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	01/11/2020

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to treat each resident in a manner that promoted each resident's dignity and enhanced their quality of life for four (4) of four (4) nursing units. Observation of nursing Units 1B, 1C, 2B, and 2C revealed staff served residents their beverages in plastic, disposable cups during meals. The findings include: Review of the facility's policy, Resident Rights revealed the facility ensured each resident admitted to the Community be treated with consideration, respect and full recognition of his or her dignity and individuality, including privacy in treatment and in care for his or her personal needs. Observation of dining on the 2B Unit, on 01/06/2020 at 12:45 PM, revealed staff served residents drinks in disposable, plastic cups during the lunch tray pass. Further observation on the 2B Unit, on 01/06/2020 at 1:00 PM, revealed lemonade and chocolate milk served in plastic, disposable cups on Resident #91's lunch tray in his/her room. Observation of dining on the 1B Unit, on 01/06/2020 at 1:10 PM, revealed staff served residents drinks in disposable plastic cups and, their milk remained in the milk carton during the lunch tray pass. Observation of Certified Nursing Assistant (CNA) #22 during 1B Unit lunch meal service, on 01/06/2020 at 1:17 PM, revealed he/she provided the resident in room [ROOM NUMBER] a meal tray and opened the milk carton. However, CNA #22 did not offer or provide a glass for the resident's milk. Interview with CNA #4, on 01/08/2020 at 9:08 AM, revealed staff preferred disposable cups and used them for juice and water. According to the CNA, the facility used disposable plastic cups off and on for three (3) or four (4) years and she thought the residents liked them better. The CNA further revealed cups were not included with the meal trays, so staff used the disposable plastic cups from the medication cart. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA #22, on 01/06/2020 at 1:26 PM, revealed if the residents asked for a cup for their drink, he then provided a plastic, disposable cup for use. Observation, on 01/08/2020 at 8:48 AM, revealed a disposable plastic cup with orange juice on Resident #55's breakfast tray. Interview with the resident during the observation revealed the facility used plastic cups for meals and it made him/her feel like a second-class citizen. Interview with Resident #23, on 01/08/2020 at 9:03 AM, revealed the facility had used disposable, plastic cups for the past four (4) or five (5) months; however, the resident stated he/she preferred a regular cup. Interview with CNA #13, on 01/10/2020 at 10:06 AM, revealed the facility was the residents' home and regular dishes should be used for meals, instead of plastic, disposable cups. Interview with CNA #16, on 01/11/2020 at 10:15 AM, revealed meals were served from the tray carts to residents as they arrived on the unit. He stated staff used plastic disposable cups during the meal services when the residents wanted actual cups for their drinks. Interview with CNA #11, on 01/10/2020 at 10:16 AM, revealed she was not aware of the purpose for the residents' drinks served in the disposable cups. According to CNA #11, it was important to use regular cups and dishware so the residents would feel at home. Interview with Licensed Practical Nurse (LPN) #4, on 01/09/2020 at 10:38 AM, revealed staff used disposable cups for meals because the kitchen ran out of glasses. According to the LPN, staff had used disposable cups on Unit 2B for about a month. Interview with LPN #11, on 01/10/2020 at 11:52 AM, revealed residents' meals should not be served on disposable plastic ware because it was a dignity issue and not homelike. Interview with the Cook, on 01/09/2020 at 3:13 PM, revealed there were not enough regular cups for residents of the entire facility. He stated he did not know why the plastic disposable cups were used; however, since the change of ownership in September 2019 they have been utilizing the disposable cups. He stated prior to the ownership change, the facility used real glass cups. He stated the manager had difficulty locating cups and trays. Further interview revealed the plastic disposable cups were not homelike, as well as being a dignity issue for the residents. Interview with the Dietary Manager, on 01/09/2020 at 3:33 PM, revealed the facility did not have enough drinking cups for residents. According to the Manager, the shortage of cups was an ongoing issue because sometimes residents kept the cups, and staff also threw them away. He stated the Certified Nurse Aides (CNA) liked to use the plastic disposable cups. Again, he stated they did not have sufficient cups; however, he would put an order in today. Additionally, he revealed the manager had trouble finding cups and trays to serve the residents during meal service. He stated this was a dignity issue for the residents, as this was not providing a homelike environment. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator, on 01/09/2020 at 12:04 PM, revealed the residents should have a comfortable, homelike setting to maintain their dignity. Continued interview with the Administrator, on 01/10/2020 at 4:40 PM, revealed he became aware of the residents' concerns, upon his arrival this week and during the survey process. He stated his greatest concern was not meeting the resident's needs. He revealed he was not aware that plastic, disposable cups were being provided to the residents during their meal services.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 35750 Based on interview, review of Resident Council Minutes, and review of the facility's policy, it was determined the facility failed to act promptly upon, address and resolve the grievances of resident groups concerning issues of resident care. Interviews revealed residents complained of their concerns with staff's response to call lights, timely medication administration, and availability of medications. Additionally, interviews revealed residents' grievances were not responded to by the facility. The findings include: Review of the facility's policy, Grievance/Complaint Log, reviewed 06/01/18, revealed the resolution of all resident grievances and/or complaints will be recorded on the facility's Resident Grievance/Complaint Log. The policy stated the Administrator/Social Services was responsible for recording and maintaining the log. Per review, the Grievances/Complaints were to be reviewed by the Quality Assurance/Performance Improvement (QAPI) Committee monthly for trends and follow up. The policy further stated it was best practice for the Grievance/Complaint resolution/follow up to be completed as soon as practicable, not to be exceeded by thirty (30) days, if feasible. Review of the Resident Council Meeting Forms completed during the monthly Resident Council meeting dated from June 11, 2019 through December 10, 2019, revealed no Old Business was carried over from any of the previous meetings. Further review revealed some forms did not contain a section for old business to ensure residents' grievances were addressed and resolution had been attempted. Review of the June 2019 through December 2019 Resident Council Meeting Forms revealed no follow-up regarding resident concerns voiced in the previous meetings. Grievances included call light response times, staff's attitudes, facility cleanliness, and trash removal. Review of the Monthly Grievance log dated August 14, 2019, through December 23, 2019, revealed residents had filed fifteen (15) grievances. During the annual survey one-hundred-fifty-one (151) residents resided at the facility. Continued review revealed two (2) residents filed most of the recorded grievances, and these pertained to Residents #55 and #57. Per review of the log, the grievances were marked as resolved, with the concern and the resolution date documented. However, further review revealed during the annual Recertification Survey screening process, both residents made it known to the Surveyor (State Survey Agency) that some of their concerns remained unresolved. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview during the Resident Group Meeting, with the Ombudsman present, on 01/07/2020 at 10:47 AM, revealed seven (7) of seven (7) residents reported their grievances had not been resolved. Per interview, the Resident Group was particularly very vocal regarding issues, such as; extended call light times primarily during the night shift and on weekends, the loud noisy units, staff congregating around the nursing station and not being available to meet residents' needs and a lack of follow up on their concerns. Residents had made their grievances known to the nurses, the Social Worker, Director of Nursing, Administrator and the Ombudsman. In addition, the residents complained of not receiving their medications in a timely manner, particularly their pain medications and sleeping pills. The residents also complained of the facility running out of the medications which they needed to take as prescribed. The primary concern voiced during the Resident Group Meeting, was a lack of responsiveness by nursing staff which frustrated the residents. Further interview revealed the Resident Group members stated they were resigned to the lack of resolution of their ongoing concerns which had been reported to the facility. Interview with the Ombudsman, on 01/07/2020 at about 12:15 PM, following the Resident Group Meeting, revealed the residents in the meeting had spoken up regarding their concerns Interview with the Social Worker (SW), on 01/11/2020 at 10:07 AM, revealed she followed up on the grievances expressed in the Resident Council meetings. She stated she was aware residents had complained of not getting their care needs resolved. Per interview, she stated as far as she knew the DON addressed the residents' concerns; however, there might be an education issue related to agency staff. The SW stated she was aware that from time to time residents' nursing care concerns were not resolved, and she had heard from residents that nursing staff had not answered their call lights. Per the SW, this made residents frustrated, and as a result, they did not want to file another grievance as there was no resolution to the original grievance. The SW stated she was primarily aware of residents' concerns on third (3rd) shift and at times on weekends. Further interview revealed the residents were at the facility to get their care needs met, and would not otherwise live at the facility if they were able to help themselves. The SW stated she expected residents to have consistent and good care provided as required, and it was not alright for residents not to have all their care needs met. Interview with the Social Services Assistant (SSA), on 01/09/2020 at 4:46 PM, revealed she took notes during the Resident Council Meeting and completed a form. The SSA stated the residents' concerns were then brought up in the next morning meeting, where the concerns were addressed by the appropriate department. According to the SSA, during the Resident Council Meeting she guided the residents through the form and provided direction and reminders. She stated she also discussed with the residents whether old business from the previous meeting had been followed up on. Per interview, she spoke to the Resident Council President next. The SSA stated however, after she reviewed the old notes if it was determined the same issue had been brought up again, a new grievance form was completed and then she addressed the grievance in the next Resident Council Meeting Form again. The SSA stated the facility had performed a lot of in-services, and dips and trends were found. Further interview with the SSA, on 01/10/2020 at 10:50 AM, revealed she had heard that residents continued to voice concerns regarding not getting their care needs met, and not receiving all their medications as prescribed. She stated the facility's goal was for the grievance process to work, and responsibility needed to be assigned to a staff member on an ongoing basis for oversight and to ensure that the grievances were resolved. