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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45990 Based on observation, interview, and review of the facility's policies, it was determined the facility failed to provide services for a safe, clean, comfortable, sanitary, and homelike environment for thirty-seven (37) of forty-eight (48) sampled residents. Facility census was one-hundred twenty-nine (129). Observation on 02/14/2024 revealed there was a strong urine odor on two (2) of two (2) sofas on the 1200 Unit and a strong urine odor on one (1) of four (4) armchairs on the 1400 Unit. The findings include: Review of the facility's policy titled, Guidelines to Good Housekeeping, revision date 02/28/2003, revealed the facility was to provide an optimum environment for the staff, resident, and visitors. Per the policy, procedures included dusting, floor cleaning and waxing, cleaning plumbing fixtures, and care of equipment. However, there was no process in the policy for cleaning common areas which would include furniture placed in those areas. Review of the facility's policy titled, Resident Rights and Facility Responsibilities, dated 03/2020, revealed the resident had the right to a safe, clean, comfortable, and homelike environment by providing housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. Observation on 02/14/2024 at 9:10 AM revealed Resident #106 sitting in an armchair on the 1400 Unit. Further observation revealed when the resident stood, his/her briefs were crooked, and there was a wet spot on the seat of his/her pants. Further observation revealed the armchair the resident had been sitting in smelled of urine. Observation on 02/14/2024 at 9:20 AM revealed a strong urine odor to both sofas on the 1200 unit. Further observation revealed the State Survey Agency (SSA) Surveyor's clothes smelled of urine after sitting on both sofas on the 1200 Unit. The SSA Surveyor's exposure to both sofas required the SSA Surveyor to shower and change clothes. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Environmental Services Floor Staff (EVS) on 02/16/2024 at 11:45 AM, she stated the sofas in the facility were steam cleaned by the facility with their own steam cleaning machine. EVS stated there should be a schedule of how often the cleaning was performed, but after looking through books on the cleaning cart, she could not find it. EVS stated she had never smelled urine on the 1200 Unit sofas. During an interview with the Environmental Services Director (ESD) on 02/16/2024 at 12:13 PM, she stated the process was for housekeepers to wipe down the furniture, vacuum under the cushions, and remove cushions with zippers it there was a stain. The ESD stated the facility had an upholstery cleaner but it was used, not weekly, but as needed to remove tough stains. The ESD stated if an odor was noted, staff would use another type of cleaner and then use laundry services if possible. She stated if a bodily fluid was on furniture, nursing took care of it first. The ESD stated she smelled urine on the cushion of one (1) of the armchairs on the 1400 Unit. During an interview with the Administrator on 02/16/2024 at 5:27 PM, she stated she had been Administrator since November of 2023. She stated her expectations of all staff members were to work together to meet all the needs of the residents.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46710 Based on interview, record review, review of the facility's investigation report, and review of the facility's policy, it was determined the facility failed to report allegations of abuse for one (1) of forty-eight (48) sampled residents, Resident #76. On 02/12/2024, in the presence of a State Survey Agency (SSA) Surveyor and State tested Nurse Aide (STNA) #7, Resident #76 alleged an unknown aide had been too rough and pushed his/her head down towards his/her chest the previous night. However, STNA #7 failed to notify the facility's administration of the allegation. The findings include: Review of the facility's policy, Abuse/Neglect/Misappropriation of Property, revised 09/2022, revealed facility staff members were to report allegations of abuse to the Administrator immediately. Further review revealed the Administrator was to report allegations of abuse to the state agency within two (2) hours of the allegation being made. Review of the facility's investigation report, dated 02/13/2024, revealed Resident #76 reported to the Corporate Educator on 02/13/2024 that State tested Nurse Aide (STNA) #19 had been too rough while providing Resident #76 a shower on 02/11/2024. Further review revealed the resident stated he/she had not previously reported the allegation to any facility staff. Review of Resident #76's Face Sheet revealed the facility admitted the resident on 06/17/2020 with diagnoses including hemiplegia (paralysis of one (1) side of the body) of the right side following cerebral infarction (stroke), chronic pain syndrome, and cervical (neck) disc degeneration. Review of Resident #76's Quarterly Minimum Data Set (MDS) Assessment, dated 01/11/2024, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as dependent on staff for toileting and as incontinent of bowel and bladder. Review of Resident #76's care plan, dated 06/17/2020, revealed the facility identified the resident was at risk for pain secondary to cervical disc degeneration and chronic pain syndrome and included the intervention to identify care and services that could aggravate pain and address those issues as possible. In an interview on 02/12/2024 at 3:30 PM, Resident #76 stated an aide whose name he/she did not know was too rough with his/her neck while changing his/her brief on the night shift of 02/11/2024. Further, Resident #76 stated State tested Nurse Aide (STNA) #18 was present when the resident complained the unknown STNA had hurt his/her neck. Per interview, Resident #76 stated STNA #18 was aware of his/her complaint of pain and dismissed it, telling the resident, You'll be okay. During this interview, STNA #7 was present at the bedside and told the resident she was sorry to hear the unknown aide was too rough