of the facility; they were allowed to come and go of their own accord. She stated there was not a policy about residents signing out prior to exiting the facility. On 02/16/2024 at 5:00 PM, the DON stated residents smoked outside at the front and at the back of the facility. She did not offer additional statements when she was asked where the residents smoked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In continued interview with the Administrator on 02/13/2024 at 5:45 PM, she stated the facility was a non-smoking campus. She stated there was not a designated smoking area, but staff members smoked in their cars. She stated she was not aware of any staff assisting residents outside to smoke. The Administrator stated residents who had a history of smoking would have been offered a smoking patch, and sometimes those patches would be initiated at the hospital prior to admission to the facility. The Administrator stated all family members were informed by the Admissions Coordinator that the facility was a non-smoking campus upon the resident's admission. She stated if a resident was found to be smoking, staff would report it to management, and it would be discussed with the family (if needed) with a goal that ensured the resident stopped smoking. She stated that would be documented in the progress notes. She stated if there was a resident who was adamant and would not stop smoking, the facility would look at discharging the resident to another facility. The Administrator stated she had not been informed staff took residents outside to smoke. She stated if it was found out staff members were taking residents out to smoke, management would address it, and disciplinary action would be provided to the staff involved. In continued interview with the Administrator on 02/13/2024 at 5:45 PM, the Administrator stated the facility did not have the required supplies for residents to safely smoke at the facility. Additionally, she stated the residents had not been assessed for smoking because residents were not permitted to smoke on the campus, inside or outside the facility. She stated she expected residents and staff to follow the facility's policy about smoking on facility property.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 46710 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care that accounted for the resident's experiences in order to mitigate triggers that might cause re-traumatization of the resident for one (1) of forty-eight (48) sampled residents, Resident #106. Resident #106's son reported the resident was sexually abused as a child, however, the facility failed to identify the resident as a trauma survivor. The findings include: Review of the facility's policy, Quality of Care-Care Planning, dated 10/2022, revealed the facility was to assess each resident for a history of trauma, including surviving physical and sexual abuse. Further review revealed the facility was to collaborate with the resident and his/her family to identify potential triggers and develop a resident-centered care plan to avoid re-traumatizing the resident. Review of Resident #106's Face Sheet revealed the facility admitted the resident on 01/16/2023 with diagnoses including unspecified dementia, insomnia, and unspecified disorientation. Review of Resident #106's Annual Minimum Data Set (MDS) Assessment, dated 12/14/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (00), indicating the resident was not able to complete the interview. Further review revealed the facility indicated the resident had disorganized thinking, irrelevant conversation, and illogical flow of ideas. Continued review revealed the facility assessed the resident as always incontinent and dependent on staff for toileting, showering, and personal hygiene. Review of Resident #106's Care Plan, dated 02/13/2024, revealed the facility failed to identify the resident as having a childhood history of abuse with the potential to affect his/her care in the facility. Further review revealed the facility assessed the resident as having a behavior problem related to dementia and disorientation but failed to include resident-centered interventions that addressed the cause of Resident #106's agitation. Continued review revealed the facility failed to include any interventions related to Resident #106's distress during incontinence care prior to the State Survey Agency (SSA) team's entrance on 02/12/2024. Review of the facility's document Social Service Assessment and History, dated 01/23/2024, revealed no questions about a history of trauma nor any information about triggers that could re-traumatize the resident. In an interview on 02/13/2024 at 1:08 PM, Resident #106's resident representative stated the resident had experienced sexual abuse as a child, which caused him/her to become combative and anxious when staff performed incontinence care. In further interview, Resident #106's resident representative stated he had told some aides about the resident's history of trauma, but he did not believe the aides communicated this to be included in the care plan because new staff were never aware of Resident #106's history when he told them. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/15/2024 at 9:25 AM, State tested Nurse Aide (STNA) #14 stated she had no way of knowing if Resident #106 had a history of trauma or if that affected the resident's reactions to caregiving activities. In further interview, STNA #14 stated Resident #106 would become agitated during incontinence care, and the only intervention she had found to help was to tell the resident they needed to take care of the water. Per the interview, STNA #14 did not know what interventions she would use for a resident with a history of trauma other than to explain to them what was happening, though she did that with all residents. In an interview on 02/16/2024 at 8:19 AM, Registered Nurse (RN) #12 stated Resident #106 became highly anxious during incontinence care, and she had wondered if the resident had been abused in his/her past. However, she stated she did not believe the facility had documented a trauma history for Resident #106. RN #12 further stated that she worked mostly night shift and did not have the opportunity to visit with families to learn about residents' histories, so she had to rely on word of mouth, the care plan, and the documented assessments for information. In an interview on 02/16/2024 at 9:44 AM, the Social Services Director (SSD) stated she assessed each resident for a history of trauma as part of the admission assessment. Per the interview, the SSD asked each resident and their families if the resident had any triggers related to a trauma history. In further interview, the SSD stated she did not recall if Resident #106 had a history of traumatic events the facility needed to be aware of in order to mitigate triggers. She stated the information should be documented on the social services intake form. However, she was unable to show documentation of Resident #106's history of trauma. In an interview on 02/14/2024 at 9:12 AM, Unit Manager (UM) #1 stated she did not know of an underlying cause for Resident #106 crying out during incontinence care. In further interview, UM #1 stated she was not aware of Resident #106 having a history of being abused as a child. In an interview on 02/16/2024 at 4:23 PM, the Director of Nursing (DON) stated her expectations for staff caring for a resident with a history of trauma would depend on the resident's triggers. Per the interview, the DON stated the facility would ask the family about a resident's triggers if the resident was cognitively impaired. In further interview, the DON stated she did not know if staff had assessed Resident #106 for a history of trauma, but the information should have been documented on the social services assessment from admission. In an interview on 02/16/2024 at 5:27 PM, the Administrator stated her expectations were for facility staff to ask residents and their families upon admission about a history of trauma so the facility could address the resident's individual needs and make referrals to outside resources as needed. The Administrator further stated she was not aware of Resident #106 having any history of traumatic events.