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Admission Coordinator, on 01/11/2020 at 9:34 AM, revealed her primary duty included getting the paperwork ready for all new resident admissions. She stated this included all clinical information, which was coordinated with the DON, to ensure the new resident's needs could be met by the facility. Continued interview revealed she also provided the packet which included resident's rights and responsibilities; however, she stated she did not read over the rights with the resident and/or responsible party unless they had a question. The Admissions Coordinator stated she did not mention the grievance process on admission, and was unsure who explained that process to new admissions. Further interview revealed most residents did not want to go over the resident rights information, which included the grievance process, and only occasionally, would a resident request she read the entire rights section. She stated she assumed the SW was explaining the grievance process in more detail, and was not sure what the facility's policy stated regarding this area. She further stated to her it seemed the facility's grievance process was not working, and the facility needed to find an overall solution for this problem. Interview with the DON, on 01/11/2020 at 12:13 PM, revealed she was aware of Resident #57's grievance and provided training to the CNA involved on how to perform perineal care appropriately for the resident. However, further interview revealed she had not known the resident's incontinent brief had not been changed in a timely manner. She stated this could have caused the resident to be affected physically, as well as, psychosocially. Interview with the Administrator, on 01/10/2020 at 4:40 PM, revealed he understood the facility's grievance process and was in the process of changing it. He stated he was aware the residents had concerns regarding the current grievance process. The Administrator stated when residents filed a grievance, he expected a follow up; however, he stated residents did not always know what the outcome of the grievance. According to the Administrator, he expected staff to review the residents' grievances and staff should address the grievances immediately, if possible. Per interview, residents should be told in person what had been done to resolve their issue/grievance. Continued interview revealed he was aware of the fact that residents had lost some confidence in reporting their grievances, as two (2) residents had told him so. The Administrator stated follow up was a part of the facility's policy which had not been completed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 34116 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure resident's had a safe, clean, and homelike environment for four (4) of four (4) nursing units, and two (2) of four (4) shower rooms. Observations revealed stained or missing ceiling tiles, broken drawers in resident rooms, broken call lights, dirty resident bathrooms, broken or missing floor tiles, dirty privacy curtains, and broken closet doors. Observations revealed resident rooms contained gray/white substances on furniture surfaces and debris on floors. Observation of the 2B Unit Shower Room, revealed a bariatric-sized chair with a brown, dried substance on the seat. Also a soiled shower bed and a stand up lift with a brown dried substance on the leg supports. Multiple soiled clothing and linen items were on the floor throughout the shower room. The shower room drain was partially covered with a thick substance. Interview with Certified Nursing Assistant (CNA) #20, regarding the 2B Unit Shower, revealed the substance, partially covering the shower drain, was stool. Further observation of the 1B Unit Shower Room, revealed stool was on the floor of the shower. Interview with Resident #101, revealed the facility was dirty. Resident #101 stated sometimes he/she had to ask the Certified Nursing Assistants (CNA's) to clean the shower room because there was feces on the floor. Further interview revealed the shower room felt like an [NAME]. Further observations revealed the elevator transition plates into the elevator car revealed a dark thick substance, loose particles and debris in the grooves. The vents in the [NAME] Dining room contained a gray substance on the vent slats. The dining room furniture in the [NAME] Dining area and Unit 1C's furniture appeared soiled with a dark substance on the arm rests and seats. Additionally, the [NAME] Dining room contained cobwebs in the corners with dead insects and the windowsills had dirt and debris. The corridor chair railing on Units 1B, and 1C contained a loose gray substance. The nurses' station on 2B contained peeling wallpaper and the vinyl baseboard was damaged and peeling away from the corner coming out into the hallway exposing a sharp edge. The findings include: Review of the Housekeeping Position Summary, not dated, revealed Housekeeping performed housekeeping and cleaning activities within well established guidelines and assigned areas and shifts to ensure that quality standards, safety guidelines and customer service expectations were met. The housekeeper performed a variety of tasks, such as dust mopping and damp mopping floors in all areas including entry ways, corridor, etc. In addition, housekeeping was responsible for cleaning bathrooms which included sinks, floors and commodes. Housekeeping was also responsible for the daily cleaning and sanitizing of resident furniture, as well as, the sitting rooms and dining room furniture. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Job Description for the Environmental Services Account Manager, not dated, revealed the Manager supervised the environmental services staff according to the policies and procedures and federal/state requirements. The Manager was responsible for coordinating and insuring the satisfactory and timely completion of projects and program work done in the building on varying shifts. Review of the facility's policy, Resident Rights, dated 2019, revealed the facility ensured the rights of each resident admitted to the Community. Continued review revealed this included ensuring each resident was treated with consideration, respect and full recognition of his or her dignity and individuality, including privacy in treatment and in care for his or her personal needs. Review of the facility's policy, Maintenance Service, revised December 2009, revealed the Maintenance Department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel included, but were not limited to: maintaining the building in compliance with current Federal, State, and local laws, regulations, and guidelines; and, maintaining the building in good repair and free from hazards. Observation of Corridor 2B leading towards the nurses' station, on 01/06/2020 at 10:22 AM, revealed multiple unpainted, white patches, on the walls on both sides of the corridor. Observation of the 2C Unit, near the area of the nurses' station and elevator corridor, on 01/06/2020 at 11:16 AM, revealed the upholstery on the resident's sofa, and chairs appeared soiled on the armrest and in the seats, along with loose particles, and debris in the seats. Observation during tour, from 2C Unit entering 2B Unit near room [ROOM NUMBER], on 01/06/2020 at 11:17 AM, revealed twelve (12) floor tiles were cracked, with missing pieces, creating depressions in the floor. Continued observations revealed a resident with a rolling walker moving in and out of the area while rolling and walking across floor tiles, with some of the floor tiles missing. Further observations revealed stains, scuff marks, and gouges in the walls down the hallway corridor between resident room doorways, with several observed between rooms [ROOM NUMBERS]. Observation of resident room [ROOM NUMBER], on 01/06/2020 at 11:02 AM, revealed a thick, gray/white substance on top of the chest of drawers and the television base. Continued observation revealed there were arts and craft beads and a medicine cup lying on the floor. Further observation revealed black scuff marks and black/brown dirt also on the floor, and in the corners of the resident's room and bathroom. The bathroom privacy curtain was soiled with a black/gray substance. Interview with Resident #101, at the time of observation, revealed the facility was dirty. According to the resident, he/she dusted and swept the room because dust was everywhere and housekeeping staff never dusted. Resident #101 stated sometimes he/she had to ask the Certified Nursing Assistants (CNA's) to clean the shower room because there was feces on the floor. During further interview, Resident #101 stated the shower room felt like an [NAME]. Observation of resident room [ROOM NUMBER], on 01/06/2020 at 11:42 AM, revealed grayish, black rings on two (2) ceiling tiles above the room's window, and a white substance splattered across the lower portion of Resident #103's closet. Observation of the bathroom revealed broken gray brackets attached to the wall tile and the towel bar was missing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of resident room [ROOM NUMBER], on 01/06/2020 at 12:06 PM, revealed the cord to the wall light was broken and hanging from the side rail of the bed. Further observation revealed the plastic covering on the resident's pillow was torn and exposed the cloth batting inside. Interview with Resident #26, at the time of the observations, revealed he/she had to leave the wall light on all night because the cord was broken. The resident stated it had been like that for about a week. Further interview revealed the light interfered with his/her sleep because it gets hot. Observation of resident room [ROOM NUMBER], on 01/06/2020 at 1:05 PM, revealed a grayish black ring on two (2) corner ceiling tiles near the window. Interview with Resident #55, on 01/08/2020 at 8:48 AM, revealed the bathroom soap dispenser had been broken for about seven (7) months. The resident stated he/she purchased his/her own hand soap due to the broken dispenser. Continued interview revealed the resident had reported the issue to staff; however, nothing ever got fixed when it was reported. Observation of the dispenser, during the interview, revealed the hand lever to dispense the soap was broken as reported by Resident #55. Observation of resident room [ROOM NUMBER], on 01/07/2020 at 9:30 AM, revealed the top drawer was missing from the resident's nightstand. Observation of Resident #4's room (#212), on 01/07/2020 at 9:46 AM, revealed three (3) drawers were missing from the four (4) drawer chest, and the resident's personal clothing was visible at the bottom. Further observation revealed the wallpaper next to the bed was torn and the brown drywall was exposed. Further observation of room [ROOM NUMBER] revealed one (1) of the drawer fronts from Resident #34's chest of drawers was lying on the floor. Interview with Resident #34, at the time of the observation, revealed the toilet paper dispenser was off the wall in the bathroom, and the closet doors were off track and difficult to move. According to Resident #34, the drawer had been broken for about a month and the dispenser for about a week. Further interview revealed the maintenance issues were ridiculous and made the resident feel pissed off. Interview with Housekeeper #1, on 01/07/2020 at 9:47 AM, revealed she was assigned to clean room [ROOM NUMBER] on 01/06/2020 and 01/07/2020. She stated she had not noticed the drawers were missing from the chests. Interview with Resident #34, at the time of the observations, revealed he/she had reported the broken chest two (2) or three (3) months ago, and the wallpaper had been scraped off for quite a while. According to the resident, the condition of the room bothered him/her, and it did not feel homelike. Interview with Certified Nursing Assistant (CNA) #3, on 01/07/2020 at 10:04 AM, revealed she had noticed the broken drawers in room [ROOM NUMBER], about two (2) weeks ago and had reported the issue to the nurse. The CNA stated it was important to repair the broken furniture because it was a dignity issue and not homelike for the residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the 2B Unit's Shower Room, on 01/07/2020 at 10:14 AM, revealed the non-skid floor strips were peeled up at the edges. Continued observation revealed a hard plastic wall covering was pulled away from the shower wall exposing a sharp edge. Further observation revealed a soiled broom and dustpan stored on top of the shower bed. Observation of the 2B Unit shower room, on 01/08/2020 at 10:00 AM, revealed two (2) rolling shower chairs, one (1) regular sized and one (1) bariatric-sized chair. The bariatric-sized chair contained a brown, dried substance on the seat. A shower bed appeared soiled. A stand up lift contained a brown dried substance, approximately five by four inches (5 x 4), on the leg supports. The stand-up lift foot base contained loose gray debris and particles, and a dried dark colored substance. Multiple soiled clothing and linen items were observed on the floor throughout the shower room. The shower room drain covers had a thick substance covering them and appeared to block the water drain. Observation of the 1B Unit's Shower Room, on 01/08/2020 at 11:31 AM, revealed a brown substance on the floor that smelled like stool. Interview with Certified Nursing Assistant (CNA) #20, on 01/08/2020 at 10:31 AM, revealed everyone was to clean the shower room after each use. She stated the floor has dried dirt at the entrance, and dried gray shoe prints were also observed on the floor. CNA #20 stated the vent over the shower, near the corner was filthy in appearance. She indicated the vent above the entrance contained dark gray, dust and dirt. She stated the thick slime over the shower drain was stool, partially covering the drain. Observation of resident room [ROOM NUMBER], on 01/08/2020 at 9:37 AM, revealed the towel bar was missing, and there was a thick, gray, fuzzy build-up on the exhaust fan. Observation of Resident #65's room, on 01/08/2020 11:25 AM, revealed the wall heating/cooling unit was loose on the right side and not secured. The floor in the resident's room, in the corners, and along the floor and baseboards contained a dark, thick coarse, dried substance. In addition, the fall strips next to the bed and bathroom appeared worn with torn and jagged edges. The bathroom floor was also soiled in the corners with a dark, thick coarse, dried substance. Continued observations revealed the bathroom ceiling vent was coated with thick grey debris on the vent slats. During interview with Resident #65, on 01/08/2020 at 11:25 AM, the resident stated, It looked like not much cleaning occurred around here. Interview with Certified Nursing Assistant (CNA) #4, on 01/08/2020 at 9:08 AM, revealed the CNA's were responsible for reporting maintenance issues to the nurse, and for completing a work order in the computer. Interview with Licensed Practical Nurse (LPN) #4, on 01/09/2020 at 10:38 AM, revealed she tried to call maintenance and submit a work order whenever she noticed a maintenance issue. However, she was not sure if the missing towel bars or broken soap dispensers were reported. She revealed it was important to address maintenance issues to maintain infection control and for the residents' dignity. According to the LPN, the rooms were not homelike if items were not available for resident use. (continued on next page)

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	185039	A. Building B. Wing	01/11/2020

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Highlands Nursing and Rehabilitation	1705 Stevens Avenue Louisville, KY 40205

