STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. Building B. Wing	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Nursing and Rehabilitation	1705 Stevens Avenue Louisville, KY 40205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 38739 Based on interview, record review, facility policy review, and the facility's Admission Packet, it was determined the facility failed to ensure the medical record included a physician order for an Advanced Directive/Do Not Resuscitate (DNR) status for one (1) of twenty-five (25) sampled residents, Resident #267. The findings include: Review of the facility's policy, Advance Directives, dated 11/01/16, revealed the facility recognized the right of each resident to issue Advanced Directives regarding his or her healthcare and would be honored. The facility would document in the medial record whether or not the resident had executed an Advanced Directive. Review of the facility's Admission Packet, dated March 2007, revealed the packet contained the Kentucky Emergency Medical Service Do Not Resuscitate Order, and the resident would have his or her Advance Directive, if any had been created, honored. Review of the Residents' Rights, not dated, revealed the resident had the right to formulate an Advance Directive. Review of Resident #267's clinical record revealed the facility admitted the resident on 10/01/18, with the diagnoses of Alzheimer's Disease, Anxiety, and Chronic Kidney Disease. Review of the Kentucky Emergency Medical Services (EMS) DNR Order revealed the resident's representative signed the consent on 10/01/18, to implement the Advance Directive/DNR. Review of the Resident #267's Physician Orders, dated 10/01/18 through 10/18/18, revealed the physician did not write or sign an order for DNR status. Interview with Registered Nurse (RN) #2, on 10/19/18 at 11:00 AM, revealed a DNR status required a physician order and signature. He stated the admitting nurse or person completing the paper work was responsible to obtain the order and write it in the chart. He stated it was not a legal document unless an order was written and signed by the physician. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Services Coordinator, on 10/20/18 at 1:00 PM, revealed she assisted with end of life care decisions. She stated once the family or resident decided to have a DNR order, she notified the Assistant Director of Nursing Services (ADNS) of the decision and nursing staff was responsible to complete the paper work including obtaining an order from the physician. Interview with the Director of Clinical Operations, on 10/20/18 at 2:30 PM, revealed it was the admitting nurse's responsibility to obtain the Advanced Directive status order. Interview with ADNS #2, on 10/20/18 at 5:08 PM, revealed a written physician order was required to complete the resident's Advance Directive/DNR status. She stated she had not audited resident charts for accuracy pertaining to orders and DNR statuses. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 5:47 PM, revealed the facility was to obtain an order for DNR status at admission or when the documentation was signed. She stated an accurate order was to be on the physical chart. She stated the facility conducted chart reviews two (2) weeks ago without issues noted for Advance Directives. Interview with the Administrator, on 10/20/18 at 6:47 PM, revealed the physician was required to sign a written order for the code status of DNR.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35750 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to notify the physician for four (4) of twenty-five (25) sampled residents, Resident's #33, #65, #85, and #98, when the residents' blood sugar levels were too low or too high. The findings include: Review of the facility's policy, Notification of Change in Resident Health Status, dated June 2017, revealed the notification served to ensure all interested parties were informed of the resident's change in health status so that a treatment plan could be developed. The facility consulted the physician, nurse practitioner or the physician assistant, and if known, the resident's representative of the need to alter treatment significantly (such as a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Further review of the policy revealed the timeframe for notifications depended on the nursing assessment and occurred either immediately or within forty-eight (48) hours. Nursing judgement was considered an integral part of the skilled care provided and was applied on a case-to-case basis keeping with acceptable nursing practice. Review of the facility's Diabetes Management Education revealed the facility followed the American Diabetes Association (ADA) goal for adults with diabetes to achieve glucose levels between 90-130 milligrams per deciliter (mg/dl) before meals and less than 180 mg/dl two (2) hours after the start of the meal. 1. Review of Resident #33's clinical record revealed physician orders, dated 08/07/18 and 09/25/18, for accuchecks before meals and at bedtime and notify the physician if the blood sugar was less than 70 mg/dl or greater than 400 mg/dl. Review of Resident #33's electronic and paper ACC Monitoring (for accuchecks), for August 2018, revealed accuchecks were performed and the resident's blood sugar was 464 mg/dl on 08/12/18 and 469 mg/dl on 08/16/18. Review of the electronic and paper ACC Monitoring, for September 2018, revealed accuchecks were performed and the resident's blood sugar was 459 mg/dl on 09/04/18, 445 mg/dl on 09/14/18, and 515 mg/dl on 09/15/18. Review of the electronic and paper ACC Monitoring, for October 2018, revealed accuchecks were performed and the resident's blood sugar was 478 mg/dl on 10/08/18 and 428 mg/dl on 10/13/18. However, further record review revealed no documentation nursing staff notified the physician when the resident's blood sugar was above 400 mg/dl on the multiple occasions from August 2018 to 10/16/18. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #65's clinical record revealed a physician order, dated 09/11/18, for accuchecks before meals and at bedtime and notify the physician if the blood sugar was less than 70 mg/dl or greater than 400 mg/dl. Review of Resident #65's electronic and paper ACC Monitoring, for September 2018, revealed accuchecks were performed and the resident's blood sugar was above 400 mg/dl on 09/11/18 with a result of 448 mg/dl. However, review of the Progress Notes, dated 9/11/18, revealed no documentation nursing staff notified the physician regarding the 448 mg/dl blood sugar. 3. Review of Resident #85's clinical record revealed physician orders, dated 01/31/18 and 05/27/18, for accuchecks before meals and at bedtime and notify the physician if the blood sugar was less than 70 mg/dl or greater than 400 mg/dl. Review of Resident #85's electronic and paper ACC Monitoring, for March 2018, revealed accuchecks were performed and the resident's blood sugar was above 400 mg/dl six (6) times, on 03/03/18, 03/04/18, 03/06/18, 03/07/18, 03/09/18, and 03/17/18, ranging from 422 mg/dl to 518 mg/dl. Review of the electronic and paper ACC Monitoring, for April 2018, revealed accuchecks were performed and the resident's blood sugar was 555 mg/dl on 04/07/18. Review of the electronic and paper ACC Monitoring, for May 2108, revealed accuchecks were performed and the resident's blood sugar was 417 mg/dl on 05/30/18. Review of the electronic and paper ACC Monitoring, for June 2018, revealed accuchecks were performed and the resident's blood sugar was above 400 mg/dl fourteen (14) times, twice on 06/08/18, 06/10/18, twice on 06/14/18, 06/15/18, 06/16/18, twice on 06/18/18, 06/22/18, 06/25/18, 06/26/18, 06/27/18, and 06/08/18, ranging from 402 mg/dl to 523 mg/dl. Review of the electronic and paper ACC Monitoring, for July 2018, revealed accuchecks were performed and the resident's blood sugar was above 400 mg/dl four (4) times, twice on 07/02/18, 07/04/18, and 07/05/18, ranging from 417 mg/dl to 444 mg/dl. Review of the electronic and paper ACC Monitoring, for October 2018, revealed accuchecks were performed and the resident's blood sugar was 63 mg/dl on 10/14/18. However, further record review revealed no documentation nursing staff notified the physician when the resident's blood sugar was below 70 mg/dl and above 400 mg/dl on the multiple occasions from March 2018 to 10/16/18, per physician order. 4. Review of Resident #98's clinical record revealed a physician order, dated 09/12/18, for accuchecks before meals and at bedtime and notify the physician if the blood sugar was less than 70 mg/dl or greater than 180 mg/dl. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic and paper ACC Monitoring, for September 2018, revealed accuchecks were performed and the resident's blood sugar was above 180 mg/dl twelve (12) times, on 09/14/18, 09/15/18, 09/16/18, 09/18/18, 09/21/18, 09/22/18, 09/23/18, 09/25/18, 09/26/18, 09/24/18, 09/29/18, and 09/30/18, with results ranging from 185 mg/dl to 300 mg/dl. Review of the electronic and paper ACC Monitoring, for October 2018, revealed accuchecks were performed and the resident's blood sugar was above 180 mg/dl eighteen (18) times between 10/01/18 and 10/17/18, ranging from 187 mg/dl to 272 mg/dl. However, further review of the clinical record revealed no documentation the nursing staff notified the physician when the resident's blood sugar was above 180 mg/dl in September 2018 and October 2018. Interview with Assistant Director of Nursing Services (ADNS) #2, on 10/17/18 at 1:43 PM, revealed the procedure for insulin administration was to check the blood glucose level of a resident, check the order, and give the insulin as ordered by the physician. If insulin could not be given as ordered, then the physician had to be notified and a progress note completed. She stated if insulin was not administered as ordered, the physician had to be notified, or there could be harm to the resident. Interview with the Director of Nursing Services (DNS), on 10/17/18 at 3:10 PM and 10/19/18 at 8:40 AM, revealed if resident's blood sugar was below 70 mg/dl or above 400 mg/dl, staff had to notify the physician. She stated she reviewed Resident #85's electronic and paper MARs and noted the blood sugars above 400 mg/dl; however, she stated she could not find physician notifications for those elevated blood sugars in the resident's clinical record. Interview with the Medical Director, on 10/17/18 at 1:12 PM and 10/20/18 at 11:58 AM, revealed every time a resident's blood sugar was high there was a risk of long-term complications such as kidney damage or damage to circulation of the limbs. If blood sugar was not controlled, a resident could go into a coma. He stated the facility usually called him with high blood sugar readings and he would order an intervention according to the issue. He stated he relied on nursing staff to follow his orders to assure accurate treatment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38739 Based on observation, interview, and review of the facility's service agreement, it was determined the facility failed to ensure resident toilets, shower chairs, and shower rooms were clean on two (2) of four (4) units, the Memory Care Unit and 2C. The findings include: Review of the facility's, Agreement of Services, dated February 2013, revealed the contractor provided housekeeping services to the facility. The services included cleaning the toilet bowls and lids. Further review revealed resident restrooms were to be cleaned daily. Review of the facility's Quality Control Inspection-Housekeeping, undated, revealed deep cleaning review of resident restrooms included resident commodes. Review of the facility's Deep Clean Schedule, dated 10/01/18, revealed Rooms 105, 107, 119, and 121 were scheduled for deep cleaning once a month. Observation of the Memory Care Unit (MCU), on 10/16/18 at 10:15 AM and 2:55 PM, revealed the joined restroom for rooms [ROOM NUMBERS] had a strong odor of urine and feces. The toilet seat cover had a large area of a smeared brown substance on the right and front of the toilet seat. The joined restroom for rooms [ROOM NUMBERS] had a large area of a smeared brown substance on the back right of the toilet, under the seat, and on the side of the base of the toilet. Observation of the MCU shower room, on 10/16/18 at 10:47 AM, revealed two (2) clumps of wet white paper under the seat of the shower chair. The shower chair had a brown substance on the back of the seat. The toilet located to the right of the shower had multiple areas of a brown substance on all surface areas of the toilet seat. Observation of the MCU, on 10/17/18 at 7:42 AM, revealed the toilet seat in the combined restroom for rooms [ROOM NUMBERS] remained soiled with a brown substance on the right and the front of the toilet seat. The restroom had a strong odor of urine and feces. Observation of the MCU, on 10/17/18 at 7:50 AM, revealed the restroom for the combined Rooms of 119 and 121 remained soiled with a brown substance under the toilet lid and on the sides of the toilet bowel. Interview with the resident who resided in room [ROOM NUMBER], on 10/17/18 at 7:42 AM, revealed the resident would not use the restroom because the toilet had feces on it and it would get on