with him/her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/16/2024 at 9:44 AM, the Social Services Director (SSD) stated her role in abuse investigations was to interview residents on the hallway with a BIMS score of eight (8) or above (indicated the resident was interviewable). She stated she had not taken part in the investigation so far but was unable to specify a reason why she had not been involved. In an interview on 02/16/2024 at 6:01 PM, the Corporate Educator stated she reported Resident #76's allegation immediately after the resident told her about it on 02/13/2024. She further stated the resident was adamant the incident he/she was reporting occurred during a shower on 02/08/2024, which did not match the incident the resident described to the SSA Surveyor. In further interview, the Corporate Educator stated, to her knowledge, no staff member had reported hearing Resident #76 allege abuse during incontinence care on 02/11/2024. In an interview on 02/16/2024 at 4:23 PM, the Director of Nursing (DON) stated she expected staff to report to her immediately if a resident made an allegation of a staff member being too rough with them. She further stated the investigation into Resident #76's allegation was ongoing, but at that point, she was not aware that Resident #76 made an allegation of abuse in front of another staff member that had not yet been reported to management. In an interview on 02/16/2024 at 5:27 PM, the Administrator stated she expected staff to notify her immediately if a resident made an allegation of abuse. She stated she was unaware a staff member heard Resident #76 make an allegation of abuse in the presence of an SSA Surveyor on 02/12/2024.

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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: 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. (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 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. 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. (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 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. 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. (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 02/15/2024 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. 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. (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 02/15/2024 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. 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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	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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46710 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide the appropriate treatment and services for a resident receiving enteral feeding to prevent complications of enteral feeding for (1) of three (3) sampled residents with a feeding tube (Resident #4). While changing Resident #4's brief, State tested Nurse Aide (STNA) #9 failed to prevent dislodgement of Resident #4's gastric tube, which required the resident to go to the emergency department for a new gastric tube placement. The findings include: Review of the facility's policy, Medication Administration via Gastric/Jejunostomy Tubes, dated 07/2018, revealed no instructions related to preventing the tube from becoming dislodged. In a document request from the facility on 02/15/2024 at 11:29 AM, this was the only policy provided related to gastric tube care. 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. 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 means for preventing dislodgement of the tube. Review of Resident #4's Progress Note, dated 12/08/2023 at 6:08 AM, revealed Registered Nurse (RN) #5 wrote a State tested Nurse Aide (STNA) notified her Resident #4's feeding tube had come out. Further review revealed RN #5 wrote that Resident #4 had to be transferred to the hospital for re-insertion of a gastric tube because the facility did not have the correct size tube for replacement. In an interview on 02/12/2024 at 4:53 PM, Resident #4 stated a while back an aide whose name he/she did not recall, was too rough while rolling him/her over during incontinence care. The resident stated the tension on the tubing caused the feeding tube to come out. Resident #4 stated his/her tube was fine now and refused to allow the State Survey Agency (SSA) Surveyor to observe the site. 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, these attempts were successful. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Registered Nurse (RN) #5 on 02/15/2024 at 8:09 AM, she stated STNA #9 told her that the tube fell out during a briefs change for Resident #4. 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 Resident #4's skin was slightly red, but not bleeding or visibly torn at that time. Per the interview, she immediately notified Advanced Practice Registered Nurse (APRN) #2 and transferred the resident to the hospital to get the tube replaced. In an interview on 02/15/2024 at 8:19 AM, RN #12 stated she expected aides, to prevent dislodgement of a gastric tube, to ask for the nurse's help when repositioning a resident if they noticed the tubing was tangled. In an interview on 02/16/2024 at 4:23 PM, the Director of Nursing (DON) stated her recollection of the cause of Resident #4's gastric tube dislodgement was that STNA #9 was not careful enough while performing incontinence care, causing too much tension on the tube, leading to dislodgement. She further stated she provided additional education to STNA #9 but not to aides facility wide. Per the interview, the DON could not produce documentation of the education she provided. In an interview on 02/16/2024 at 5:27 PM, the Administrator stated she expected nurse's aides to use caution in repositioning residents with a feeding tube to reduce the risk of dislodgement. She stated she believed the DON provided the STNA involved with additional education. However, she stated she did not believe all aides were educated at that time about precautions to take with feeding tubes.