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with LPN #10 on 01/09/2020 at 11:07 AM, revealed she called Maintenance or asked housekeeping staff to help her regarding maintenance issues because she did not know the correct procedure for submitting work orders in the computer. Interview with Housekeeper #3, on 01/10/2020 at 10:45 AM, revealed she was responsible for trash removal, cleaning bathrooms, and sweeping/mopping resident rooms every day. She stated she was also responsible for ensuring paper towels, toilet paper, soap and hand sanitizer were stocked in all the rooms. The Housekeeper stated if she noticed the soiled privacy curtains she notified the Manager. She stated she sprayed deodorizer on the privacy curtains when she cleaned; however, the Floor Tech and Housekeeping Manager were responsible for changing/washing the curtains. According to the Housekeeper, she would not want her family to live there because the rooms did not look clean. She stated some housekeeping staff did not clean until State Surveyors (State Survey Agency) were in the building. She further stated she reported the issues to the Housekeeping Director who addressed the problems; however, it had not done any good. Interview with the Maintenance Director, on 01/10/2020 at 9:34 AM, revealed he performed monthly preventative maintenance according to the electronic maintenance program. The Director stated nursing staff was responsible for submitting electronic work order requests as needed. However, further interview revealed the Housekeeping Department did not have access to the electronic maintenance program system and the Housekeeping Director notified him of maintenance issues by word of mouth. Review of the computerized Work Orders, for the period of 10/01/2019 thru 01/08/2020, revealed no evidence of work orders related to the missing towel bars, stained ceiling tiles, broken soap dispenser, broken wall light, broken floor tiles, broken and/or missing drawers, broken closet doors, or of the peeling non-skid strips and wall covering in the 2B Unit's shower room. Observation of the corridors leading to the [NAME] Dining Room, on 01/06/2020 at 12:01 PM revealed the corridors contained a thick, dried brown, black substance on the floors along the corners and at the transitions between the corridors and the door entries. The exit to the resident's smoking area contained loose debris, was observed to be heavily soiled, and dirty in appearance on the floor and walls. Observation of the [NAME] Dining Room, during lunch meal service, on 01/06/2020 at 12:06 PM, revealed ten (10) stained ceiling tiles. The windowsills contained a powdery, loose grayish substance. The airflow vents were coated with a thick gray substance over the vent slats. In addition, there was a broken wobbly table stored in the dining room and scooted over to the side. Interview with the Account Manager for Housekeeping Services, on 01/09/20 at 9:49 AM, revealed his role was to oversee housekeeping services. He stated the routine floor care, included a dry dust mop daily. The initial sweeping in the hallways was followed by an auto scrubber, which lightly scrubbed the floor. He stated this process occasionally occurred in the shower room and resident rooms. He stated he completed a round of the facility upon his hire back in August of 2019, and made notes of areas in need of attention. However, he did not have documented notes of his findings. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Continued interview with the Accounts Manager revealed he identified floor corner and edges needed to be stripped bare and at this time they were still trying to address those areas. He stated he did not have a schedule, or a plan of when the identified cleaning tasks would be completed. He stated the resident's privacy curtains should be taken down for deep cleaning once a month, and otherwise as needed when found soiled. Further interview revealed it was the policy for staff to clean resident rooms daily. He stated that Housekeeping staff were educated on expectations during orientation, annually, and as needed if an issue was identified. He stated his audit practice included a daily audit of one to two rooms; and during the audit, his focus was looking at all of the high touch areas, to determine if they were cleaned. In addition, he randomly audited a second room to see if it was deep cleaned, according to policy. Continued interview revealed he had not identified any issues during the audits. He stated housekeepers were responsible for cleaning vents. However, vents were only cleaned during the deep cleaning of the room, which occurred once every four weeks. In addition, he stated housekeeping would not clean the vents unless maintenance identified the vents were dirty and removed them for housekeeping to clean. He further stated he could not say if maintenance had notified housekeeping of the need to clean the vents when they were taken down. He stated the role of housekeeping was to keep the facility clean and sanitary for the residents. Tour of the facility and interview with the Administrator, the Director of Maintenance (DOM), and the Director of Housekeeping (DOH), on 01/09/2020 at 12:04 PM, revealed the vents in the [NAME] Dining Area contained a dust and lint type substance, and they expressed concerns for residents with respiratory type diagnoses worsening with the potential of poor air quality. The DOH revealed the windowsills, and the chair railing in the [NAME] Dining area were dusty, contained cobwebs, and dead insects in the corners, and on the windowsills. The DOM stated the ceiling tiles were stained, and had been for a while, as they had previously had leaking areas. The dining area chairs were soiled, and in dis-repair. Further interview with the DOM, and Administrator revealed these items were less than sanitary, and not acceptable for the residents' dining area, or for their visitors, or staff's working environment. The DOM and Administrator stated the nurses' stations were in need of repair; and the walls, and the doors needed painting. Observation of the 2B Unit shower room with the Administrator, DOM, and the DOH revealed the scales, and resident transfer lift, should be maintained in a clean and sanitary manner. In addition, the vents, drainage systems, soiled utility rooms should all be maintained in a clean and sanitary manner, ensuring trash was removed, service carts were all kept clean throughout the facility. Further interview with the Administrator, revealed the areas of concern were not acceptable for residents, or their visitors to experience. He stated much repair in the facility was necessary.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 21585 Based on interview, record review, and facility policy review, it was determined the facility failed to notify the Ombudsman (OMB) of discharges and transfer. In addition, the facility did not record resident information related to the resident's transfer to ensure continuity of care nor was the resident given a written statement of rights or the OMB contact information for one (1) of one (1) of a total sample of thirty-two (32) residents (Resident #107). The findings include: Review of the facility's policy titled, Resident Rights, dated 2019, revealed resident needs, wants and wishes must be considered prior to the decisions made in the facility. As a company we place a tipr priority on preserving resident rights, ensure their rights were not voilated. When residents were transferred or discharged on ly for medical reasons, or his or her welfare or that of other residents the facilty would provide advance notice to ensure orderly transfer or dischargem and such actions would be documented in the resident's medical file. Review of the facility's policy titled, Transfer or Discharge Notice, revised 2016, revealed a copy of the transfer or discharge notice would be sent to the Office of the State Long-Term Care Ombudsman. In addition, the reason for the transfer or discharge would be documented in the resident's medical record. Review of the closed record for Resident #107, revealed the facility admitted the resident on 02/09/2009 with a history of Heart Failure, Acute Myocardial Infarction (heart attack), Chronic Kidney Disease and Diabetes. The facility transferred the resident to an Acute Care Hospital on 10/12/2019, after a change in condition and readmitted the resident on 10/21/2019. Further review revealed the facility again transferred the resident to the hospital for shortness of air on 01/03/2020. Continued review of Resident #107's clinical record revealed, the facility did not record resident information to ensure continuity of care during each transfer process, nor the location to which the resident was transferred. In addition, no evidence the resident or the responsible party was provided a written statement of the resident's appeal rights or the State Long Term Care Ombudsman's contact information, during or after each transfer. Also the facility did not have written evidence that the Ombudsman was provided notice of Resident #107's emergency transfers. Interview, on 01/09/2020 at 3:05 PM, with the Assistant Social Services Director and the Director of Social Services, revealed it was not their responsibility to notify the Ombudsman of resident transfers and discharges. Interview, on 01/09/2020 at 3:38 PM, with the Business Office Manager, revealed she did not know the facility's process for making notifications to the Ombudsman office related to the transfers and discharges. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Ombudsman, on 01/09/2020 at 3:50 PM, revealed the Ombudsman's (OMB) office was not receiving notifications from the nursing facility related to transferred or discharged residents. Interview with the Director of Nursing, on 01/09/2020 at 3:10 PM, revealed she did not know who was responsible for providing the Ombudsman with the resident's transfer and discharge information. In addition, she was not aware the facility was not providing the resident or the responsible party with information on resident rights or OMB contact information after the facility transferred a resident. In addition, she did not know the facility was not recording resident information during transfer to ensure continuity of care. Interview with Administrator, on 01/10/2020 at 8:22 AM, revealed the process for the facility staff to send notice to the ombudsman and to document in the medical record information regarding resident transfer or discharge, to ensure continuity of care. He stated he did not know how this was missed for Resident #107, and would have to investigate.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28733 Based on interview, record review, and facility policy review, it was determined the facility failed to provide the resident and the resident's representative written notice related to the bed-hold policy upon transferring a resident to a hospital or when a resident went on therapeutic leave for two (2) of two (2) residents of a total sample of thirty-two (32) residents (Residents #83, and #107). The findings include: Review of facility's policy, Notice of Transfer or Discharge, not dated, revealed resident's had the right under 900 [NAME] 2:05E to appeal any discharge by informing the Cabinet of Health & Family Services, in writing, within fifteen (15) days of date of notice. If transferred the resident's bed would be reserved for Medicaid or Medicaid application pending residents for up to fourteen (14) days per year while in a hospital for an acute condition, and it was reasonably expected the resident would return to the same level of care. Ten days per year were allowed for home visits or therapeutic leave. If bed hold days were exhausted the resident may hold the bed by paying privately for the bed, at current private pay rate. If this option was not exercised, the resident would be placed on a waiting list for the next bed available, with the same sex resident roomate. The bed hold form would be provided to the resident and responsible party upon transfer. 1. Review of Resident #83 clinical records revealed the facility admitted the resident on 11/25/2019 with the diagnoses of Atrial Fibrillation, Coronary Artery Disease, Cardiovascular Disease, Diabetes Mellitus, Dementia, and Hypertension. Review of the record revealed Resident #83 was admitted to the hospital on 12/10/2019, and on 12/20/2019. However, there was no documented evidence the facility provided bed hold information to the resident or the resident's representative for the transfers. 2. Record review revealed the facility readmitted Resident #107 on 10/21/2019, from an Acute Care Hospital stay with the diagnoses of Chronic Congestive Heart Failure, Cardiomyopathy. Further review revealed the resident was transferred to an Acute Care Hospital on 01/03/2020 for shortness of air. However, there was no documented evidence the facility provided bed hold information to the resident or resident's representative for these transfers. Interview with the Social Services Assistant, and the Director of Social Services, on 01/09/2020 at 3:05 PM, revealed they do not make any notification of bed hold information, or any information related to transfers and discharges. Interview with Director of Nursing (DON), on 01/09/2020 at 3:10 PM, revealed she was not sure who was responsible for the resident's transfer and discharge information with the bed-hold notifications. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Business office Manager (BOM), on 01/09/2020 at 3:38 PM, revealed the facility's consulting company outsourced the bed holds. She stated the consulting company would make the offer of bed hold notification. Continued interview revealed she was not sure if the liaisons made notifications to the residents and their families or not. She stated she was not sure if the Ombudsman Office was notified of the transfers and discharges. Interview with Administrator, on 01/10/2020 at 8:22 AM, revealed the process for the facility was to send all residents transferred with the bed-hold information, or send to the responsible party. In addition, a copy of the bed hold information was placed in the financial file. He stated the Social Services, the Business Office Manager, or the clinical liaisons were to follow up if the resident became a discharge.