him/her. The resident stated having feces on the toilet was gross and he/she wanted to know why feces was on the toilet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of 2C's Central Shower Room, on 10/17/18 at 8:45 AM, revealed the mirror over the sink was hazy and cloudy. There was an opened tube of toothpaste, a used toothbrush, and a plastic drinking glass with tan colored liquid on the sink. A white tee shirt hung on a hanger beside the toilet with the lower half of the shirt touching the floor. A light brown dry substance was on the wall behind the toilet, and a light yellow substance was dried on the toilet seat. The shower chair had brown dried substance on the lid. There were four (4) large tiles broken from the toilet area and sat behind the toilet. The chair near the bathtub area had two (2) spoons on it. Interview, on 10/17/18 at 8:25 AM, with Assistant Director of Nursing Services (ADNS) #1 revealed the Central Shower Room appeared to be very un-homelike. She stated staff should have cleaned the shower room after each use, and all personal items should be labeled and kept in the appropriate resident room. She stated the condition of the shower room was a concern for all the residents, and she did not monitor the shower room after daily use, but probably should. Interview with the Housekeeping Technician, on 10/17/18 at 3:08 PM, revealed he was responsible to ensure all areas were clean in the facility, which included the toilets and shower rooms. He stated he did not follow a list; he just cleaned and stated he cleaned the restroom for rooms [ROOM NUMBERS]. He stated he was audited on the work completed by the company but not by the facility. He stated cleaning the bathrooms were important to prevent the spread of germs and prevent residents from getting sick. He stated he would not like his toilet to be dirty and stated it was gross. Interview with the Housekeeping Supervisor, on 10/20/18 at 1:00 PM, revealed resident rooms were to be cleaned daily and as needed. He stated resident toilets were wiped down on the outside surfaces, as well as sanitized, and the inside of the bowls were cleaned with a brush. He stated the resident rooms were to be cleaned to maintain resident dignity and for infection control. He stated four (4) rooms were monitored at random on a daily basis for cleanliness. Interview with Certified Nursing Assistant (CNA) #1, on 10/20/18 at 2:14 PM, revealed CNAs were responsible to keep resident rooms clean because the facility was the resident's home and cleanliness was important. She stated the condition of the residents' room affected the residents' condition. Interview with ADNS #1, on 10/20/18 at 5:08 PM, revealed she would want her room to be cleaned, including the bathroom, because it was an infection control issue. She stated she had not identified issues with unclean shower rooms or toilets, and she observed the floor daily. She stated cognitively impaired residents were at risk for getting ill because they touched the toilets and then placed their hands in their mouths, which might not have been washed well, or at all, after using the toilet. She stated unclean toilets could affect residents' health and all staff was responsible to keep resident toilets clean. She stated the facility had not conducted audits of cleanliness of resident toilets or showers. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 5:47 PM, revealed housekeeping cleaned resident rooms to a certain extent, the toilets were cleaned as often as needed, and shower chairs were to be cleaned after use. She stated she was not aware of a deep cleaning schedule. She stated she monitored cleanliness of the rooms and restrooms when she made walking rounds. She stated it was all staffs' responsibility to keep resident rooms and surfaces clean and she would not sit on a toilet if it were not clean. She stated she would be concerned if cognitively impaired residents bathrooms were dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator, on 10/20/18 at 6:47 PM, revealed the contracted agency was responsible for cleaning the resident areas. She stated she did random walking audits, and if she found resident rooms dirty, she addressed it immediately. She stated the housekeeping manager was on site daily and available to discuss concerning issues.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 34116 Based on interview, record review, facility investigation review, and facility policy review, it was determined the facility failed to ensure residents were free from misappropriation of medication for one (1) of twenty-five (25) sampled residents, Resident #467. Two (2) Oxycodone pills prescribed for Resident #467 were unaccounted for on 10/11/18 during a narcotic count on the 2B Hall. The findings include: Review of the facility's Abuse Policy, effective June 2018, revealed misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Any time there was any allegation of abuse, neglect, exploitation, injuries of unknown origin or misappropriation, the center must report the alleged violation to the Administrator/Director of Nursing and initiate an immediate investigation and prevent further potential abuse. Review of the facility's policy, Medication Ordering and Receiving from Pharmacy, revealed one (1) Registered Nurse (RN) or one (1) Licensed Practical Nurse (LPN) or Certified Medication Aide (CMA) going off duty and one (1) RN or one (1) LPN or CMA coming on duty must count and justify the narcotic supply for each individual resident at the change of each shift. After the supply was counted and justified, each nurse must record the date and his/her signature verifying that the count was correct. If the count was not correct, the nurse and/or CMA going off duty were not to leave until the count was correct. If unable to justify the count, staff was to contact the Director of Nursing or Quality Assurance Director immediately. Further review of the policy revealed the narcotics key was to be carried at all times by the nurse/CMA who counted and verified the controls. Review of the facility's policy, Specific Medication Administration Procedures, revealed the purpose of the policy was to ensure medications were administered in a safe and effective manner. The policy stated the administration of medication should be documented in the Medication Administration Record (MAR), and if a medication was refused, the refusal should be documented in the MAR as well. When administering an as needed (PRN) medication, observed medication actions/reactions should be recorded in the PRN effectiveness sheet/nurses' notes. Review of the clinical record revealed the facility admitted Resident #467 on 10/04/18, with diagnoses of Pain, Immobility Syndrome (paraplegic), Aphonia, and Flaccid Hemiplegia affecting the right dominant side. Review of the Physician Orders, dated October 2018, revealed an order for Oxycodone/Acetaminophen (APAP) 5-325 milligram (mg) one (1) or two (2) pills every four (4) to six (6) hours PRN pain starting 10/09/18. Review of the Controlled Drug Record for Oxycodone/APAP 5-325 mg revealed LPN #7 signed out six (6) doses of the medication on 10/11/18. However, review of Resident #467's MAR, dated October 2018, revealed LPN #7 did not document the six (6) doses of Oxycodone/APAP was administered to the resident on 10/11/18. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurses' Notes, dated 10/09/18, revealed no documentation LPN #7 administered the medication to the resident. In addition, continued review of the Controlled Drug Record revealed two (2) Oxycodone/APAP (2) pills were not signed out nor accounted for. Review of the facility's investigation revealed Resident #467 was unable to recall how many doses of the narcotic the LPN administered to him/her on 10/11/18. The LPN was contracted through a staffing agency and the facility interview with the LPN revealed he assessed residents' pain prior to administering PRN narcotics and completed follow-up assessments for effectiveness; however, he did not document the findings on the MAR or nurses' notes. The nurse reported his nursing license was under investigation because a coworker reported he was not documenting PRN medication administrations and stealing narcotics. Attempted interviews with LPN #7 by telephone were unsuccessful as the nurse did not answer or return the phone calls. Interview, on 10/20/18 at 11:35 AM, with Assistant Director of Nursing Services (ADNS) #2 revealed she count narcotics on the 2B medication cart assigned to LPN #7 with ADNS #1. She stated there were two (2) Oxycodone/APAP pills missing, which ADNS #1 reported to the Director of Nursing Services (DNS). Interview, on 10/20/18 at 12:41 PM, with ADNS #1 revealed on 10/11/18, she and ADNS #2 counted narcotics on the 2B medication cart with LPN #7. She stated LPN #7 signed off a couple of the count sheets prior to the narcotic count because he had not signed out the medications. The ADNS stated she notified the DNS when they discovered two (2) Oxycodone/APAP pills were missing and could not be accounted for. According to ADNS #1, staff should sign out narcotics on the count sheet when they remove the pills from the card, and document in the MAR. She stated there were potentially more narcotics unaccounted for because the LPN signed the narcotic count sheets just prior to the count. Interview, on 10/19/18 at 2:27 PM, with the Assistant Administrator revealed another facility notified this facility on 10/11/18, of potential drug diversion by LPN #7. She stated LPN #7 was escorted from the building after two (2) nurses counted the narcotics in the medication cart and discovered two (2) Oxycodone/APAP pills unaccounted for during the count. She revealed the staffing agency was responsible for background checks of their staff. She stated the clinical team looked at other units where the LPN worked prior to 10/11/18, but she was not aware of the findings. Interview with the DNS, on 10/19/18 at 3:10 PM, revealed ADNS #1 and #2 counted narcotics with LPN #7 and discovered (2) Oxycodone/APAP pills unaccounted for on the medication cart the LPN was assigned and ADNS #1 took control of cart. The DNS stated narcotics should be signed out on the count sheet and the MAR as they were given. She further stated it was important to ensure pain medication was documented on the MAR to account for medication administered and monitor for effectiveness. She stated she was not aware of any issues related to PRN pain medication and narcotic count sheets other than this incident and there was not an audit process in place related to narcotic counts. According to the DNS, the staffing agency was responsible for background checks and validating licensure of LPN #7. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview with the DNS, on 10/20/18 at 5:47 PM, revealed the facility unsubstantiated the allegation of misappropriation of medication because there was no evidence the LPN actually took the medication; however, she stated she was aware the LPN did not document one (1) PRN narcotic administration on the count sheet. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed the facility unsubstantiated misappropriation of medication because the facility could not say for sure the LPN took the medication. The Administrator stated she did not think the facility reviewed MARs and narcotic counts for residents assigned to the alleged LPN prior to 10/11/18 and could not recall if there were any concerns identified during the investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34116 Based on interview, record review, and facility policy review, it was determined the facility failed to conduct a thorough investigation related to misappropriation of medication for one (1) of twenty-five (25) sampled residents, Resident #467. The findings include: Review of the facility's Abuse Policy, effective June 2018, revealed misappropriation of resident property meant the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The policy stated any time there was an allegation of abuse, neglect, exploitation, injuries of unknown origin, or misappropriation, the facility must report the alleged violation to the Administrator/Director of Nursing and initiate an immediate investigation to prevent further potential abuse. Based on investigation findings, the facility would implement corrective actions to prevent recurrence. Further review of the policy revealed the investigation would include interviews of team members, visitors, residents, volunteers, and vendors who might have knowledge of the alleged incident. Record review revealed the facility admitted Resident #467 on 10/04/18, with diagnoses of Pain, Immobility Syndrome (paraplegic), Aphonia, and Flaccid Hemiplegia affecting the right dominant side. Review of the Physician Orders, dated October 2018, revealed an order for Oxycodone/Acetaminophen (APAP) 5-325 milligrams (mg) one (1) or two (2) pills every four (4) to six (6) hours as needed for pain, starting 10/09/18. Review of the Controlled Drug Record for Oxycodone/APAP 5-325 mg revealed Licensed Practical Nurse (LPN) #7 signed out six (6) pills on 10/11/18. However, review of Resident #467's Medication Administration Record (MAR), dated October 2018, revealed there was no documentation on 10/11/18 that LPN #7 administered Oxycodone/APAP 5-325 mg to the resident. In addition, continued review of the Controlled Drug Record revealed two (2) additional pills were not signed out and were unaccounted for. Review of the facility's investigation revealed Resident #467 was unable to recall how many doses of Oxycodone/APAP LPN #7 administered to him/her on 10/11/18. Further review of the investigation revealed the LPN was contracted through a staffing agency and the facility interview with the LPN revealed he assessed residents' pain prior to administering an as needed narcotic and completed follow-up assessments for effectiveness; however, he did not document the findings on the MAR or nurses' notes. He reported his nursing license was being investigated because a co-worker said he was stealing narcotics because he was not documenting as needed pain medication administration. The surveyor attempted to reach the LPN by telephone for interview, but the nurse did not answer or return the calls. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Staffing Schedule revealed LPN #7 worked on 06/28/18, 06/29/18, 06/30/18, 07/05/18, 07/06/18, 07/07/18, 07/20/18, 07/05/18, 10/06/18, 10/07/18, and 10/11/18. Further review of the schedule revealed the LPN worked on 1C (Memory Care Unit), 1B Unit, and the 2B Unit. Interview with Assistant Director of Nursing Services (ADNS) #2, on 10/20/18 at 11:35 AM, revealed she assisted ADNS #1 to count narcotics on the 2B medication cart assigned to the LPN, cart #2. She stated there was one (1) discrepancy for two (2) missing pills and ADNS #1 reported the discrepancy to the DNS. ADNS #2 stated she did not participate in the investigation of the incident. Interview with ADNS #1, on 10/20/18 at 12:41 PM, revealed she counted narcotics on the 2B medication cart on 10/11/18 with LPN #7 and ADNS #2. The ADNS revealed the LPN signed off a couple of the narcotic count sheets prior to the count because he stated he had not signed out the medications. According to the ADNS, she notified the DNS when they discovered two (2) Oxycodone/APAP 5-325 mg pills were missing and unaccounted for during the count. ADNS #1 stated narcotics should be signed out on the count sheet as they were removed from the card and documented on the MAR. She stated there were potentially more narcotics unaccounted for because the LPN signed out the sheets prior to the count. ADNS #1 revealed the facility interviewed and assessed four (4) residents prescribed pain medication and assigned to the LPN on 10/11/18. The ADNS stated she was not sure if other residents assigned to the LPN on 10/11/18 were assessed for pain. The nurse stated she had not conducted any audits of MARs or narcotic count sheets for residents assigned to the LPN prior to 10/11/18. Interview with the Assistant Administrator, on 10/19/18 at 2:27 PM, revealed the facility was notified by another facility on 10/11/18 of a potential drug diversion by LPN #7. Two (2) nurses counted the narcotics with the LPN and he was escorted from the facility. She stated two (2) Oxycodone/APAP were unaccounted for during the count of the LPN's assigned medication cart, cart #2. She stated the facility assessed and interviewed the LPN's assigned residents who were prescribed as needed pain medications and determined there were no negative findings. She was not aware if the staffing agency conducted a drug screen because of the allegation. The Assistant Administrator revealed the facility interviewed ADNS #1, LPN #7, and five (5) residents on the 2B unit during the investigation. She stated the facility did not interview other residents assigned to the LPN on other days and other units. She stated she believed the ADNS' looked at other units where the LPN worked prior to 10/11/18, but she was not aware of the findings. The Assistant Administrator stated the DNS led the investigation and the Administrator advised on the process. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS), on 10/19/18 at 3:10 PM, revealed she was responsible for the investigation of the alleged misappropriation of medication on 10/11/18. She stated the two (2) ADNS' counted with the LPN and discovered (2) Oxycodone/APAP was unaccounted for on the 2B medication cart #2. ADNS #1 took over the cart for the LPN and the facility assessed/interviewed residents prescribed as needed narcotic medication assigned to the LPN; however, the facility did not interview residents prescribed routine narcotics to see if they had any issues with getting their medication. The DNS revealed the facility interviewed the two (2) ADNS' and the LPN, but did not interview any additional staff. She further revealed the facility did not assess or interview other residents assigned to the LPN prior to 10/11/18. According to the DNS, the staffing agency was responsible for background checks and validating licensure of the LPN. The DNS stated as needed narcotics should be signed out on the count sheet and the MAR as it was given. She revealed it was important to ensure pain medication was documented on the MAR to account for the medication administered and to monitor for effectiveness. She stated she was not aware of any issues related to as needed pain medication and narcotic count sheets other than this incident. The DNS revealed she did not do routine audits related to narcotic counts. Further review of the facility's investigation revealed the facility interviewed ADNS #1 on 10/17/18 at 8:30 PM. The facility did not provide a copy of ADNS #2's statement. Beside LPN #7, there were no other staff interviews. Further interview with the DNS, on 10/20/18 at 5:47 PM, revealed the facility unsubstantiated the allegation of misappropriation of medication because there was no evidence the LPN actually took the medication. She stated the facility did not interview the nurse assigned to medication cart #1 on the unit on 10/11/18, therefore she did not know if anyone else had access to the keys for medication cart #2 during the shift. She stated narcotics should be documented as they were administered and not immediately before the count. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed she was responsible for oversight of investigations at the facility and stated the facility unsubstantiated misappropriation of medication because the facility could not say for sure the LPN took the medication. According to the Administrator, there was some question as to whether another nurse counted right, and the facility could not say the alleged LPN was the one who took the medication. The Administrator revealed she did not think the facility reviewed MARs and narcotic counts for those residents assigned to the LPN prior to 10/11/18 and could not recall if there were any concerns identified because of the investigation. The Administrator revealed it was ultimately her responsibility to ensure agency nurses were okay to work in the facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 28734 Based on observation, interview, and record review, it was determined the facility failed to develop and implement a baseline care plan for one (1) of twenty-five (25) sampled residents, Resident #268, related to safe smoking. The findings include: The facility did not provide a policy related to Care Plans. Record review revealed the facility admitted Resident #268 on 08/09/18, with diagnoses of Vascular Dementia with Behaviors, Repeated Falls, Disorientation, Muscle Weakness, and Cognitive Communication Deficit. The record contained a physician follow-up visit, completed in the resident's home, dated 07/09/18 (prior to admission), which determined the resident had a history as a one (1) pack per day smoker. Observation of Resident #268, on 10/17/18 at 1:30 PM, revealed him/her sitting in a wheelchair and smoking a cigarette outside on the smoking porch. Activities Staff Member #1 was handing out and lighting cigarettes, and told Resident #268 he/she had not been given approval by the facility to smoke, nor was he/she allowed to smoke unless he/she had his/her own cigarettes. She informed the resident the facility did not permit borrowing cigarettes from other residents and the resident continued to smoke for the remainder of the smoke break. However, review of the resident's Care Plan revealed smoking was not addressed until 10/17/18, when the facility added potential for injury related to smoking. Interview, on 10/17/18 at 1:30 PM, with Resident #268 revealed the resident got cigarettes from a friend, and one of the residents on the smoking patio lit the cigarette for him/her but he/she did not know whom. The resident stated he/she was a long time smoker and liked it. Review of the facility's Smokers List revealed it did not list the resident as a smoker. Interview, on 10/17/18 at 1:40 PM, with Activities Staff Member #1 revealed she was not sure how Resident #268 got a cigarette and a light and could not say why she permitted the resident to smoke when the resident did not have a safe smoking assessment completed. She stated she had notified the Social Services Coordinator the resident needed a smoking assessment in the past. She revealed the resident attempted to smoke for a while now even though his/her name was not on the approved smoking list. Interview, on 10/17/18 at 1:55 PM, with the Social Services Coordinator revealed the facility had not assessed Resident #268 for safe smoking, however, she stated a smoking assessment should have been completed within two (2) days of the resident's admission to the facility. She stated she had not received any notifications from staff the resident attempted to go out onto the smoking porch and smoke. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing Services (ADON), on 10/20/18 5:06 PM, revealed she was not sure who created the base line care plan, but the purpose of the plan was to provide quality of care and ensure consistency of care. She stated it would be concerning if a plan for smoking was not developed because staff would not know if the resident was safe to smoke or not. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 5:47 PM, revealed the admitting nurse should complete the baseline care plan, which would include a smoking care plan, and care plans were a guide for proper resident care. She stated smoking assessments on residents were completed within forty-eight (48) hours of admission to the facility. Interview with the Administrator, on 10/20/18 at 6:37 PM, revealed all the resident floors had a list of residents assessed as safe smokers. The admission nurse should initiate resident care plans within forty-eight (48) hours of admission and a smoking assessment would be completed at that time. She stated the initial care plan was used to develop the comprehensive care plan.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, it was determined the facility failed to implement the plan of care for three (3) of twenty-five (25) sampled residents, Resident #54, #65, and #71. Resident #54 did not receive weighted utensils for meals and Resident #71 was not monitored for safe smoking practices. Resident #65 had a surgical wound and care planned to receive treatment and care as ordered; however, documentation revealed staff did not provide the treatment and care and the resident's wound worsened requiring antibiotic treatment and further surgical intervention. The findings include: The facility did not provide a policy related to Care Plans. Review of the CMS RAI Manual 3.0, Chapter 4, dated October 2017, revealed the comprehensive care plan was an interdisciplinary tool and must include measurable objectives and time frames. The care plan must describe services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arrange must be consistent with each resident's written plan of care. 1. Review of the clinical record revealed the facility readmitted Resident #54 on 03/14/18, with diagnoses of Protein-Calorie Malnutrition, Extrapyramidal and Movement Disorder, and Dementia with Behavioral Disturbance. Review of the Physician Orders, dated October 2018, revealed Resident #54 had an order for weighted utensils and a divided plate with all meals. Review of the Care Plan, dated 03/01/16, revealed the resident was at nutritional risk with a goal for the resident to be without further significant weight change through the next review. Interventions included providing adaptive equipment as ordered. Observation, on 10/16/18 at 9:37 AM, revealed Resident #54 seated on the side of the bed eating his/her cereal with a weighted fork, there were no other utensils available on the breakfast tray. Observation, on 10/16/18 at 1:00 PM, revealed Resident #54 tearing steak with his/her fingers. Interview during observation with the resident revealed he/she needed a knife to cut the steak; however, there was not a knife available on the tray. Review of the resident's tray card revealed meals should be served with weighted utensils. Interview, on 10/18/18 at 10:44 AM, with Licensed Practical Nurse (LPN) #5 revealed the purpose of the care plan was to ensure residents care needs were met. She stated Resident #54 was supposed to have weighted utensils with meals and staff was responsible for checking tray cards to make sure adaptive utensils were on the tray. The LPN stated she gave Resident #54 a plastic spoon one day instead of a weighted spoon because she was busy. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview, on 10/20/18 at 10:23 AM, with Dietary Aide #2 revealed adaptive equipment improved a resident's ability to eat and all dietary staff was responsible for ensuring adaptive equipment was provided on meal trays. The Aide stated staff stationed at the end of the tray line was responsible for verifying the correct utensils were on the tray prior to loading the tray onto the cart. Interview, on 10/20/18 at 12:41 PM, with Assistant Director of Nursing Services (ADNS) #1 revealed she was not aware of any issues related to missing adaptive equipment on meal trays and she monitored when she was on the floor. The ADNS stated staff was responsible for notifying the dietary department for the required utensils so the resident could eat and drink. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 5:47 PM, revealed she was not aware of any concerns related to adaptive equipment or care plans. 2. Record review revealed the facility readmitted Resident #65 on 09/09/18, with diagnoses of Acquired Absence of Leg below Knee and Peripheral Vascular Disease. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of six (6) of fifteen (15) and determined the resident was cognitively impaired. Review of the hospital Discharge Summary for Resident #65, dated 09/08/18, revealed a right above the knee (AKA) amputation was performed on 09/04/18 due to gangrene of the right foot. Review of the facility's Wound Assessment, dated 09/10/18, revealed Resident #65 had a surgical incision related to right AKA. The incision was closed, healing, and the staples were intact. Interview with Resident #65, on 10/18/18 at 9:48 AM, revealed his/her wound dressing was not changed daily. Observation revealed a dressing, dated 10/18/18, on the resident's right AKA stump. Review of Physician Orders, dated 09/10/18, for Resident #65 revealed a treatment order to cleanse the right surgical stump incision with soap and water, dry well, and cover with border gauze daily. Review of Resident #65's Care Plan, dated 09/09/18, revealed the resident had a surgical wound to his/her right AKA site related to a new amputation. Interventions included incision care as ordered by the physician and treatment as ordered. Review of the Treatment Administration Record (TAR), dated September 2018, revealed the treatment order on the TAR; however, staff did not document the treatment was completed for twelve (12) of nineteen (19) days. The facility did not provide paper TAR documentation completed by agency nurses. Further review of Resident #65's Wound Assessment, dated 09/19/18, revealed the surgical site was dry, no redness or drainage, and the skin was intact with staples. Review of a Wound Assessment, dated 09/28/18, revealed the incision had deteriorated, the site looked dark and scabbed with redness outside the incision. Review of the Nurses' Notes, dated 10/01/18, revealed the right stump incision site had some bogginess and was a little red with some darker skin. The wound nurse scheduled an appointment with the surgeon for 10/02/18 related to deterioration of the incision site. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the surgeon's Visit Note, dated 10/02/18, revealed the surgeon ordered an oral antibiotic (Bactrim double strength) and an antibiotic (Bacitracin) ointment to be applied to the incision daily, and rescheduled the resident for follow up on 10/16/18. Review of a Physician Order, dated 10/05/18, revealed an order for Bactrim, one (1) tablet daily for fourteen (14) days. Review of Resident #65's Medication Administration Record (MAR), dated October 2018, revealed no documentation the oral antibiotic was administered to the resident on two (2) of the fourteen (14) days the medication was ordered. The facility did not provide paper MAR documentation completed by agency staff. Review of a Wound Care Assessment, dated 10/05/18, revealed the right stump incision line had some eschar (dead matter cast off from the surface of the skin. The tissue could be hard, black or brown, and leathery in texture.) Review of Physician Orders, dated 10/12/18, revealed a change in the treatment order to cleanse the right stump incision with normal saline, apply Santyl ointment (removes dead tissue from wounds) with 4 x 4 gauze, and cover with a border gauze daily and as needed. Review of the TAR, dated October 2018, revealed no documentation the treatment was completed on three (3) of four (4) days. The facility did not provide paper TAR documentation completed by agency nurses. Further review of the Nurses' Notes, dated 09/10/18 through 10/16/18, revealed no documentation the resident refused his/her treatments or medication. Review of the surgeon's Follow-up Visit Note, dated 10/16/18, revealed there was an area of necrosis (the death of most or all of the cells in an organ or tissue due to disease or injury) without infection of the medial stump. The surgeon recommended surgical debridement (removal of dead, damaged, or infected tissue) of the stump with postoperative admission for wound care. The surgeon scheduled the resident for right above the knee debridement on 10/22/18. Interview, on 10/18/18 at 3:59 PM, with the Wound Care Nurse revealed she monitored Resident #65's surgical incision weekly to ensure the treatment was in place and she assessed for healing progress. She stated the incision site became soft and boggy and she scheduled an earlier post-op appointment with the surgeon. According to the nurse, a resident's assigned nurse was responsible for completing prescribed treatments. Interview with LPN #5, on 10/18/18 at 10:44 AM, revealed the purpose of the care plan was to ensure resident care needs were met. She stated it was the responsibility of the resident's assigned nurse to ensure wound care and treatments were completed according to the care plan to prevent infections. Interview with LPN #4, on 10/19/18 at 1:54 PM, revealed dressing changes should be documented in the TAR and in the nurses' notes to show the care plan interventions were followed to meet the goal. He stated if the care was not documented, then it was not done and the care plan was not followed. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview with Assistant Director of Nursing Services (ADNS) #2, on 10/20/18 at 5:09 PM, revealed staff was to follow resident care plans. Interview with the DNS, on 10/20/18 at 5:47 PM, revealed staff was to follow the care plan to ensure proper care for residents. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed care plans guided residents' care. She revealed there could be a negative outcome or adverse reaction for residents because of not following physician orders. 28734 3. Review of the facility's policy, Safe Smoking, dated 11/01/16, revealed the purpose of the policy was to maximize the facility's ability to provide a safe environment for all residents who smoked. Staff would monitor or obtain fire-igniting material (matches/lighters) at the nurses' station or other designated location. Review of the facility's Smoking Rules revealed during supervised smoking time, the resident would be handed cigarettes and lighter. All resident cigarettes would be secured at the reception desk. Residents would not be allowed to keep any smoking items such as cigarettes and lighters with them outside of the designated smoking time, and resident's must be able to provide their own funds for cigarettes. Observation, on 10/17/18 at 1:30 PM, revealed Resident #71 sitting in a wheelchair and smoking a cigarette in the outside smoking area. The resident placed a pack of cigarettes into his/her bag and held a lighter in his/her hand and put the lighter into his/her bag when the smoke break was over. Activities Staff Member #1 was supervising the residents during the smoke break. Review of Resident #71's clinical record revealed the facility admitted the resident on 05/02/13. Current diagnoses included Generalized Muscle Weakness, Dementia without Behaviors, Congestive Heart Failure, and Nicotine Dependence. The Quarterly MDS, dated [DATE], revealed the facility assessed the resident with a BIMS score of fifteen (15) of fifteen (15) and determined the resident was interviewable. Review of Resident #71's Care Plan, dated on 01/13/16, revealed the resident had the potential for injury related to smoking with interventions for the resident to be aware his/her room might be inspected for lighters and cigarettes, which were not allowed; maintain appropriate level of supervision as determined by the smoking assessment; keep lighter at nurses' station; smoke only in designated smoking areas; and redirect the resident when inappropriate smoking habits were observed. Continued record review revealed Resident #71 signed the facility's Smoking Rules agreement on 05/22/18, which agreed to the rules. Interview, on 10/17/18 at 1:30 PM, with Activities Staff Member #1 revealed she did not see the cigarettes and lighter Resident #71 kept in his/her bag. She stated the facility assessed the resident as a safe smoker and he/she had been educated in regards to the smoking rules, which included not having any smoking materials in his/her possession outside of the supervised smoking area. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview, on 10/17/18 at 4:55 PM, with the Social Services Coordinator revealed she spoke to Resident #71 about having cigarettes and a lighter, as staff confirmed the resident had cigarettes and a lighter in his/her bag. She stated the resident was care planned for smoking and staff should observe residents closely whenever they smoked. Interview with the DNS, on 10/20/18 at 6:37 PM, revealed resident care plans guided proper care of the residents and staff was to follow the plans. She stated the facility did not allow residents to keep smoking materials in their possession. Interview with the Administrator, on 10/20/18 at 6:37 PM, revealed staff was expected to follow care plans in order to give proper care to the residents. She stated residents could go outside and smoke with staff supervision at certain times.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Nursing and Rehabilitation	1705 Stevens Avenue Louisville, KY 40205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide wound care according to physician orders for one (1) of twenty-five (25) sampled residents, Resident #65. The resident had a right above the knee amputation with physician orders for wound treatment. Record review revealed staff did not provide treatment to the surgical site as ordered and the wound worsened, which required antibiotic administration and scheduled surgical debridement (removal of damaged tissue). The findings include: Review of the facility's policy, Skin Care Guideline, dated July 2018, revealed the purpose of the policy was to provide a system for evaluation of skin to identify risk and identify individual interventions to address the risk. When an open area was identified, evaluation of the wound should be documented in the electronic medical record including location, size, exudate/if present, pain/if present, appearance of wound bed, including evidence of healing. The wound should be reassessed and interventions reevaluated and revised when progress was not noted within fourteen (14) days. If there was any deterioration of the wound status, comprehensive reevaluation should be initiated and the physician and/or resident representative notified. Review of the facility's policy, Specific Medication Administration Procedures, revealed after administration, the nurse should return to the cart and document administration in the Treatment Administration Record (TAR). If a resident refused a medication, document the refusal in the TAR. Review of the clinical record revealed the facility readmitted Resident #65 on 09/09/18, with diagnoses to include Acquired Absence of Leg Below Knee and Peripheral Vascular Disease. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of six (6) of fifteen (15) and determined the resident cognitively impaired. Review of the hospital Discharge Summary, dated 09/08/18, revealed a right above the knee (AKA) amputation was performed on 09/04/18 related to gangrene of the right foot. Review of the facility's Wound Assessment for Resident #65, dated 09/10/18, revealed a surgical incision related to right AKA. The incision was closed and healing with staples intact. Review of Resident #65's Physician Orders, dated 09/10/18, revealed a treatment order to cleanse the right surgical stump incision with soap and water, dry well, and cover with border gauze daily. Interviews with Resident #65, on 10/17/18 at 2:11 PM and 10/18/18 at 9:48 AM, revealed he/she was recently hospitalized for leg surgery and had a treatment for his/her leg. The resident stated his/her wound dressing was not being changed daily. Observation revealed a foam dressing, dated 10/18/18, on the right amputation stump. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the TAR, dated September 2018, revealed the physician ordered treatment on the TAR. The nurses did not document the treatment as given for twelve (12) of nineteen (19) days. The facility did not provide paper TAR documentation completed by agency nurses. Review of Resident #65's Wound Assessment, dated 09/19/18, revealed the surgical site was dry and had no redness or drainage. In addition, the skin was intact with staples. Further review of Wound Assessments, dated 09/28/18, revealed the incision had deteriorated. The surgical site looked dark and scabbed with redness noted outside the incision. Review of Physician Orders, dated 09/28/18, revealed the physician changed the treatment order to cleanse the right stump incision with normal saline, dry, and apply Betadine along the incision line. Nursing staff was to monitor the surgical incision to the right stump for increased redness every shift for three (3) days. Continued review of the TAR revealed a check mark under 09/28/18, 09/29/18, and 09/30/18, indicating nursing staff completed an assessment of Resident #65's wound. However, the TAR did not provide evidence the wound had improved or deteriorated. In addition, review of the nursing documentation for 09/28/18, 09/29/18, and 09/30/18, revealed no assessment or description to whether the surgical wound showed improvement or had continued to deteriorate. Review of the Nurses' Notes, dated 10/01/18, revealed the wound nurse scheduled an appointment with the surgeon for 10/02/18, related to deterioration of the incision site. The note revealed the right stump incision site continued with some bogginess and was a little red with some darker skin. According to the note, the redness had improved since the last assessment on 09/28/18. Review of the surgeon's Post-Op Visit Note, dated 10/02/18, revealed the right AKA was a little red and likely related to an irritation from the staples. The surgeon ordered an oral antibiotic (Bactrim double strength), an antibiotic (Bacitracin) ointment to be applied to the incision daily, and rescheduled the resident for follow up on 10/16/18. Review of Physician Orders, dated 10/05/18, revealed an order for the antibiotic Bactrim DS, one (1) tablet by mouth daily for fourteen (14) days. Review of Resident #65's Medication Administration Record (MAR), dated October 2018, revealed staff did not document administration of the oral antibiotic for two (2) of the fourteen (14) days the medication was ordered. The facility did not provide paper MAR documentation completed by agency staff. Review of a Wound Assessment, dated 10/05/18, revealed the right stump incision line had some soft eschar (dead matter cast off from the surface of the skin that could be hard, black or brown, and leathery in texture.) Review of Physician Orders, dated 10/12/18, revealed the physician changed the treatment order to cleanse the right stump incision with normal saline, apply Santyl ointment (removes dead tissue from wounds) with 4 X 4 gauze, and cover with a border gauze daily and as needed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the TAR, dated October 2018, revealed staff did not document the treatment was completed for three (3) of four (4) days. The facility did not provide paper TAR documentation completed by agency staff. Further review of the Nurses' Notes, dated 09/10/18 through 10/16/18, revealed no documentation indicating the resident refused his/her treatments or medication. Review of the surgeon's Follow-up Office Visit Note, dated 10/16/18, revealed there was a continuous area of necrosis (death of most or all of the cells in an organ or tissue due to disease or injury) without infection of the medial stump. The surgeon recommended surgical debridement of the stump with postoperative admission for wound care. The surgeon scheduled right above the knee debridement on 10/22/18. Interview with Licensed Practical Nurse (LPN) #5, on 10/18/18 at 10:44 AM, revealed it was the responsibility of the resident's assigned nurse to ensure wound care and treatments were completed according to the physician order. She stated the nurse should document in the nurses' note and the TAR if a treatment was not completed or the resident refused. The nurse revealed it was important to follow the physician order for daily wound care to prevent potential infection and to aide in the healing process. Interview with LPN #4, on 10/19/18 at 1:54 PM, revealed the purpose of cleansing an incision site with soap and water was to prevent infection of the site. He stated dressing changes should be documented in the TAR and in the nurses' notes and include the appearance of the wound, presence of any drainage, and presence of any pain. LPN #4 revealed it was important to ensure complete documentation of care to monitor wound healing and ensure continuity of care. He stated if it was not documented, then it was not done. According to LPN #4, if a nurse and Certified Medication Technician (CMT) were assigned to the hall, the nurse was responsible for completing resident treatments for the hall. Interview with the Wound Care Nurse, on 10/18/18 at 3:59 PM, revealed the residents' assigned nurse was responsible for completing prescribed treatments. The nurse stated she monitored Resident #65's surgical incision weekly to ensure the treatment was in place and assessed for healing progress. She revealed she also notified the physician as needed for potential changes of treatment orders. The nurse stated she had concerns with the appearance and drainage of the incision site, but had not identified any concerns with the prescribed treatment/dressing changes. The Wound Nurse stated the incision site became soft and boggy and she scheduled an earlier post-op appointment with the surgeon. According to the Wound Nurse, staff should sign off the treatment in the TAR and document any abnormal changes with the wound in the nurses' notes. The nurse stated nursing staff had not reported any concerns related to the wound. Interview with Assistant Director of Nursing Services (ADNS) #1, on 10/20/18 at 12:41 PM, revealed agency nurses did not have access to the electronic MAR/TAR and therefore were required to document on a paper MAR/TAR. She stated she was responsible for reconciling the paper TAR to the electronic TAR, but was not able to reconcile all of them because she had multiple responsibilities and not enough time. She stated it was important to reconcile the documentation to ensure all care was provided for the resident because if staff did not perform wound care, the wound could deteriorate, which could lead to infection. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with ADNS #2, on 10/20/18 at 5:07 PM, revealed a complete and accurate MAR/TAR should not have any omissions. According to the ADNS, anything going on with the resident should be documented in the record and not documented meant it was not done. She stated if wound treatments were not done according to the physician order, it lessened the quality of care. The resident's wound could worsen and the resident could become septic. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 5:47 PM, revealed resident refusal of a medication or treatment should be documented in the MAR/TAR, or nurses' note, and the physician/family notified. The DNS revealed there was a potential for resident harm if treatment was not provided according to the physician orders. Interview with the Physician, on 10/20/18 at 11:58 AM, revealed he was not aware of any concerns related to Resident #65's prescribed dressing changes. The Physician stated the incision appeared to be healing and he was not aware of any changes in the progress. He stated it was important to perform wound treatment to promote healing. The MD stated there was a potential for no improvement and/or worsening of the wound if the treatment was not administered according to the orders. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed if care was not documented then it did not happen, because there was no proof care was given. She stated staff should follow physician orders and any reasons for deviation from the order should be documented in the clinical record. She revealed there could be a negative outcome or adverse reaction for the resident because of not following physician orders. The Administrator further revealed a negative outcome was considered poor quality of care.

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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** 28734 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for two (2) of twenty-five (25) sampled residents, Resident #71 and #268, related to smoking. The findings include: Review of the facility's policy, Safe Smoking, dated 11/01/16, revealed the purpose of the policy was to maximize the facility's ability to provide a safe environment for all residents who smoke and for non-smokers. The policy stated the facility would assess the ability of residents to smoke safely and determine any measures needed to protect residents from possible self-injury due to smoking. Review of the facility's Smoking Rules revealed during supervised smoking time, the resident would be handed cigarettes and lighter. All resident cigarettes would be secured at the reception desk, residents would not be allowed to keep any smoking items such as cigarettes and lighters with them outside of the designated smoking time, and resident's must be able to provide their own funds for cigarettes. 1. Observation of the outside resident smoking porch, on 10/17/18 at 1:30 PM, revealed Resident #268 sitting in a wheelchair and smoking a cigarette. Activities Staff Member #1 handed out and lit other residents' cigarettes. The staff member told Resident #268 he/she had not been given approval by the facility to smoke nor was he/she allowed to smoke unless he/she had his/her own assigned cigarettes. The staff member continued to inform the resident that borrowing other resident cigarettes was not permitted by the facility. The resident continued to smoke for the remainder of the smoke break. Record review revealed the facility admitted Resident #268 on 08/09/18, with diagnoses of Vascular Dementia with Behaviors, Disorientation, and Cognitive Communication Deficit. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of five (5) of fifteen (15) and determined the resident not interviewable. Review of the Care Plan revealed the resident did not have a care plan in place for smoking until 10/17/18. Interview with Resident #268, on 10/17/18 at 1:30 PM, revealed the resident got cigarettes from a friend, and one of the residents on the smoking patio lit the cigarette for him/her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Activities Staff Member #1, on 10/17/18 at 1:40 PM, revealed she was not sure how Resident #268 got a cigarette and light. She stated she had informed the Social Services Coordinator the resident needed a smoking assessment and the resident attempted to smoke for a while now even though his/her name was not on the approved smoking list. She stated it was dangerous for a resident to give another resident a cigarette, and dangerous if a resident kept a lighter on them. She stated she was unsure why she continued to permit the resident to smoke even though the resident did not have a safe smoking assessment in place. Interview with the Social Services Coordinator, on 10/17/18 at 1:55 PM, revealed the facility had not assessed Resident #268 for safe smoking but the resident did have a desire to smoke cigarettes. She stated she was aware the facility did not have any cigarettes for the resident and the resident did not have the means to purchase them. She stated the resident should not have smoked on the smoking porch, and she did not know why he/she was allowed to continue to smoke with staff supervision present. She revealed she had not received notification from staff the resident had attempted to go out and smoke. The Coordinator stated all resident smoking paraphernalia had to be kept with staff, which included cigarettes and lighters, to prevent a danger to all residents in the facility. 