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	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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46710 Based on interview and record review, it was determined the facility failed to ensure competent nursing staff for one (1) of three (3) sampled residents with feeding tubes (Resident #4). State tested Nurse Aides (STNA) interviewed stated they were not trained on precautions they needed to take when caring for a resident with a feeding tube. The findings include: Review of the facility's chart for mandatory new hire and annual required computer learning modules, revised 12/13/2023, revealed no courses geared toward care of residents with indwelling devices, such as gastric tubes. In an interview on 02/15/2024 at 1:55 PM, STNA #14 stated communication was terrible at the facility related to knowing what to do to care for residents with specific needs, such as a feeding tube. She stated she had not been trained on the precautions to take with a feeding tube. However, she stated she knew, from her own experience, to make sure Resident #4's feeding tubing was not tangled in the blankets because she had seen it tangled to the point it would have pulled out if she was not paying attention. In an interview on 02/15/2024 at 2:39 PM, STNA/KMA (Kentucky Medication Aide) #4 stated she did not recall any training about precautions for residents with feeding tubes. In further interview, STNA/KMA #4 stated the facility did not conduct refresher training in the form of return demonstrations, but staff did complete online learning modules periodically. Per the interview, the online training did not include information about feeding tubes. In an interview on 02/15/2024 at 3:22 PM, Licensed Practical Nurse (LPN) #7 stated she did not know what training aides received on precautions involved with caring for a resident with a feeding tube. She further stated she would expect aide training to include precautions to take to prevent dislodgement of the feeding tube. In an interview on 02/16/2024 at 8:19 AM, Registered Nurse (RN) #12 stated she did not know what training the facility provided for aides related to feeding tube precautions. However, she stated she would want an aide to notify her if the aide noticed any issues with the feeding tube, such as not having enough slack for repositioning a resident. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/16/2024 at 1:55 PM, the Staff Recruitment and Retention Coordinator (SRRC) stated the nurse aide training the facility provided as part of orientation did not include specific considerations for caring for a resident with a feeding tube. She further stated the process for nurse aide training included being paired with an experienced aide for two (2) weeks to learn the routines of residents and expectations for staff. In continued interview, the SRRC stated if the aide's assignment during those two (2) weeks did not include one of the three (3) residents in the facility with a feeding tube, the aide would not have any training specific to the needs of the resident with a tube feeding. Per the interview, the SRRC stated the nurses aides would need to know to be careful with the tubing that connected the tube feeding bag to the resident's appliance and to raise the head of the bed to thirty (30) degrees before leaving the room. In an interview on 02/16/2024 at 3:45 PM, the Assistant Director of Nursing (ADON) stated aides received training on their responsibilities with feeding tube care as part of the course they took in order to become initially certified. She further stated she did not know of specific training the facility provided to nurse aides related to feeding tube precautions. In continued interview, the ADON stated annual nurse aide training was computer based rather than a return demonstration in a skills fair setting. Additionally, the ADON stated she and the Director of Nursing (DON) did walking rounds, observing care, and addressing any issues they saw with immediate education. In an interview on 02/16/2024 at 4:23 PM, the Director of Nursing (DON) stated the facility oriented STNAs using online learning modules, two (2) weeks working with residents with a preceptor, and ongoing education as needed from the DON and ADON. The DON further stated she provided education to STNA #9 regarding being cautious and observant when providing incontinence care to residents with devices such as feeding tubes. Per the interview, the DON stated she did not provide this education to other aides also working in the facility at that time. In an interview on 02/16/2024 at 5:27 PM, the Administrator stated she worked closely with the DON on ensuring all employees completed initial and annual training as required. She further stated she was not clinical and would refer more detailed questions on what training the facility provided for nurse aides to the ADON and DON.