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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 the facility's policy, it was determined the facility failed to develop/implement the care plan for six (6) of thirty-two (32) sampled residents (Residents #34, #57, #91, #101, #135, and #493). Interviews and record review revealed the facility failed to administer pain medication as ordered and care planned, implement falls prevention interventions as care planned, and provide respiratory services as care planned. Review of Resident #34's Medication Administration Record (MAR), dated December 2019, revealed Percocet 10-325 mg was not administered on 12/14/2019 at 4:00 PM and 8:00 PM; 12/15/2019 at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM; or 12/16/2019 at 12:00 AM. Further review of the MAR revealed staff failed to assess the resident's pain level from 12/14/2019 at 4:00 PM until 12/16/2019 at 4:00 AM. Further review of Resident #101's clinical record revealed a Physicians Order, dated 09/27/2019, for Oxycodone-APAP 10-325 mg give one (1) tablet by mouth every four (4) hours for pain. Review of Resident #101's MAR, dated October 2019, revealed a total of fourteen (14) missed doses of Oxycodone-APAP. Continued review of the MAR, dated November 2019, revealed a total of six (6) missed doses of Oxycodone-APAP. The findings include: Review of the facility's policy, Care Plans, Comprehensive Person - Centered, revised December 2016, revealed a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The policy stated a comprehensive care plan for each resident would be developed within seven (7) days of completion of the required comprehensive assessment (MDS- Minimum Data Set). The policy further revealed the comprehensive, person-centered care plan would describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; and incorporate risk factors associated with identified problems. The person-centered care plan included measurable objectives and timetables that met the resident's physical, psychosocial and functional needs. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care planning process included the resident's strength and needs and culture preferences. The IDT reviewed and updated the care plan when a resident had a significant change, when the desired outcome was not met, when a resident was readmitted to the facility from a hospital stay and quarterly, in conjunction with the required Quarterly Minimum Data Set (MDS) Assessment. 1. Review of Resident 91's clinical record revealed the facility admitted the resident on 03/18/2019 with diagnoses which included Dementia without Behavioral Disturbance, Atrial Fibrillation, and Type 2 Diabetes Mellitus. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #91's Comprehensive Care Plan for Fall Risk, initiated 10/16/2019, revealed the resident was at risk for falls related to Dementia with confusion, incontinence, poor communication/comprehension, and poor safety awareness. Continued review revealed the goal of the care plan was the resident would have a reduced risk for falls and fall related injury. Interventions included assist with transfers and encourage/assist resident to wear non skid footwear. However, there was no intervention related to side rail assessment/safety. Observation, on 01/06/2020 at 11:22 AM, revealed Resident #91's side rail was not secured to the bed and was partially resting on the floor. Further observation revealed the resident attempted to move his/her legs over the broken rail. Interview with Certified Nursing Assistant (CNA) #2, on 01/06/2020 at 11:36 AM, revealed the broken side rail was a safety issue and could cause an accident. Interview with CNA #4, on 01/08/2020 at 9:08 AM, revealed the broken rail was a fall and trip hazard. Interview with LPN (Licensed Practical Nurse) #4, on 01/06/2020 at 11:28 AM, revealed the side rail appeared to be broken. She stated Resident #91 could potentially fall out of bed. Interview with LPN #2, on 01/10/2020 at 4:54 PM, revealed the nurses were responsible for completion of the Side Rail Assessment Screen when a resident was admitted . LPN #2 stated she was not sure of the facility's protocol for utilizing side rails. Interview with Licensed Practical Nurse #12, on 01/10/2020 at 2:47 PM, revealed the purpose of the care plan was to communicate resident care needs. Interview with the MDS Coordinator #1, on 01/11/2020 at 10:24 AM, revealed she reviewed the clinical record and diagnoses to develop the initial and comprehensive care plans. The MDS Coordinator stated the care plan communicated resident care needs. Interview with the Director of Nursing (DON), on 01/10/2020 at 5:04 PM, revealed she had not initiated any audits related to care plans. 2. Review of the facility's policy Pain Management, dated October 2018, revealed a plan of care would be written with the initiation of pain medication and individualized to the resident, addressing potential side effects, limitations due to pain, behavioral symptoms, and alternative pain relief techniques. Observation, on 01/07/2020 at 10:22 AM, revealed Resident #34 neatly groomed and seated on the bedside. Interview during the observation revealed the resident went two (2) days without pain medication because the facility let it run out. Review of the clinical record revealed the facility admitted Resident #34 on 10/28/2019 with diagnoses which included Low Back Pain, Radiculopathy, and Nontraumatic Compartment Syndrome of Unspecified Lower Extremity. Review of the 5-day Minimum Data Set (MDS) Assessment, dated 11/03/2019, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15) and determined the resident was interviewable. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Further review of the clinical record revealed a Physicians' Order, dated 11/06/2019, for Percocet 10-325 mg (Oxycodone-Acetaminophen, pain medication) give one (1) tablet by mouth every four (4) hours related to Nontraumatic Compartment syndrome of Unspecified Lower Extremity. Review of the Care Plan for Pain, revised 11/05/2019, revealed a goal that Resident #34 would verbalize adequate relief of pain. Interventions included administering pain medications as ordered; notifying the physician of unrelieved or worsening pain; observing and reporting changes in usual routine, sleep patterns, decrease in functional abilities, decrease in range of motion (ROM), withdrawal or resistance to care; observing for non-verbal pain; and providing the resident and family with information about pain and options available for pain management. Review of Resident #34's Medication Administration Record (MAR), dated December 2019, revealed Percocet 10-325 mg was not administered on 12/14/2019 at 4:00 PM and 8:00 PM; 12/15/2019 at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM; or on 12/16/2019 at 12:00 AM. Further review of the MAR revealed staff failed to assess the resident's pain level from 12/14/2019 at 4:00 PM until 12/16/2019 at 4:00 AM. Review of the Progress Notes, dated 12/14/2019 at 4:49 PM, revealed Resident #34's Percocet was not available. Further review of the Progress Notes revealed staff did not assess the resident's pain level, implement non-pharmacological interventions, or notify the physician to manage the resident's pain for the two (2) days the Percocet was unavailable. Interview with LPN #11, on 01/10/2020 at 11:52 AM, revealed non-pharmacological pain interventions would include applying a cold/warm compress, offering fluids or diversional activities. LPN #11 stated she should have assessed Resident #38's pain level, implemented non-pharmacological intervention(s), and probably should have notified the physician for a one-time order for pain medication; however, she was sometimes swamped and did not document everything. LPN #11 further revealed the resident could be in a lot of pain if their pain medication was not administered. Interview with LPN #12, on 01/10/2020 at 2:47 PM, revealed non-pharmacological interventions to manage pain could include deep breathing, repositioning, and positive visualization. She further revealed pain assessments and interventions should be documented in the progress notes. According to LPN #12, Resident #34 was very upset about not having pain medication available. Interview with LPN #4, on 01/09/2020 at 10:38 AM, revealed the care plan was not implemented if the prescribed services or medications were not administered. Interview with LPN #12, on 01/10/2020 at 2:47 PM, revealed the care plan communicated the resident's care needs. LPN # 12 stated Resident #34's care plan was not implemented for pain management. 3. Observation, on 01/10/2020 at 10:33 AM, revealed Resident #101 seated at the bedside. Interview during observation revealed the resident's pain medication was sometimes not available. Review of the clinical record revealed the facility readmitted the resident on 03/25/2017 with diagnoses to include Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Primary Osteoarthritis. Review of the Quarterly Minimum Data Set, dated dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) and determined the resident was interviewable. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan for Pain, revised 09/20/2019, revealed a goal the resident would verbalize adequate relief of pain or ability to cope with incompletely relieved pain. Interventions included administer analgesia as per orders; monitor/record/report to nurse resident's complaints of pain or requests for pain treatment; and notify the physician if interventions were unsuccessful or if the current complaint was a significant change from the resident's past experience of pain. Further review of the clinical record revealed a Physicians Order, dated 09/27/2019, for Oxycodone-APAP 10-325 mg give one (1) tablet by mouth every four (4) hours for pain. Review of the MAR, dated October 2019, revealed a total of fourteen (14) missed doses of Oxycodone-APAP on 10/02/2019, 10/04/2019, 10/07/2019, 10/09/2019, 10/11/2019, and 10/13/2019. Review of the MAR, dated November 2019, revealed a total of six (6) missed doses of Oxycodone-APAP on 11/20/2019, 11/21/2019, and 11/26/2019. Interview with Licensed Practical Nurse (LPN) #4, on 01/09/2020 at 10:38 AM, revealed pain could affect a resident's activities of daily living (ADL). The LPN further revealed the care plan was not implemented if the prescribed pain medication was not administered. Interview with LPN #12, on 01/10/2020 at 2:47 PM, revealed the purpose of the care plan was to communicate resident needs. The LPN stated the care plan was not implemented if medications were not administered to manage the resident's pain. 35750 4. Observation of Resident #57, on 01/07/2020 at 9:12 AM, revealed the resident had oxygen on via nasal cannula at three (3) Liters per minute (3L/min) and a BI-PAP (Bilevel Positive Airway Pressure) machine sat atop the resident's closet. Observation of Resident #57, on 01/07/2020 at 3:18 PM, revealed the resident rested in bed, eyes closed without the BI-PAP machine on for use. The equipment was atop of the bed and was not administered during the resident's naptime. Resident #57's clinical record review revealed the facility readmitted the resident, on 11/16/2019, with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction, and Chronic Obstructive Pulmonary Disease. Resident #57's Quarterly Minimum Data Set review, dated 11/22/2019, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15) determining the resident was interviewable. The resident's functional status was determined to be extensive assistance with one (1) to two (2) staff for all activities of daily living (ADL). The facility determined the resident had shortness of breath with exertion, when sitting and at rest and received oxygen therapy. Resident #57's Minimum Data Set review dated 10/14/2019, revealed the Care Area Assessment triggered care planning for Activities of Living (ADL) function, Urinary Incontinence. Section O, Special Treatment Programs which included Oxygen and BI-PAP applications, as needed during daytime naps. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Resident #57's Medication Administration Record (MAR) reviewed for September, November and January revealed nursing staff had not implemented the planned care related to administration of the BI-PAP, as planned. The order for the BI-PAP was not transcribed onto the October 2019 MAR and was not received for December of 2019. Further review revealed the resident had not received his/her showers as scheduled. Resident #57's shower sheet forms review, 11/29/2019 through 01/04/2020, revealed the resident only received six (6) of the twelve scheduled showers. Interview, on 01/07/2020 at 9:12 AM, with Resident #57, revealed he/she was supposed to wear a BI-PAP; however, the resident stated the equipment was placed on top of his/her closet. The resident stated the physician ordered for him/her to wear the equipment when he/she took a nap during the daytime and at night. Resident #57 stated he/she talked to the staff nurse, the Unit Manager and the Director of Nursing, about not getting the BI-PAP during nap times. The resident further stated, he/she had filed grievances with the facility about the BI-PAP, not receiving timely brief changes and not getting his/her showers as scheduled. Resident #57 stated because of the situation and as a last resort, in order to obtain the care and services, he/she filed a complaint with the State (State Survey Agency). Interview, on 01/10/2020 at 3:47 PM with CNA #10, revealed at times a lack of staff affected the residents care needs. She stated at times she could not provide the showers, or knew who was receiving a shower because of a lack of effective communication. CNA #12 stated Resident #57 was supposed to get a bed bath; however, she was not always sure who received a shower/bed bath and there was not always enough staff to provide it. She stated the resident sat in his/her soiled and wet brief at least twice a week when she came on shift and the resident had a right to complain. CNA #12 stated when there was a lack of staff, especially on the weekends, there were more falls and residents did not get the care. The CNA stated if staff followed the care plan and the policy there would not be as many complaints. Interview, on 01/10/2020 at 4:03 PM, with LPN #2 revealed she knew Resident #57 had a PRN BI-PAP order. However, she did not follow the policy or the order. Continued interview at 4:10 PM, revealed the facility did not have enough staff and there was a lack of oversight by facility leadership with reordering medications and at times there was only on pill left in the narcotic box. She further stated there was definitely an issue with the shower schedule for CNA's who did not know which resident got a shower and on what shift the showers should be provided. She stated the ADL policy was not followed and residents complained often about this. 5. Resident #135's thirty (30) day Minimum Data Set (MDS) review, dated 09/19/2019, revealed the facility assessed Resident #135 with a Brief Interview for Mental Status score of four out of fifteen (4/15) and determined the resident was cognitively severely impaired. The resident required total assistance with one (1) staff for bed mobility and surface to surface transfers. The facility assessed the resident had two (2) or more injury falls. Resident #135's Quarterly MDS review, dated 12/26/2019, revealed the facility assessed Resident #135 with a BIMS score of five out of fifteen (5/15), determining the resident was cognitively severely impaired. The resident required extensive assistance with two (2) staff for bed mobility and surface to surface transfers. The facility determined the resident had one (1) non-injury fall during this period. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Resident #135's Comprehensive Care Plan review revealed a revised goal date of 12/27/2019, and the facility determined the resident was at risk for falls related to his/her gait/balance problems, incontinence and psychoactive drug use, vision/hearing problems and impaired cognition. The goal for the resident was to be free of falls through the next review on 04/20/2020. Interventions included to encourage the resident to lay down after lunch and as needed (PRN), keep his/her remote and call light within reach and encourage him/her to use it, prompt response to all requests for assistance, appropriate footwear and non-skid socks when ambulating or mobilizing in wheel chair. In addition, the facility planned to review information on past falls and attempt to determine the cause of falls, record possible root causes and educate the resident/family/caregivers/IDT as to the causes. However, interview with the Director of Nursing (DON) on, 01/10/2020 at 12:36 PM, revealed she could not locate the fall evaluation, post fall investigation, root cause, or the Interdisciplinary Team meetings (IDT) notes for Resident #135's falls, on 08/24/2019, on 09/01/2019, 09/06/19 and 11/07/2019. Resident #135's medical record review revealed the resident was readmitted to the facility on [DATE] with diagnoses including Essential Hypertension, Diabetes Mellitus, Unspecified Cerebral Infarction, Pneumonia, Enterocolitis due to Clostridium Difficile, Sepsis due to Enterococcus, Vascular Dementia and Bradycardia. Interview, on 01/10/2020 at 3:41 PM with CNA #10, revealed Resident #135 was confused and yelled out and really did not know what he/she needed, did not always know what the call light was used for and it was hard to know at times what the resident needed. However, she stated since the resident had many falls she thought staff had not checked adequately on him/her. CNA #10 stated staff needed to check on the resident when he/she yelled out. Interview, on 01/10/2020 at 2:59 PM, with CNA #11 revealed Resident #135 understood at times, and at times he/she did not understand. She stated the resident required monitoring and supervision and he/she fell because staff had not checked on the resident often enough. Interview, on 01/11/2020 at 10:24 AM, with MDS Coordinator #1, revealed it was not normal for Resident #135 to have frequent falls. However, she stated, with the resident's cognition it was hard to prevent the resident from getting up and somebody would have to stand right by his/her bed. She stated the facility was to keep residents as safe as possible. However, the resident was one you provided care for (him/her) and two (2) minutes later the resident tried to get up. She stated the care plan was updated each time a change in the resident's care occurred; and fall interventions were in place. The MDS Coordinator stated the resident's call light and non-skid socks could help prevent a fall; but one to one (1:1) supervision, one hundred (100%) of the time, would help more. MDS Coordinator #1 stated the care plan did not have interventions related to monitoring, although the facility had tried to put interventions in place. She further stated, when a patient fell the IDT team met, and as part of the IDT team, she reviewed Nurse's Notes and the care plan and put interventions in place. However, MDS Coordinator #1 stated, the DON followed up on the root cause for falls. Interview, on 01/11/2020 at 12:24 PM, with the Director of Nursing, revealed she could not locate the Post Fall/Trauma documentation for Resident #135, the IDT Notes or the root cause of the resident's falls. She stated she was not sure that the floor-nursing staff had received any training because the forms the facility was currently using came out around November. She stated she believed the forms she had reviewed were complete; however, if she felt information was missing she reached out to staff. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	6. Resident #493's Physician's Order Sheet (POS) review, dated 01/01/2020, revealed the resident had orders including Lamotringe 100 milligram (mg) Tablet, by mouth (PO), two (2) times per day (BID) as related to diagnoses of Essential Tremor and Generalized Anxiety Disorder, Topiramate Tablet, 50 mg, one (1) time a day related to a diagnosis of Essential Tremor and Xanax Tablet, 2 mg, give one (1) every eight (8) hours as needed (PRN) related to a diagnosis of Essential Tremor and an order to administer 2 Liters of oxygen per minute (2L/Min) and keep the resident's oxygen saturation > 92% PRN as related to COPD via nasal cannula. Resident #493's Admission Summary Note review, dated 01/01/2020 at 3:39 PM, revealed the facility admitted the resident around 2:00 PM. The note stated at the time of admission, the resident's lungs sounds were diminished, and his/her oxygen saturation was ninety-five percent (95%) on room air. In addition, the resident appeared to get Short of Air (SOA) with ambulation and the nurse reviewed all medications with the physician. Resident #493's MDS review, dated 01/06/2020, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of thirteen out of fifteen (13/15) determining the resident was interviewable. Further review revealed the resident had shortness of breath with exertion and was on oxygen therapy and received antianxiety medications. Review of Resident #493's Baseline Care Plan revealed the resident received oxygen therapy and, as needed (PRN) and psychotropic medications. Review of Resident #493's Pharmacy Delivery Manifest, dated 01/02/2020 at 12:44 PM, revealed Resident #493's medications, Lamotringe 100 mg, Topiramate 50 mg and Alpazaoalm (Xanax) 2 mg, had arrived at the facility. Review of Resident #493's Progress Note, dated 01/02/2020 at 12:45 PM, revealed the resident got his/her Xanax 2 mg administered, for the first time since his/her admission, on 01/01/2020 at approximately 2:00 PM. However, the resident had remained without his/her ordered medications for twenty-two hours and twenty-five (22 hrs 25m) minutes. Interview, on 01/06/2020 at 10:57 AM, with Resident #493 revealed the physician ordered Lamictal, Xanax and Topamax and he/she had not received these medication for thirty-six (36) hours. The resident further stated he/she made this concern known to the nurse at the desk and also told LPN #11 about his/her frustration. Resident #493 stated LPN #11 informed him/her the medications should arrive in about four (4) hours. However, at 10:00 PM, the medications had not arrived from the pharmacy. The resident stated, he/she, felt extreme anxiety, as he/she suffered from Congestive Obstructive Pulmonary Disease. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview, on 01/11/2020 at 12:29 PM with the Director of Nursing (DON) revealed she discussed with the IDT what interventions were in place at the time of the fall and, if there was a need to put any additional interventions in place. She stated, after the IDT met the MDS Coordinator revised the care plan. The DON further stated, that during the weekend she directed staff to call her with any falls and she provided staff with direction to provide the care. She stated if the care plan was not revised then residents would not receive the resident specific care. Continued interview with the DON revealed she expected the staff to provide brief changes every two to three (2-3) hours when they made rounds. She stated, she expected nursing staff to document when they provided care, such as BIPAP administration. The DON stated she had identified omissions in the medical records and was looking to identify a trend. Interview, on 01/10/2020 at 4:55 PM, with the Administrator revealed he expected interventions related to falls to be in place, root cause analysis should be conducted, and they should review medications and find out if there was a trend at a certain time of day.