2. Observation of Resident #71, on 10/17/18 at 1:30 PM, revealed the resident sitting in a wheelchair and smoking a cigarette. The resident placed a pack of cigarettes into his/her bag, and held a lighter in his/her hand. When the cigarette break was over, the resident put the lighter into his/her bag. Activities Staff member #1 was supervising residents during the smoke break. Record review revealed the facility admitted Resident #71 on 05/02/13. The resident's current diagnoses included Dementia without Behaviors, Congestive Heart Failure, and Nicotine Dependence. Review of the Quarterly MDS, dated [DATE], revealed the facility assessed the resident with a BIMS score of fifteen (15) of fifteen (15) and determined the resident was interviewable. Review of Resident #71's Care Plan, dated on 01/13/16, revealed the resident had the potential for injury related to smoking. Interventions included the resident was aware his/her room might be inspected for lighters and cigarettes which were not allowed, maintain appropriate level of supervision as determined by the smoking assessment, keep lighter at nurses' station, resident to smoke only in designated smoking areas, and redirect resident when inappropriate smoking habits observed. Continued record review revealed Resident #71 signed his/her Smoking Rules agreement on 05/22/18. Interview with Activities Staff Member #1, on 10/17/18 at 1:30 PM, revealed she did not see cigarettes and a lighter in Resident #71's bag. She stated the resident was assessed as a safe smoker, and all resident who smoked were educated in regards to the smoking rules, which included not having any smoking materials in their possession outside of the supervised smoking area. Further interview with Activities Staff Member #1, on 10/18/18 at 9:40 AM, revealed when she was hired in June 2018, she received very little education related to safe smoking. She stated all she had been told was how to ensure specific residents had the proper smoking apron on and how to maintain the Smoking Log. She stated she frequently supervised the residents while they smoked and she should notify social services with any concerns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Services Coordinator, on 10/17/18 at 4:55 PM, revealed she had spoken to Resident #17 in regards to cigarettes and lighter in his/her bag. She stated staff confirmed the resident had a pack of cigarettes and lighter in his/her bag. She revealed the facility had not done room searches in the past because this had not been an issue. Interview with the Director of Nursing Services, on 10/20/18 at 6:37 PM, revealed residents were not allowed to keep any smoking materials in their possession. She stated the facility was smoke-free inside, and it was a safety issue to all residents if a resident kept smoking supplies in their possession because it could cause a fire. Interview with the Administrator, on 10/20/18 at 6:37 PM, revealed all the resident floors had a list of the residents assessed as safe smokers. She stated residents went outside and smoked at certain times and only with staff supervision.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34116 Based on interview, record review, and facility policy review, it was determined the facility failed to ensure controlled drugs were accounted for on three (3) of eight (8) medication carts, on 2B and the Memory Care Unit (MCU). Record review revealed missing staff signatures on the Narcotic Count Sheet and the Shift Count Narcotic Logs. The findings include: Review of the facility's policy, Controlled Medication Disposal, revised 03/11/14, revealed when controlled medication was removed from the container for administration, but not given, it was not placed back in the container, it was destroyed in the presence of two (2) licensed nurses or one (1) licensed nurse and a pharmacist. The disposal was documented on the accountability record on the line representing that dose. Review of the facility's policy, Schedule Drug Count, not dated, revealed the purpose of the policy was to justify the amount of narcotics remaining when control of supply was released to the nurse coming on duty. One (1) Registered Nurse (RN), or Licensed Practical Nurse (LPN), or Certified Medication Aide (CMA) going off duty and one (1) RN, LPN, or CMA coming on duty must count and justify the narcotic supply for each individual resident at the change of each shift. Each nurse must record the date and his/her signature verifying that the count was correct. Review of a Narcotic Count Sheet on medication cart #2 on the 2B Unit for Oxycontin 10 milligram (mg) tablets, dispensed 09/07/18, revealed one (1) tablet was wasted on 10/10/18 at 9:00 AM; however there was only one (1) nurse signature and no witness signature verifying the waste. Further review of narcotic count sheets for Oxycontin 10 mg tablets, dispensed 08/29/18, revealed three (3) tablets were wasted, one (1) tablet on 09/22/18 at 9:00 AM, one (1) on 09/24/18 at 9:00 AM, and one (1) on 10/03/18 at 9:00 AM. There was only one (1) nurse signature for the wastes. Interview with LPN #4, on 10/19/18 at 4:50 PM, revealed all narcotic waste required two (2) nurse signatures on the narcotic count sheet. The LPN revealed two (2) signatures were required to ensure the medication was disposed of properly and prevent someone from stealing the medication. He revealed he sometimes worked alone on the unit and it was not always possible to get a second nurse signature. Review of the MCU Shift Count Narcotic Log for cart #1, dated August 2018, revealed staff did not complete a narcotic count verifying and accepting responsibility for the correct count on the following dates/shifts: 08/02/18 at 7:00 PM and 08/17/18 at 7:00 PM. Continued review revealed the narcotic count was not signed by the off going staff on 08/04/18, 08/06/18, 08/11/18, and was not signed by incoming staff on 08/11/18. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MCU Shift Count Narcotic Log for cart #1, dated September 2018, revealed staff did not complete a narcotic count verifying and accepting responsibility for the correct count on the following dates/shift: 09/02/18 at 7:00 PM, 09/03/18 at 7:00 AM, 09/25/18 at 7:00 AM, and 09/29/18 at 7:00 PM. Continued review revealed staff did not provide a signature(s) for the counts on 09/06/18, 09/07/18, and 09/27/18. Review of the MCU Shift Count Narcotic Log for cart #1, dated October 2018, revealed staff did not complete a narcotic count verifying and accepting responsibility for the correct count on 10/03/18 at 7:00 PM. Review of the MCU Shift Count Narcotic Log for cart #2, dated August 2018, revealed staff did not complete a correct count on the following dates/shift: 08/01/18 at 7:00 AM, 08/02/18 at 7:00 PM, 08/03/18 at 7:00 AM, and 08/17/18 at 7:00 AM. Continued review revealed staff did not provide a signature(s) for counts on 08/04/18 and 08/06/18. Review of the MCU Shift Count Narcotic Log for cart #2, dated September 2018, revealed staff did not complete a narcotic count on 09/15/18 at 7:00 PM. Continued review revealed staff did not provide a signature(s) for the counts on 09/06/18 and 09/07/18. Review of the MCU Shift Count Narcotic Log for cart #2, dated October 2018, revealed staff did not complete a narcotic count on 10/03/18 at 7:00 PM and 10/12/18 at 7:00 PM. Interview with LPN #5, on 10/18/18 at 10:44 AM, revealed two (2) nurses were responsible for counting narcotic cards and pills during shift change to verify and ensure accuracy of the count. She stated nurses were also responsible for notifying the DNS for any identified discrepancy during the count. Interview with Assistant Director of Nursing Services (ADNS) #1, on 10/20/18 at 12:41 PM, revealed she tried to audit narcotic count sheets at least once a week. She stated she identified issues with staff signing off the narcotic count sheet, but not documenting the administration of the medication on the Medication Administration Record (MAR). The ADNS further revealed she identified concerns with staff not getting two (2) staff signatures for witnessing waste of narcotics. She revealed it was important to get two (2) signatures for waste of narcotics to prevent potential diversion of medication. Interview with the Consultant Pharmacist, on 10/18/18 at 2:29 PM, revealed he was responsible for auditing clinical records to ensure controlled substances were handled and destroyed according to regulatory standards. He stated he did not have consistent access to the facility's computers, but nursing staff assisted him in reviewing MARs for clinical issues. He revealed he reconciled random MARs and narcotic count sheets and had not identified concerns related to controlled medications. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 3:10 PM, revealed two (2) nurses should witness waste of narcotics and sign the count sheet to validate the medication was wasted to prevent potential diversion. She further revealed the clinical managers were responsible for ensuring the record was complete and accurate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34116 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure medications were securely stored in one (1) of eights (8) medication carts, on the 2B Unit. In addition, the facility failed to monitor temperatures for medication refrigerators on two (2) of four (4) units, 1C and 2B. The findings include: Review of the facility's policy, Storage of Medications, not dated, revealed medications and biologicals should be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) were allowed access to medications and medication rooms, carts, and medication supplies should be locked or attended by persons with authorized access. 1. Observation on the 2B Unit, on 10/19/18 at 1:49 PM, revealed medication cart #2 was unlocked and unattended. At 1:50 PM, a Certified Nursing Assistant (CNA) walked past the unlocked cart. Interview with Licensed Practical Nurse (LPN) #4, on 10/19/18 at 1:51 PM, revealed he forgot to lock the cart when he was called away to a room. He stated it was important to ensure the cart was locked to prevent access to residents and visitors. LPN #4 stated a resident could accidentally ingest a medication and get sick. Interview with Assistant Director of Nursing Services (ADNS) #2, on 10/20/18 at 5:07 PM, revealed staff should keep medication carts locked at all times because a resident could pass the cart and grab some pills. The ADNS revealed she had not identified any issues related unlocked carts and was not aware of any formal audits related to monitoring the carts. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 5:47 PM, revealed staff should lock medication carts when unattended to ensure no resident gained access to the cart. The DNS stated she walked the halls all the time and had not identified any concerns related to unlocked carts. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed she conducted walking rounds of the facility and was not aware of any concerns related to unlocked medication carts. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Nursing and Rehabilitation	1705 Stevens Avenue Louisville, KY 40205

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Further review of the policy revealed medications requiring refrigeration or temperatures between 36 degrees Fahrenheit (F) and 46 degrees F should be kept in a refrigerator with a thermometer to allow temperature monitoring. Refrigerated medications should be kept in a refrigerator designated for medications and liquids/foods used in administering medications in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. (Other foods such as employee lunches and activity department refreshments should not stored in this refrigerator.) The policy stated medication storage areas were to be kept clean, well lit, and free of clutter and extreme temperatures. Medication storage conditions should be monitored on a monthly basis and corrective action taken if problems were identified. Observation of the 2B Unit's medication refrigerator, on 10/16/18 at 11:13 AM, revealed a plastic bag, dated 10/03/18, which contained a sandwich, cookies, fruit cup, and a bottle of water. In addition, there was a 6-ounce carton of nutritional orange drink and an ice cream sandwich in the freezer. There was a thick brown liquid running down the back of the refrigerator and heavy buildup of ice surrounding the freezer. Further observation of the medication refrigerator revealed there were stored medications that required refrigeration including Tuberculin serum, Influenza vaccine, and Hepatitis B vaccine. Interview with Registered Nurse (RN) #1, on 10/16/18 at 11:13 AM, during observation revealed food items should not be stored in the medication refrigerator due to the risk of cross contamination. The RN stated nurses were responsible for ensuring the refrigerator was kept clean. He further stated he was not sure where the temperature logs were located or who was responsible for defrosting the freezer. Review of 2B's Medication Refrigerator Temperature Logs revealed staff did not document the temperature twenty-two (22) of thirty-one (31) days in July 2018; seventeen (17) of thirty-one (31) days in August 2018; twenty (20) of thirty (30) days in September 2018; and five (5) days to date for October 2018. Review of 1C's Medication Refrigerator Temperature Logs revealed staff did not document the temperature for four (4) of thirty (30) days in September 2018 and fifteen (15) of thirty-one (31) days in August 2018. Interview with LPN #1, on 10/16/18 at 11:59 AM, revealed he was not sure who was responsible for checking the temperatures or defrosting the medication refrigerators. He stated it was probably the responsibility of nursing staff. Interview with LPN #5, on 10/16/18 at 11:09 AM, revealed the night shift nurse was responsible for checking the refrigerator temperature daily. She stated medication needed to be stored at the proper temperature to maintain effectiveness. Further interview at 12:02 PM, revealed the night shift nurse was responsible for completing tasks listed on the 3rd shift checklist, including defrosting the medication refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 3rd shift Daily Task checklist revealed the nurse should ensure each task was completed, initialed, and turned in to the supervisor/DNS at the end of each shift. Daily tasks to be completed included checking the refrigerator temperature (Ranges 32-42 degrees F), adjusting as needed, and then rechecking. Further review revealed there was no task listed for defrosting the refrigerator. Interview with the ADNS #1, on 10/20/18 at 12:41 PM, revealed she started monitoring the refrigerator temperature logs in October because the thought the night shift nurse was checking them. She stated it was important to monitor the temperature to ensure medications were stored correctly. The ADNS revealed the freezer should be defrosted routinely to allow for adequate airflow and maintain the correct temperature. Interview with the DNS, on 10/20/18 at 5:47 PM, revealed it was not appropriate to store food items in the medication refrigerator. The DNS stated she identified issues with monitoring of refrigerator temperatures the week of the survey. She revealed improper storage temperatures could affect the efficacy of the medication and potentially the resident. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed she was not aware of any issues related to monitoring of refrigerator temperatures prior to the survey.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 34116 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide adaptive utensils during meals for one (1) of twenty-five (25) sampled residents, Resident #54. Observations of dining revealed prescribed adaptive utensils were not provided to Resident #54 during breakfast and lunch on 10/16/18. The findings include: Review of the facility's policy, Tray Identification, effective 08/01/12, revealed the tray card must include a resident's dietary food preferences, and other pertinent information needed for proper food service (i.e., adaptive equipment, food texture). The policy revealed tray cards identified the various diets, needs/preferences, and assisted in setting up and serving the accurate tray/diet to residents. Observation, on 10/16/18 at 9:37 AM, revealed Resident #54 eating his/her cereal with a weighted fork. Further observation revealed there were no other utensils available on the breakfast tray. Observation of meal service, on 10/16/18 at 1:00 PM, revealed Resident #54 tearing steak with his/her fingers. Interview with the resident during observation revealed he/she needed a knife to cut the steak. There was a weighted fork and spoon on the lunch tray, but no knife available. Review of the tray card revealed meals should be served on a divided plate with weighted utensils. Record review revealed the facility readmitted Resident #54 on 03/14/18, with diagnoses to include Protein-Calorie Malnutrition, Extrapyramidal and Movement Disorder, and Dementia with Behavioral Disturbance. Review of the Physician Orders, dated October 2018, revealed Resident #54 had an order for weighted utensils and a divided plate with all meals. Review of the Nutrition Care Plan revealed the resident would be without further significant weight change with an intervention to provide adaptive equipment as ordered. Interview with Certified Nursing Assistant (CNA) #2, on 10/18/18 at 10:07 AM, revealed CNAs were responsible for ensuring adaptive utensils were on the meal tray when it was delivered to the resident. She stated staff delivering the tray was responsible for getting any missing utensils from the kitchen. According to CNA #2, Resident #54 required weighted utensils with meals to allow him/her to eat better and prevent potential weight loss. Interview with CNA #4, on 10/18/18 at 11:13 AM, revealed Resident #54 sometimes got upset if the weighted utensils were not on the meal tray. According to the CNA, the resident had tremors and needed the utensils to eat. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #5, on 10/18/18 at 10:44 AM, revealed staff was responsible for checking tray cards to make sure adaptive utensils were on the tray. She stated Resident #54 was supposed to have weighted utensils with meals, but she gave the resident a plastic spoon on 10/16/18 because she was busy. LPN #5 revealed the weighted utensils helped the resident to eat independently. Interview with Dietary Aide #2, on 10/20/18 at 10:23 AM, revealed all dietary staff was responsible for ensuring adaptive equipment was provided on meal trays. He further revealed the dietary aide at the end of the tray line was responsible for verifying the correct utensils were on the tray prior to loading on the cart. The Aide stated adaptive equipment improved a resident's ability to eat. Interview with Assistant Director of Nursing Services (ADNS) #1, on 10/20/18 at 12:41 AM, revealed she monitored staff daily by observing care and visiting with residents. She stated she had identified issues with food items missing from meal trays, but had not identified any issues related to missing adaptive equipment. She stated staff was responsible for notifying the dietary department as needed to ensure residents could eat and drink. Interview with the Director of Nursing Services (DNS), on 10/20/18 at 5:47 PM, revealed she was not aware of any issues related to the availability of adaptive utensils during meals. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed she was not aware of any issues related to adaptive equipment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34116 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to maintain complete and accurate clinical records for seven (7) of twenty-five (25) sampled residents, Resident #19, #26, #33, #85, #98, #103, and #467. As needed (PRN) controlled medications were signed out but not documented as administered in the medication administration record (MAR) for Resident #26 and #467. Resident #19, #33, #85, #98, and #103 accuchecks and insulin administration documentation was incomplete. The findings include: 1. Review of the facility's policy, Purpose of the Patient (Resident) Record, undated, revealed the facility maintained clinical records to provide complete and accurate resident information for continuity of care. The clinical record contained the documented course of the resident's health care and provided a medium of communication among health care professionals involved in the resident's care. Review of the facility's policy, Specific Medication Administration Procedures, undated, revealed the policy ensured medications were administered in a safe and effective manner. The administration of medication should be documented in the medication administration record (MAR), and if a medication was refused, the refusal should be documented in the MAR as well. When administering a PRN medication, observed medication actions/reactions should be recorded in the PRN effectiveness sheet/nurses' notes. Once removed from the package or container, unused doses should be disposed of in accordance with the medication destruction policy. If the medication was a controlled substance, the procedure for destruction of controlled substances was followed. Review of the facility's policy, Disposal of Medications and Medication-Related Supplies, revised 03/11/14, revealed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances were subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. The policy revealed the Director of Nursing Services (DNS) and the consultant pharmacist were responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. When staff removed a dose of a controlled medication from the container for administration, but refused by the resident or not given for any reason, staff did not place it back in the container. The controlled medication was destroyed in the presence of two (2) licensed nurses or a licensed nurse and a pharmacist, and the disposal was documented on the corresponding line, representing that dose in the accountability record. The same process applied to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason. Review of Resident #467's Physician Orders, dated October 2018, revealed an order for Oxycodone/Acetaminophen (APAP) 5-325 milligram (mg) one (1) or two (2) pills every four (4) to six (6) hours PRN pain starting 10/09/18. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #467's Controlled Drug Records for Oxycodone/APAP 5-325 mg tablet, dispensed 10/04/18 and 10/09/18, revealed staff signed out thirty-five (35) doses for October 2018. However, review of Resident #467's MAR, dated October 2018, revealed only five (5) of the thirty-five (35) doses were documented as administered. Review of the Nursing Notes for Resident #467 revealed no documentation related to pain assessment, PRN administration of Oxycodone/APAP, or follow-up assessment for effectiveness. Review of Resident #26's Physician Orders, dated October 2018, revealed an order for Hydrocodone/APAP 10-325 mg one (1) tablet every twelve (12) hours as needed for pain starting 08/02/18. Review of Resident #26's Controlled Drug Records for Hydrocodone/APAP 10-325 mg, dispensed 09/28/18 and 10/04/18, revealed thirty-three (33) doses were signed out for October 2018. However, review of Resident #26's MAR, dated October 2018, revealed only five (5) of the thirty-three (33) doses were documented as administered. Interview with Licensed Practical Nurse (LPN) #5, on 10/18/18 at 10:44 AM, revealed staff signed out PRN narcotics on the narcotic count sheet and documented in the MAR when administered to a resident. She stated nurses were responsible for performing a follow up assessment to determine the effectiveness of the pain medication and for documenting those findings in the MAR and/or nurses' notes. She stated staff documented administration of medications in the MAR to ensure they followed the physician order and it provided the time of last administration of the medication. LPN #5 revealed if staff did not document the administration of a medication on the MAR, it provided a potential for a medication error. Interview with Assistant Director of Nursing Services (ADNS) #1, on 10/20/18 at 12:41 PM, revealed she had identified issues with documentation in the MARs, including missing documentation for administration of PRN narcotics. She stated agency nurses had no access to the electronic MAR (eMAR) and documented on a paper MAR. She revealed she was responsible for reconciling the paper MAR to the eMAR, but was not always able to reconcile them because of other responsibilities. The ADNS revealed it was important to reconcile the MARs to ensure medications were administered. Interview with the Director of Nursing Services (DNS), on 10/19/18 at 3:10 PM, revealed nurses were responsible for documenting all PRN narcotics in the MAR in order to account for and monitor the effectiveness of the medication. Interview with the Administrator, on 10/20/18 at 6:46 PM, revealed she was aware of concerns related to MAR documentation. 35750 2. Further review of the facility's policy, Purpose of the Patient Record, revealed the facility ensured the clinical health information records were maintained in accordance with professional practice standards. The policy stated regardless of the documentation form (hybrid, electronic, and paper) the clinical record was maintained to provide complete and accurate resident information for continuity of care, justify diagnosis and treatment, and have results documented accurately. In addition the resident clinical record shall be readily accessible and systematically organized. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the facility's policy, Specific Medication Administration Procedures, revealed staff returned to the medication cart and documented administration on the MAR and Treatment Administration Record (TAR). In addition, staff documented a resident refusal of a medication on the MAR/TAR. Review of the facility's Process for Agency Access and Documentation, not dated, revealed agency staff with no access to the electronic documentation on the computer accessed paper documentation, paper MAR and paper TAR, including the skilled notes and assessments records. The ADNS reviewed and reconciled documentation of the paper MAR/TAR to the electronic MAR/TAR. Review of Resident #85's electronic and paper ACC Monitoring (for accuchecks and insulin administration), for March 2018, revealed accuchecks were to be performed before meals and at bedtime; however, accuchecks were not documented as completed on 03/15/18 at 4:30 PM, 03/16/18 at 8:00 PM, and on 03/30/18 at 7:30 PM. In addition, Lantus insulin, 95 units, was to be administered every 9:00 PM. There was no documentation insulin was administered on 03/20/18. Review of Resident #85's Nursing Progress Notes, dated 03/15/18 to 03/20/18, revealed no documentation the resident refused the accuchecks or insulin. Review of Resident #85's electronic and paper ACC Monitoring, for May 2018, revealed an order, dated 05/27/18, for accuchecks before meals and at bedtime on the electronic monitoring form; however, the order was not on the paper monitoring form. In addition, documentation revealed accuchecks were not performed on 05/02/18 at 11:00 AM, 05/09/18 at 11:00 AM, 05/15/18 at 8:00 AM, 05/23/18 at 11:00 AM, 05/24/18 at 11:00 AM, 05/27/18 at 4:30 PM, 05/28/18 at 11:30 AM and 4:30 PM, and 05/31/18 at 8:00 PM. Further review revealed twenty-five (25) doses of insulin not documented as administered. Review of Nursing Progress Notes, for May 2018, revealed no documentation the resident refused accuchecks or insulin. Review of the telephone orders for Resident #85 revealed an order dated 05/12/18, for