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44000 Based on observation, interview, record review, review of the manufacturer's guidelines for Fluticasone (a corticosteroid nasal spray), and review of the facility's policy, it was determined the facility failed to ensure medications used by residents were not expired for one (1) of eight (8) sampled medication carts. The medication cart on the 1300 Unit contained a bottle of Fluticasone nasal spray, opened date 10/31/2023, prescribed for Resident #94. The manufacturer's guidelines for Fluticasone nasal spray revealed each bottle would provide one hundred twenty (120) sprays, and the bottle should be discarded when the labeled number of sprays had been used. However, Resident #94 had received two hundred and ten (210) sprays since the opened date of 10/31/2023, as documented on the resident's medication administration record (MAR). The findings include: Review of the facility's medication storage policy titled, Care Spring Health Care Management Medication Storage Policy, dated 12/2021, revealed, Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Review of the manufacturer's guidelines, enclosed in the Fluticasone box, revealed each bottle would provide one hundred twenty (120) actuations (sprays). Also, it stated the bottle should be discarded when the labeled number of actuations (sprays) had been used. Review of Resident #94's Face Sheet revealed the facility admitted the resident on 10/22/2021 with major diagnoses to include stroke, chronic pain, and seizures. Review of Resident #94's Quarterly Minimum Data Set (MDS) Assessment, dated 11/27/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven (11) of fifteen (15), indicating the resident was moderately cognitively impaired. Review of Resident #94's Physician's Orders revealed the order for Resident #94's Fluticasone was written on 02/04/2023 with instructions, 1 spray in both nostrils one time a day. Review of Resident #94's Medication Administration Record revealed Resident #94 received two hundred ten (210) sprays from 10/31/2023 to 02/13/2024. Observation on 02/14/2024 at 9:30 AM of the bottom drawer for the medication cart on the 1300 Unit revealed Resident #94 had a bottle of Fluticasone in a box dated with a black marker 10/31/2023. Kentucky Medication Aide (KMA) #4 took the bottle out of the box and looked on the bottle for a date, but the bottle was not dated. Also observed was a light brown, approximately one-fourth (1/4) inch substance on the nasal tip of the bottle. The instructions on the bottle stated, 1 SPRAY IN EACH NOSTRIL DAILY FOR ALLERGIES. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with KMA #4 on 02/14/2024 at 9:30 AM, she stated she did not know when the Fluticasone expired. She further stated when a medication was opened it was supposed to be dated on the date it was opened. She stated she thought eye drops, nasal sprays, and inhalers expired three (3) months after opening or by the manufacturer's date on the box. Observation on 02/14/2024 at 1:58 PM and on 02/15/2024 at 9:12 AM revealed Resident #94's Fluticasone was still in the bottom drawer of the 1300 Unit medication cart and dated with a black marker 10/31/2023. During interview with Registered Nurse (RN) #6 on 02/14/2024 at 9:36 AM, she stated she did not know when Resident #94's Fluticasone expired. She stated she looked in the computer and discovered the medication was delivered on 10/30/2023 in the evening. When asked to see the medication storage policy, RN # 6 looked in the computer and the screen said access denied. RN #6 stated staff usually went by the date on the box, and that was the date the medication expired. She also stated the night shift inspected the medication carts to make sure there were no expired medications. She stated she also inspected the carts periodically to assure there were no expired medications. She stated if an expired medication was given to a resident, it might not be effective. She stated there could also be bacteria on the bottle, and the resident could potentially become sick. During interview with the Director of Nursing (DON) on 02/14/2024 at 9:39 AM, she stated the medication expired on the date on the box. When asked to see the facility's medication storage policy, she stated staff was updating the system, and she would have to go to the office to view the policy. She also stated if a medication was given that had expired it might not be effective. She also stated if the medication was not effective, the resident could be harmed. During interview with the Pharmacist on 02/14/2024 at 10:47 AM, the Pharmacist stated the Fluticasone nasal sprays should be discarded after one hundred twenty (120) sprays. She stated if medications were not discarded when directed, the resident could get an infection, and/or the medication might not be effective. During interview with the DON on 02/14/2024 at 1:53 PM, she stated Pharmacy did a monthly audit of the medication carts, and the night shift nurses also did audits. She stated she discussed the audits with the Pharmacist after they were completed. She stated all staff members were educated on when medications expired and how to document this on the medications