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 21585 Based on interview, record review and policy review it was determined the facility failed to revise the plan of care to include dietary supplement recommendations in order to address identified weight loss for (1) of thirty-two (32) sampled residents (Resident #107). The findings include: Review of the undated policy, Goals and Objectives, Care Plans, revealed the care plan would incorporate goals and objectives that lead to the resident's highest obtainable level of independence. The care plan goals and objectives were defined as the desired outcome for a specific resident problem. When goals and objectives were not achieved the resident's documentation in the medical record would occur as to why they were not achieved and new goals and objectives would be established. Care plans would be modified accordingly. All disciplines would have access to the information and would be able to report whether or not the desired out comes were being achieved. The goals and objectives would be reviewed and revised when the resident had a significant change in condition, when the desired outcome was not achieved, when the resident was readmitted to the facility from a hospital and at least quarterly. Review of the facility's policy for Weight Assessment and Intervention, not dated, revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for the residents. Assessment information would be analyzed by the multidisciplinary team and conclusions would be made regarding resident's target weight range, approximate calorie needs and medical condition. Review of the closed record for Resident #107, revealed the facility admitted the resident on 02/09/2009, and readmitted the resident on 10/21/2019, after a hospitalization . The resident had a history of Heart Failure, Acute Myocardial Infarction (heart attack), Chronic Kidney Disease and Diabetes. Review of Resident #107's Nutrition/Dietary Note, made on 11/26/2019, revealed the resident's weight was 104.1 pounds. The Dietary Note stated the resident had a significant weight change of 10.3 percent in thirty (30) days and a 10.3 percent weight loss in the last three months and 11.8 percent in six months. Further review revealed a recommendation for eight ounces of Nepro (a supplement), every day between meals, to provide additional Kilocalories and Protein. However, the supplement did not get transferred to the plan of care, nor to the Treatment or Medication Administration Record (TAR/MAR). Further review of the Nutrition/Dietary Note made on 12/05/2019, revealed Resident #107 weighed 103.2 pounds and the resident had a significant weight loss of 11.8 percent in the last three months and 11.3 percent in the last six (6) months. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #107's Physician's Order Set for December 2019, revealed an order for staff to provide the resident eight ounces of the supplement, Glucerna, two times a day. However, no order was provided for the Dietitian's recommended eight ounces of Nepro (a supplement), every day between meals, to provide additional Kilocalories and Protein. On 01/10/2020 at 12:20 PM, interview with Certified Medication Technician (CMT) #1, revealed she did not know Resident #107 had experienced a weight loss. CMT #1 stated if the resident had an order for supplements they would be on the MAR/TAR. She stated she could not remember administering supplements to the resident. CMT #1 stated if the staff did not revise the plan of care then the recommended supplements would not be administered to address the identified weight loss and the resident could experience a decline. Interview with Licensed Practical Nurse (LPN) #15, on 01/11/2020 at 10:38 AM and 1:03 PM, revealed Resident #107 was a diabetic and small in stature. However, due to her being agency staff, she could not remember much more about the resident. LPN #15 stated the Interdisciplinary team revised resident care plans routinely. She stated the facility did not bring it to her attention the resident had a significant weight loss or additional supplements were recommended. Continued interview revealed there was nothing was on the MAR to alert her to this either. She stated she also did not review the plan of care, she just depended on the MAR to direct her in the care of the resident. LPN #15 stated if staff did not provide the recommended supplements the resident could experience a decline. Interview on 01/11/2020 at 12:55 PM, with the Director of Nursing (DON), revealed she had not identified that Resident #107's plan of care was not revised to reflect the recommended supplement of Nepro for the resident. She stated if the facility did not revise care plans to ensure the recommended dietary supplements were placed on the plan of care, residents could experience a decline. Interview with the Administrator, on 01/11/2020 at 2:03 PM, revealed he expected staff to revise care plans with dietary recommendations after a resident was identified with weight loss. He stated he was new to his role and was still in the process of evaluating the facility's system issues.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35750 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide the Activities of Daily Living (ADL) assistance necessary to ensure good personal hygiene and grooming for one (1) of thirty-two (32) sampled residents (Resident #57). Resident #57 was not provided timely incontinent care on multiple occasions resulting in the resident being left in his/her soiled brief until the oncoming shift assisted him/her. In addition, the resident did not receive his/her showers as scheduled. The findings include: Review of the facility's policy, Quality of Life - Accommodation of Needs, revised August 2009, revealed the facility's environment and staff behaviors were to be directed toward assisting residents in maintaining and/or achieving independent function, dignity and well-being. Review of Resident #57's clinical record revealed the facility readmitted the resident on 11/16/2019 with diagnoses including, Hemiplegia and Hemiparesis following a Cerebral Infarction, Obesity, Chronic Pain Syndrome, Acute and Chronic Respiratory Failure with Hypercapnia, Sleep Apnea, Chronic Obstructive Pulmonary Disease, Generalized Anxiety Disorder, and Vascular Dementia without Behavioral Disturbance. Review of the facility's Quarterly Minimum Data Set (MDS) for Resident #57 dated 11/22/2019 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), which indicated he/she was not cognitively impaired and was interviewable. Continued review revealed the facility assessed the resident's functional status as requiring extensive assistance with one (1) to two (2) staff for all Activities of Daily Living (ADL), which included brief changes and showers. Review of the facility's shower schedule for Resident #57, for the 2 B-Hall from Sunday through Saturday, revealed the facility scheduled the resident's showers for Tuesday and Friday of each week. Review of the facility's Shower Sheets for the timeframe of 11/29/2019 through 01/04/2020, revealed Resident #57 had received six (6) of the twelve (12) scheduled showers. Per review of the shower sheets, Resident #57 received only one (1) shower per week instead of the two (2) scheduled per week. Interview, on 01/07/2020 at 9:12 AM, with Resident #57 revealed he/she filed many grievances regarding having to lay in his/her feces for hours. The resident stated he/she had remained in a brief soiled with feces and urine for over three (3) hours the previous night. Per interview the resident stated, I have a clock on the wall and know . what time he/she called staff for assistance. Continued interview revealed nursing staff promised him/her they would do better; however, the resident stated he/she remained in soiled briefs time and time again. Resident #57 stated, I don't get my showers as scheduled, sometimes I have to wait almost two (2) weeks to get a shower. Further interview revealed the shower issue had been going on for about one (1) year. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 01/10/2020 at 11:06 AM, with Certified Nursing Assistant (CNA) #13, revealed when she came to work on her shift Resident #57 had several times been wearing a soiled brief because the prior shift had not changed his/her brief. Interview, on 01/10/2020 at 3:58 PM, with CNA #10, revealed Resident #57 was supposed to get a bed bath. She stated she did not always know which resident was to be showered, and at times the facility did not have enough staff. Per interview, the shower schedule was confusing. According to CNA #10, Resident #57 had not always received his/her showers. Continued interview revealed Resident #57 fussed and complained if he/she had not received his/her shower. CNA #10 stated the resident asked her and the nurses what could be done about this issue. The CNA #10 stated Resident #57 had sat in his/her poop at least twice a week previously, and had had a puddle under his/her brief. She further stated Resident #57 had a right to complain about these issues. Interview, on 01/10/2020 at 11:22 AM, with CNA #12, revealed Resident #57 was the only resident she knew who had sat in his/her own urine. Per interview, at times when she had changed the resident's brief, the urine felt like ice water. She stated Resident #57 was not always an accurate reporter of details; however, there was at least an ounce of truth in his/her statements. Interview, on 01/10/2020 at 11:10 AM, with Certified Medication Technician (CMT) #2, revealed the CNA's reported to her at times when nursing staff from the night shift had not changed Resident #57's soiled briefs. Per interview, the CNA's talked about finding the resident in soiled briefs. The CMT stated there was a high resident to nurse ratio at the facility, which affected the care and services for the residents living there. According to the CMT, however, it was not alright to leave a resident in a soiled brief and just go home. Interview, on 01/10/2020 at 4:19 PM, with LPN #2, revealed the facility had an ineffective shower schedule. Per interview, staff were confused about which residents got showers on what shift. She stated residents complained about it all the time. Further interview revealed the residents' complaints were valid, as this was an ongoing issue. Interview, on 01/10/2020 at 12:18 PM, with Licensed Practical Nurse (LPN) #11, revealed she assisted the CNA's as much as possible with turning and repositioning residents and with providing incontinent care. She stated however, incontinent care might take three (3) hours and it delayed her from passing the residents' medications timely. The LPN revealed this affected the residents greatly because they had not been cared for in a timely manner. Continued interview revealed she had found Resident #57 sitting in his/her own excrements before and stopped what she was doing to clean the resident up. LPN #11 stated residents should be kept dry and clean otherwise, it could affect their skin. Further interview revealed if they were not kept clean and dry they could have an odor from the soiled briefs, and this was a dignity issue for a resident. Interview, on 01/09/2020 at 11:37 AM, with the Social Services Assistant (SSA), revealed Resident #57 had told her about not receiving timely brief changes before. She stated if the resident remained for several hours in his/her own excrements it would be more than just a physical discomfort, it was humiliating and uncomfortable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 01/11/2020 at 12:13 PM, with the Director of Nursing (DON), revealed she expected staff to perform brief changes when they conducted their rounding, every two (2) hours. According to the DON, if a resident remained in his/her soiled brief for longer times, than the two (2) hours, it could cause them skin irritation. Continued interview revealed it could also possibly cause skin impairment, and if an odor remained from the presence of the soiled brief, it could affect the resident's psychosocial well-being. She stated nursing staff had made her aware Resident #57 refused assistance at times and she told staff they had to approach the resident again. The DON stated her expectation was for nursing staff to perform brief changes in a timely manner. Further interview revealed she had not performed audits related to this concern yet, but had reeducated one (1) CNA who she had received a concern about regarding residents' perineal care. Interview, on 01/10/2020 at 5:02 PM, with the Administrator, revealed he expected residents to get their showers when they were scheduled. He stated he also expected residents to receive timely assistance with incontinent care. Per interview, if a resident did not receive timely assistance they would not feel like they were being cared for as they should be cared for.