Apidra Insulin, 30 units before breakfast and 30 units before lunch with the previous order of 27 units of Apidra Insulin discontinued. However, review of the May 2018 electronic and paper ACC Monitoring revealed the new order was not transcribed onto the ACC Monitoring record. Two (2) days later, the physician changed the dose back to 27 units. Review of Resident #85's electronic and paper ACC Monitoring, for July 2018, revealed accuchecks were to be performed before meals and at bedtime; however, documentation revealed eleven (11) accuchecks were not performed. In addition, seventeen (17) doses of insulin were not documented as administered. Review of Nursing Progress Notes, for July 2018, revealed no documentation the resident refused accuchecks or insulin. Review of Resident #85's electronic and paper ACC Monitoring, for August 2018, revealed accuchecks were to be performed before meals and at bedtime; however, documentation revealed seventeen (17) accuchecks were not performed. In addition, twenty-one (21) doses of insulin were not documented as administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Nursing Progress Notes, for August 2018, revealed no documentation the resident refused accuchecks or insulin. Review of Resident #85's electronic and paper ACC Monitoring, for September 2018, revealed nineteen (19) doses of insulin not documented as administered. Review of Nursing Progress Notes, for September 2018, revealed no documentation the resident refused insulin. Review of Resident #85's electronic and paper ACC Monitoring, for October 2018, revealed accucheck were to be performed before meals and at bedtime; however, documentation revealed eleven (11) accuchecks were not performed. In addition, twelve (12) doses of insulin were not documented as administered. Review of Nursing Progress Notes, for October 2018, revealed no documentation the resident refused accuchecks or insulin. Review of Resident #33's electronic and paper ACC Monitoring, for August 2018, revealed accuchecks were to be performed before meals and a bedtime; however, documentation revealed thirty (30) accuchecks were not performed. In addition, twenty-one (21) doses of insulin were not documented as given. Review of Nursing Progress Notes, for August 2018, revealed no documentation the resident refused accuchecks or insulin. Review of Resident #33's electronic and paper ACC Monitoring, for September 2018, revealed twenty-five (25) accuchecks were not documented as performed. In addition, seventeen (17) doses of insulin were not documented as administered. Review of Nursing Progress Notes, for September 2018, revealed no documentation the resident refused accuchecks or insulin. Review of Resident #98's electronic and paper ACC Monitoring, for October 2018, revealed accuchecks were to be performed before meals and at bedtime; however, documentation revealed nine (9) accuchecks were not performed. In addition, three (3) doses of insulin were not documented as administered. Review of Nursing Progress Notes, for October 2018, revealed no documentation the resident refused accuchecks or insulin. Review of Resident #103's electronic and paper ACC Monitoring, for October 2018, revealed seventeen (17) accuchecks were not documented as performed. In addition, ten (10) doses of insulin were not documented as administered. Review of Nursing Progress Notes, for October 2018, revealed no documentation the resident refused accuchecks or insulin. Review of Resident #19's electronic and paper ACC Monitoring, for August 2018, revealed six (6) accuchecks were not documented as performed. In addition, eighteen (18) doses of insulin were not documented as administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's electronic and paper ACC Monitoring, for September 2018, revealed thirteen (13) doses of insulin were not documented as administered. Review of Resident #19's electronic and paper ACC Monitoring, for October 2018, revealed ten (10) accuchecks were not documented as performed. In addition, eight (8) doses of insulin were not documented as administered. The facility did not provide Resident #19's Progress Notes. Interview with LPN #3, on 10/20/18 AT 10:12 AM, revealed she was an agency nurse and did not have access to the electronic ACC Monitoring records, even though the facility had educated her on the electronic system during orientation. She further stated she documented accuchecks and insulin on the paper ACC Monitoring forms, which were kept in a binder on the unit; however, she stated she was concerned with the accuracy of the paper forms. One main concern was she felt the facility might not update the paper forms with new orders. LPN #3 stated since she did not have access to the electronic system, she could not be sure if orders were correct on the paper forms. She further stated some residents had voiced concerns to her, in particular, Resident #85, who told her he/she did not receive insulin on time and other medications were given late. Interview with ADNS #2, on 10/17/18 at 1:43 PM and 10/20/18 at 5:07 PM, revealed the medical record included all aspects of a residents stay at the facility and should not have any omissions; however, if omissions occurred it should be documented why the omission occurred. She stated if a medication was held and not administered the nurse needed to specify the reason in the progress notes. She stated the facility had many agency staff, which made it hard to figure out who gave medications. She stated the procedure for insulin administration was to check the resident's blood sugar level, check the order, and give the insulin as ordered by the physician. If insulin could not be given as ordered, or was given late, a progress note should to be completed. The ADNS further stated she did not monitor for accurate medication administration. Interview with ADNS #1, on 10/20/18 at 12:56 PM, revealed she was responsible for reconciling the paper and electronic documents but it was difficult because she was responsible for many different things. She tried to locate agency staff to complete charting to ensure care was completed. Interview with the DNS, on 10/19/18 at 8:40 AM and 3:35 PM, revealed she reviewed Resident #85's electronic and paper records to determine accuracy of accuchecks and insulin administration and could not account for all the omissions. Her review revealed nurses had not documented possible reasons for omissions and to the best of her knowledge, the records seemed incomplete because not all documentation could be found. The DNS stated she became aware of documentation issue during the survey. Continued interview on 10/20/18 at 5:47 PM, revealed she expected clinical records to be accurate and complete. She stated nurses should document medication when they gave it and there was an issue with documentation. The DNS stated if a resident refused a medication, the nurse was to document the refusal in the detail section of the medication administration record or in the progress notes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Clinical Operations, on 10/17/18 at 2:22 PM, revealed agency staff had no access to the electronic system and should document on the paper record, which was a hard copy. She stated each time an agency staff worked, the electronic record and paper record had to be reconciled to assure medications were given as ordered. She stated she could not provide a clear answer on how accurate the system worked; however, she thought nurses on the units were not confused about the process. Interview with the Senior Director of Clinical Operations, on 10/18/18 at 7:09 AM, revealed paper documentation was not consistently noted in the electronic system. She stated not all agency staff had access to the electronic record. Interview with the Administrator, on 10/20/18 at 6:47 PM, revealed she had concerns that agency staff had no access to the electronic record and identified how burdensome and ineffective it was to monitor two (2) systems, the electronic and paper records. Interview with the Medical Director, on 10/20/18 AT 11:58 AM, revealed he was aware of documentation issues with agency nurses because they had no access to the electronic system and documented on paper, and there was no good way to put the information in the electronic system. Interview with the Senior Regional [NAME] President, on 10/18/18 at 11:25 AM, revealed the facility was aware of the issue with the electronic and paper records and inaccurate/incomplete clinical records of the residents. The [NAME] President stated leadership had identified the facility had issues pertaining to documentation in the clinical record with agency and facility nurses.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 28734 Based on interview, record review, and facility policy review, it was determined the facility failed to ensure six (6) of six (6) glucometers (used to check blood sugar levels) were monitored for accuracy. The findings include: Review of the facility's policy, Quality Control Testing on Assure Platinum Meter, not dated, revealed quality control testing using the Assure Dose Control Solution checked to ensure if the meter (glucometer) and test strips were working correctly as a system and if staff tested correctly. The policy stated the level of responsibility to perform the Quality Control Testing should be delegated to the Registered Nurse (RN) or a Licensed Practical Nurse (LPN), and did not use the system if the control solution was out of range. Review of the facility's 3rd shift Daily Task Checklist revealed daily tasks included checking glucometers and completing the log. Review of 2C's Glucose Meter Quality Control Log revealed glucometer #10404549641 was not tested for quality control twenty-nine (29) of thirty-one days (31) in May 2018, twenty-eight (28) of thirty (30) days in June 2018, thirty (30) of thirty-one (31) days in July 2018, thirty (30) of thirty-one (31) days in August 2018, and one (1) of seventeen(17) days in October 2018. Review of 1C's Glucose Meter Quality Control Log revealed glucometer #10404733759 was not tested for quality control fourteen (14) of thirty-one (31) days in July 2018, fifteen (15) of thirty-one (31) days in August 2018, and three (3) of thirty (30) days in September 2018. Review of 2B's Glucose Meter Quality Control Log revealed glucometer #10404808564 was not tested for quality control twenty-four (24) of thirty-one (31) days in July 2018, twenty-two (22) of thirty-one (31) days in August 2018, and nine (9) of seventeen (17) days in October 2018. The facility was unable to provide the control logs for May 2018 and June 2018. Review of 2B's Glucose Meter Quality Control Log revealed glucometer #10404808501 was not tested for quality control twenty (20) of thirty-one (31) days in July 2018, seventeen (17) of thirty-one (31) days in August 2018, twenty (20) of thirty (30) days in September 2018, and five (5) of (17) days in October 2018. The facility was unable to provide the control logs for May 2018 and June 2018. Review of 1B's Glucose Quality Control Log revealed glucometer #10404808506 was not tested for quality control eighteen (18) days of thirty-one (31) days in May 2018; documentation on 05/30/18, revealed there was no control solution for the glucometer. Continued review revealed the glucometer was not tested twenty-four (24) of thirty (30) days in June 2018, and twenty-six (26) of thirty-one (31) days in July 2018 The facility did not provide control logs for August 2018 and September 2018. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. Building B. Wing	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Nursing and Rehabilitation	1705 Stevens Avenue Louisville, KY 40205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of 1B's Glucose Quality Control Log revealed glucometer #10404808508 was not tested for quality control eighteen (18) of thirty-one (31) days in May 2018; documentation on 05/30/18, revealed there was no control solution for the glucometer. Continued review revealed the glucometer was not tested twenty-four (24) of thirty (30) days in June 2018, and twenty-seven (27) of thirty-one (31) days in July 2018. The facility did not provide control logs for August 2018 and September 2018. Interview with Licensed Practical Nurse #6, on 10/20/18 at 12:57 PM, revealed the night shift nurses should be checking the glucometers every night to ensure they were working correctly, and the results placed in a log located on top of each medication cart. She stated if the glucometers were not working correctly, a potential outcome could be an inaccurate dose of insulin given to a resident, or insulin might be withheld and a resident could suffer from a diabetic coma or even death. Interview, on 10/20/18 at 11:45 AM, with the Assistant Administrator revealed the Glucose Meter Quality Control documentation had several missing glucometer checks. She stated she did not know why the checks were not completed and the checks were to validate accuracy of the glucometer. She stated the facility expectation was for the nurse to check the glucometer every night shift. Interview with the Administrator, on 10/20/18 at 6:47 PM, revealed the night nurses were to check the glucometers every night to ensure accuracy.