when they were opened. During interview with the Administrator on 02/16/2024 at 5:38 PM, she stated she expected staff to follow the facility's policies regarding the expiration date on medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45990 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to sanitize one (1) of four (4) mechanical lifts between resident use on the first floor. The findings include: Review of the facility's policy, Infection Control Transmission Based Precautions (Airborne, Contact, Droplet) All Staff, last revision date 09/2023, revealed Standard Precautions would be used regardless of the residents' suspected or confirmed infection status. Additional review revealed Transmission-Based Precautions would be used for residents with documented or suspected communicable disease or with infections that could be transmitted to others. Continued review revealed general considerations included to dedicate the use of non-critical resident care equipment to avoid sharing between residents but if unavoidable then equipment should be adequately cleaned and disinfected before use for another resident. Observation on 02/15/2024 at 10:16 AM revealed State tested Nurse Aide/Kentucky Medication Aide (STNA/KMA) #4 taking the Hoyer lift (a mechanical lift used to transfer patients from one surface to another) into a resident's room. Further observation revealed no disinfectant wipes stored on the lift and no disinfection performed by staff prior to entering the room. In an interview on 02/15/2024 at 10:27 AM with STNA/KMA #4, she stated the facility's process for cleaning Hoyer lifts was to clean them at night or when visibly soiled. Further, she stated though she used the lifts with multiple different residents, she did not clean the lifts between each use. In an interview on 02/14/2024 at 1:55 PM, STNA #14 stated she had never been told she needed to clean the Hoyer lifts. She further stated she thought night shift aides might wipe down the lifts, but she was not sure. During an interview with State tested Nurse Aide (STNA) #16 on 02/14/2024 at 10:07 AM, he stated the facility had not offered any training on disinfecting shared medical equipment after each use, but he wiped down the equipment with bleach wipes anyway. He stated he could not remember if any training was offered to disinfect the vital sign machine after each use. During an interview with STNA #20 on 02/15/2024 at 2:15 PM, she stated she did disinfect medical equipment with either a Bleach or Sani-wipe but had never disinfected the Hoyer lift. However, she stated the Hoyer lift should be disinfected, and she was under the impression night shift disinfected the Hoyer lifts. During an interview with STNA #12 on 02/15/2024 at 2:30 PM, she stated she did disinfect medical equipment after each use with bleach wipes but was unsure of disinfecting the Hoyer lift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Practical Nurse (LPN) #11 on 02/16/2024 at 10:58 AM, she stated she brought her personal medical equipment for use to the facility, which was a blood pressure cuff, stethoscope, an oximetry unit, and a no touch thermometer. She stated she disinfected the equipment with bleach wipes, with the exception of the oximetry unit, which she disinfected with alcohol wipes. She stated if the proper infection control protocol was not followed, germs from undisinfected shared equipment could be spread to all the residents. During an interview with Registered Nurse (RN) #7 on 02/16/2024 at 10:51 AM, she stated shared medical equipment should be disinfected including the Hoyer lifts. In an interview with the Infection Preventionist (IP) Nurse on 02/14/2024 at 3:39 PM, she stated staff received training on infection control. She stated she assured staff was following protocol by performing audits for hand hygiene and peri-care; however, no audits were provided after a request was made during the interview. In an additional interview with the Infection Preventionist (IP) Nurse on 02/15/2024 at 2:20 PM she stated staff should be disinfecting shared medical equipment with Sani-wipes between residents. In an interview with the Director of Nursing (DON) on 02/16/2024 at 4:45 PM, she stated the Infection Preventionist oversaw and audits were performed to ensure staff was following infection control protocol. She stated the facility ensured it had the most current protocol for infection control by relying on the Corporate Educator. During an interview with the Corporate Educator on 02/16/2024 at 5:00 PM, she stated the Hoyer lifts should be disinfected if used on someone in isolation. She stated the policy for disinfecting medical equipment was in the infection control policy, adding the facility did not go by the Centers for Disease Control and Prevention (CDC) guidelines but used the guidelines/regulations from the Centers for Medicare and Medicaid Services (CMS). In an interview with the Administrator on 02/16/2024 at 5:27 PM, she stated her expectations from staff was for all to work together and follow the facility's policies. 46710