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	185039	A. Building B. Wing	01/11/2020

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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(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** 35750 Based on interview, record review and review of the facility's policy it was determined the facility failed to ensure residents were provided medications in a timely manner for one (1) of thirty-two (32) sampled residents (Resident #493). The findings include: Review of the facility's policy, Administering Medications, dated April 2019, revealed medications were to be administered in a safe and timely manner, and as prescribed. Continued review revealed medications were only to be administered by licensed persons, or as permitted by the state, to prepare, administer and document the medication administration. According to the policy, medications were administered in accordance with the prescriber's orders to include the required time frame, and for the optimal therapeutic effect of the medication. Further review revealed this was performed to honor the resident's choices and preferences, consistent with his/her care plan. If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering it was to initial the Medication Administration Record (MAR) in the space provided for the drug. Review of the facility's policy, Quality of Life - Accommodation of Needs, revised August 2009, revealed the facility's environment and staff's behaviors were directed towards assisting residents in maintaining and/or achieving independent function, dignity and well-being. Review of Resident #493's clinical record revealed the facility readmitted the resident on 01/01/2019 with diagnoses including, Acute and Chronic Respiratory Failure with Hypercapnia, Chronic Obstructive Pulmonary Disease (COPD) and Generalized Anxiety Disorder, Urinary Tract Infection Site not specified and Essential Tremor. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #493 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was interviewable. Further review revealed Resident #493 was assessed to have shortness of breath with exertion and was on oxygen therapy, and received antianxiety medications. Review of Resident 493's Physician Order Sheet (POS) dated 01/01/2020, revealed the resident had orders which included the following medications: Lamotringe (an anticonvulsant) 100 milligram (mg) tablet by mouth (PO) two (2) times per day (BID) related to a diagnosis of Essential Tremor and Generalized Anxiety Disorder; Topiramate (an anticonvulsant) tablet 50 mg one (1) time a day related to a diagnosis of Essential Tremor; and Xanax (an antianxiety) tablet 2 mg one (1) every eight (8) hours as needed (PRN) for diagnosis of Essential Tremor. In addition, further review of the Physician's Order Sheet revealed an order for Oxygen (O2) to be administered at two (2) liters (L) of oxygen per minute (2L/Min) via nasal cannula as needed (PRN), to keep the resident's oxygen saturation level greater than (>) 92% related to COPD diagnosis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Admission Summary Note for Resident #493, dated 01/01/2020 at 3:39 PM, revealed the resident was admitted at approximately 2:00 PM to the facility. Continued review revealed at the time of admission the resident's lungs sounds were diminished and his/her O2 level was 95% on room air. Further review revealed Resident #493 appeared to have shortness of air (SOA) with ambulation at times. In addition, the Admission Summary Note revealed the nurse had reviewed all the resident's medications with the Physician. Review of the Pharmacy Delivery Manifest, dated 01/02/2020 timed 12:44 PM, revealed the following medications were delivered to the facility for Resident #493: Lamotringe 100 mg, Topiramate 50 mg and Alprazolam (generic medication for Xanax) 2 mg. Review of facility's Progress Note for Resident #493, dated 01/02/2020 at 12:45 PM, revealed the resident received his/her Xanax 2 mg, for the first time since his/her admission on 01/01/2020 at 2:00 PM. Review of the facility's Medication Administration Record (MAR) for Resident #493 revealed the Physician's Orders for Topamax, Lamotringe and Xanax had been transcribed onto the MAR on 01/02/2020 at 8:00 AM. However, record review revealed the Physician ordered all the medications on 01/01/2020. Review of the Inventory Replenishment Report, printed date of 11/13/2019 at 3:57 PM, revealed no documented evidence the facility had Resident #493's ordered Topamax, Lamotringe and Xanax medications in their stock inventory available for use for the resident. Interview with Resident #493, on 01/06/2020 at 10:57 AM, revealed he/she had been to the facility for strengthening after a hospital stay. Per interview, the resident stated he/she had not received his/her medications, Lamictal, Xanax and Topamax for about thirty-six (36) hours after admission. According to Resident #493, I asked the nurse and was told my medications would be here within four (4) hours, but then it was already 10:00 PM. After I asked several more times the nurse told me the pharmacy was located about four (4) hours away. Continued interview revealed the resident stated, I felt extreme anxiety, had not received my breathing therapy although having COPD. All I could do was to take deep breaths, inhale and exhale. Thankfully, the hospital had loaded me up with steroids. Resident #493 further stated, I had chest pains and I told myself I had to control it mentally, when in reality it was physical. I paced around and wondered when my medications would arrive. Interview with Certified Nursing Assistant (CNA) #3, on 01/10/2020 at 11:49 AM, revealed Resident #493 had been primarily concerned about all his/her medications, but mostly the as needed (PRN) medication regarding the delayed delivery. Further interview revealed CNA #3 stated some other residents had voiced the same concern to her before. Interview with Licensed Practical Nurse (LPN) #2, on 01/10/2020 at 4:03 PM, revealed the facility had an issue with medication delivery. Per interview, in respect to medication delivery, she stated medications usually got to the facility; however, the issue was nobody oversaw the reordering/ordering of medications. Interview with LPN #11, on 01/10/2020 at 12:18 PM and again at 12:27 PM, revealed the facility had ordered the medications. According to LPN #11, residents were not getting their medications on time (at the facility). She stated when the Pharmacy had staff then they sent the medications over. LPN #11 stated she believed this affected the residents. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON), on 01/11/2020 at 1:16 PM, revealed the facility had trouble with nurses following up on Physician's Orders. She stated she knew the nurses struggled to reorder medications, and acknowledged it had also been a struggle for her as well. Interview with the Director of Nursing (DON), on 01/11/2020 at 12:43 PM, revealed she had identified some concerns on medication reordering and educated nurses on how to follow up on medications. Interview with the Administrator, on 01/10/2020 at 5:02 PM, revealed he was not a clinician; however, the nurse should have tried to get Resident #493's medication STAT (immediately). According to the Administrator, if the medication had been available in the Emergency Drug Kit, then the nurses should have gotten it out of there. He stated not getting the medication timely made Resident #493 anxious and as a result the facility failed to provide quality of care.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 21585 Based on interview, record review and policy review it was determined the facility failed to ensure residents with an identified weight loss were monitored for further weight loss and that supplements were provided as recommended for one (1) of thirty-two (32) sampled residents (Resident #107). Review of the December 2019 Physician's Orders for Resident #107, revealed on 09/30/2019, the physician ordered the facility to weigh the resident two (2) times per week, every Monday and Thursday, related to Heart Failure. The resident also had an order for staff to provide eight (8) ounces of the supplement, Glucerna, two (2) times a day. Review of the facility's electronic Weight Log, revealed Resident #107 weighed 116 pounds on 10/03/2019, and 102 pounds, on 10/24/2019. Further review revealed this was a 14 pound weight loss. Continued review of the log revealed staff did not weight the resident per the physician's order on seventeen days between October 14, 2019 and December 31, 2019. No weights were documented for January 2020. Review of Nutrition/Dietary Note made on 12/05/2019, revealed Resident #107 weighed 103.2 pounds and the resident had a significant weight loss of 11.8 percent in the last three months and 11.3 percent in the last six months. The dietitian recommended eight ounces of Glucerna two times a day. Review of Medication Administration Record revealed the Glucerna supplement was inconsistently documented as given. The findings include: Review of the facility's policy for Weight Assessment and Intervention, not dated, revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for the residents. The nursing staff would measure resident weights on admission, the next day, and weekly for two (2) weeks thereafter. If no weight concerns were noted at this point, weights would be measured monthly. Weights would be recorded in each unit's Weight Record or notebook and in the individual's medical record. Any weight changes of 5% or more since the last weight assessment would be retaken the next day for confirmation. The threshold for significant unplanned and undesired weight loss would be based on the following criteria. For a one month time frame a 5% weight loss was significant and a greater than 5% weight loss was severe. For a three month time frame a 7.5% weight loss was significant and a greater than 7.5% weigh loss was severe. During a six months time frame a 10% weight loss was significant and greater than 10% was severe. Assessment information would be analyzed by the multidisciplinary team and conclusions would be made regarding resident's target weight range, approximate calorie needs, and medical condition etc. The team and the physician would identify conditions and medications that may be causing weight loss. Review of Resident #107's closed record revealed the facility initially admitted the resident on 02/09/2009, and readmitted the resident on 10/21/2019, after a hospitalization . The resident had a history of Heart Failure, Acute Myocardial Infarction (heart attack), Chronic Kidney Disease and Diabetes. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the December 2019 Physician's Orders for Resident #107, revealed on 09/30/2019, the physician wrote orders for the facility to weigh the resident two (2) times per week, every Monday and Thursday, related to Heart Failure. The resident also had an order for staff to provide eight (8) ounces of the supplement, Glucerna, two (2) times a day. Review of the facility's electronic Weight Log, revealed Resident #107 weighed 116 pounds on 10/03/2019, and was 102 pounds, on 10/24/2019; which was a 14 pound weight loss. Continued review of the log revealed staff did not weight the resident per the physician order on 10/14/2019, 10/17/2019, 10/28/2019, 10/31/2019, 11/04/2019, 11/07/2019, 11/14/2019, 11/18/2019, 11/22/2019, 11/25/2019, 12/02/2019, 12/05/2019, 12/09/2019, 12/16/2019, 12/23/2019, 12/26/2019, or 12/30/2019. No weights were documented for January 2020. Review of the Nutrition/Dietary Note made on 12/05/2019, revealed Resident #107 weighed 103.2 pounds and the resident had a significant weight loss of 11.8 percent in the last three months and 11.3 percent in the last six months. The resident's diet was a mechanical soft modified diabetic diet with thin liquids. The Dietitian recommended eight ounces of Glucerna two times a day. Review of the Medication Administration Record revealed the Glucerna supplement was inconsistently documented as given. Review of Resident #107's Nutrition/Dietary Note, made on 11/26/2019, revealed the resident's weight was 104.1 pounds. The Dietary Note stated the resident had a significant weight change of 10.3 percent in thirty days; a 10.3 percent weight loss in the last three months; a 11.8 percent in the six months and recommendations were made for eight ounces of Nepro (a supplement), every day between meals, to provide additional Kilocalories and Protein. However, the supplement did not get transferred to the plan of care nor to the Treatment or Medication Administration Record (MAR/TAR). Interview with Certified Medication Technician (CMT) #1, on 01/10/2020 at 12:20 PM, revealed she was agency staff and did not know Resident #107 had experienced a weight loss. She stated her role as a CMT was to remind the Certified Nursing Assistants (CNA) to weigh residents. She stated she did not document resident's weights because the nurse documented the weights obtained. CMT #1 also stated if the resident had orders for supplements they would be on the MAR/TAR. She stated she could not remember administering supplements to the resident. CMT #1 stated if the staff did not monitor residents' weights or administer supplements per the physician's order they could experience a decline. Interview, on 01/11/2020 at 10:38 AM and 1:03 PM, with Licensed Practical Nurse (LPN) #15, revealed Resident #107 was diabetic, small in stature and sat in a wheelchair. However, due to her being agency staff, she could not remember much more about the resident. She stated the facility did not bring it to her attention the resident had a significant weight loss or that the resident was not being weighed as ordered. LPN #15 stated nothing was on the MAR to alert her to this either. She stated she believed the leadership team discussed residents with identified weight loss in the morning meetings, which she did not attend. LPN #15 stated she also did not review the plan of care, she just depended on the MAR to direct her in the care of the resident. She stated if staff did not weigh the resident or provide supplements as ordered they could contribute to a decline. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing (DON), on 01/11/2020 at 12:55 PM, revealed she had identified staff were not routinely obtaining weights as ordered. The DON stated she recently assumed her role and had not yet fixed the system issues related to monitoring residents with identified weight loss. She stated the facility tried to pull staff aside at the time they identified non-compliance with physician orders or when staff did not follow policy. The DON stated she had not identified Resident #107's weight loss, nor did she remember a discussion in the morning meeting about the staff not weighing the resident or providing the supplements as ordered. She stated if the facility did not assess or monitor residents for weight loss, residents could experience a decline. Interview with the Administrator, on 01/11/2020 at 2:03 PM, revealed he expected staff to follow facility policy and physician orders related to obtaining resident's weights.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35750 Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to provide respiratory services for one (1) of thirty-two (32) sampled residents (Resident #57). The facility failed to apply the Bilevel Positive Airway Pressure (BIPAP) machine on Resident #57, during day time nap times and at times during night sleep times, as ordered by the physician. The findings include: Review of the facility's policy Administering Medications, dated April 2019, revealed medications were administered in a safe and timely manner, and as prescribed and only by persons licensed or permitted by the state to prepare, administer and document the administration. The Director of Nursing services supervised and directed all personnel who administered medications and/or related functions. Medications were administered in accordance with prescriber orders, including the required time frame and for the optimal therapeutic effect of the medication which honored the resident's choices and preferences, consistent with his/her care plan. Further review revealed if a drug was withheld, refused, or given at a time other than the scheduled time, the individual initialed the Medication Administration Record (MAR) in the space provided for the drug. Observation of Resident #57, on 01/07/2020 at 9:12 AM, revealed the resident had oxygen on via nasal cannula at three (3) Liters per minute (3L/min) and a BIPAP machine sat on top of the resident's closet. Observation of Resident #57, on 01/07/2020 at 3:18 PM, revealed the resident rested in bed, eyes closed without the BIPAP machine on. The equipment was atop the bed and was not administered during the resident's naptime. Review of Resident #57's clinical record revealed the facility readmitted the resident on 11/16/2019 with diagnoses including Acute and Chronic Respiratory Failure with Hypercapnia, Sleep Apnea, Hemiplegia and Hemiparesis following Cerebral Infarction, Chronic Obstructive Pulmonary Disease, Generalized Anxiety Disorder, Vascular Dementia without Behavioral Disturbance and Chronic Pain Syndrome. Review of Resident #57's Significant Change Minimum Data Set, dated dated [DATE] and the Care Area Assessment Summary revealed the resident received oxygen therapy and BIPAP treatment. Review of Resident #57's Quarterly Minimum Data Set, dated dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15) determining the resident was interviewable. The resident's functional status was determined to be extensive assistance with one (1) to two (2) staff for all activities of daily living (ADL). The facility determined the resident had shortness of breath with exertion, when sitting and at rest and received oxygen therapy. Review of Resident #57's Medication Administration Record (MAR) revealed an order dated, 09/23/2019, for the resident to have a BIPAP machine on every evening at bedtime. The physician also ordered the same treatment, as needed (PRN) during the day, whenever, the resident was sleeping/napping. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #57's MAR for September, October, November of 2019, and January of 2020, revealed the nurses had never applied the as needed (PRN) BIPAP during daytime sleep/nap hours, as ordered by the physician. The December 2019 MAR for routine and PRN medications was requested but not received. Review of Resident #57's routine, bedtime BIPAP, on the September MAR revealed nurses had not administered/applied the treatment four (4) times in September and five (5) times in November of 2019. Review of Resident #57's routine MAR for October 2019 revealed the resident had no order for the routine, bedtime BIPAP. Review of the Progress Notes revealed no documented evidence nursing staff had applied the ordered therapy. The December 2019 MAR for routine and PRN medications was requested but not received. Review of Resident #57's Progress Notes from 10/15/2019 through 01/07/2020 revealed no documented evidence the resident received the as needed BIPAP as ordered by the physician during daytime/nap hours. Interview with Resident #57, on 01/07/2020 at 9:12 AM, revealed he/she was supposed to use a BIPAP machine; however, the resident stated nursing staff had not put it on during the night and they never put the equipment on during the day when he/she napped. Interview with Certified Medication Tech (CMT) #2, on 01/10/2020 at 11:35 AM, revealed she knew the resident used a BIPAP machine at night, ordered by physician. She stated the nurse that worked at night was supposed to put the equipment on because the resident needed the equipment to get proper oxygenation. However, if the resident did not have the BI-PAP the resident might not adequate oxygen flow to his/her brain and could have a stroke. The CMT stated if the physician ordered it, the nursing staff should have followed it. Interview with Licensed Practical Nurse (LPN) #2, on 01/10/2020 at 4:03 PM, revealed she worked the first shift and she knew Resident #57 received the BIPAP as needed/PRN, she stated she knew the resident had an order and stated, The nurse should follow the order. However, she acknowledged she had not applied the equipment, PRN, as ordered. She stated the order was for the resident's health, for breathing and nobody should have to gasp for air. LPN #2 stated the resident could die without this equipment or have other complications. Interview with the Director of Nursing (DON), on 01/11/2020 at 12:40 PM, revealed she knew Resident #57 used a BIPAP and had occasionally refused it. The DON stated the resident wanted the nurse to clean the equipment prior to putting it on and she expected staff to document if they had not provided the treatment. She further stated there were omissions in the medical records that she had identified and was looking to identify a trend. Interview with the Administrator on, 01/10/2020 at 5:02 PM, revealed he expected nurses to put the BIPAP machine on the resident as it was ordered by the physician.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure effective pain management for two (2) of thirty-two (32) sampled residents (Residents #34 and #101). The facility failed to have an effective system to ensure pain medications were available when needed. A total of nine (9) missed doses of pain medication for the resident experiencing chronic pain. The findings include: Review of the facility's policy, Pain Management, dated October 2018, revealed the purpose of the policy was for each resident to be assessed for pain, and to maintain the resident as free from pain as possible. The policy revealed the physician would be notified of unrelieved or worsening pain in a resident. According to the policy, residents receiving routine pain medication were to be assessed each shift by the Charge Nurse during rounds and/or during medication pass. Per the policy, the reason for administration, and effectiveness of the pain medication were to be documented on the Medication Administration Record (MAR), or on the facility's specific Pain Management Flow Sheet. 1. Observation on 01/07/2019 at 10:22 AM, revealed Resident #34 neatly groomed and seated on the bedside in no apparent distress. Interview during the observation revealed Resident #34 stated he/she needed pain medication for his/her back and neck pain. According to the resident, he/she had been without his/her pain medication for two (2) days because the facility let it run out. Review of the clinical record for Resident #34 revealed the facility admitted the resident on 10/28/2019 with diagnoses which included Low Back Pain, Radiculopathy (disease of a nerve root), and Nontraumatic Compartment Syndrome of Unspecified Lower Extremity (a painful condition occurring when pressure levels in a muscle builds up to a dangerous level). Review of the facility's Minimum Data Set (MDS) Assessment, dated 11/03/2019, revealed the facility assessed Resident #34 with a Brief Interview for Mental Status (BIMS) total score of twelve (12) out of fifteen (15), indicating the resident was not severely cognitively impaired and therefore was interviewable. Review of Resident #34's History & Physical (H&P) dated 10/24/2019, revealed a Chief Complaint of Intractable Back Pain (severe, constant, relentless and debilitating pain that is not curable). Further review of the H&P revealed an Magnetic Resonance Imaging (MRI), performed prior to admission, showed significant disc disease of the resident's lumbar spine. Review of the facility's Physician's Orders revealed an order dated 11/06/2018, for Percocet 10-325 mg (Oxycodone-Acetaminophen) give one (1) tablet by mouth (PO) every four (4) hours related to the diagnosis of Nontraumatic Compartment Syndrome of Unspecified Lower Extremity. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's MAR for Resident #34 dated December 2019, revealed no documented evidence the resident's Percocet 10-325 mg was administered on the following dates: 12/14/2019 at 4:00 PM and 8:00 PM; 12/15/2019 at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM; and 12/16/2019 at 12:00 AM. A total of nine (9) missed doses of pain medication for the resident experiencing chronic pain. Further review of the MAR revealed no documented evidence staff had assessed the resident's pain level from 12/14/2019 at 4:00 PM until 12/16/2019 at 4:00 AM, a period of thirty-six (36) hours. Review of the facility's Progress Note dated 12/14/2019 at 4:49 PM, revealed Resident #34's Percocet pain medication was not available to administer. The Note stated the nurse had notified the Pharmacy and would continue to monitor the resident. Review of the Progress Note dated 12/15/2019 at 4:02 PM,{twenty-four (24) hours after the medication was documented to have been unavailable for administration}, revealed the nurse had notified the Physician to get a prescription for Resident #34's Percocet pain medication. Review of Progress Note, dated 12/16/2019 at 3:39 AM{approximately thirty-six (36) hours after the medication had not been available for administration}, revealed the nurse had obtained a one-time order to administer Percocet to Resident #34 from the facility's Emergency Drug Kit (EDK) box. Further review of the Progress Notes revealed no documented evidence staff had assessed Resident #34's pain level, implemented any non-pharmacological interventions, or had notified the Physician in order to manage the resident's pain for the thirty-six (36) hours his/her prescribed Percocet had been unavailable. Interview with Licensed Practical Nurse (LPN) #2 on 01/08/2020 at 10:02 AM, revealed the facility had problems getting medications from the pharmacy and stated there were lots of issues getting residents' narcotic pain medication ever since the facility switched pharmacies. She further revealed there were also issues with delivery of stat medication orders. LPN #2 stated the pharmacy was located out of town and sometimes a resident could miss two (2) doses before the medication was delivered to the facility. According to LPN #2, Oxycodone was not available in the emergency drug kit (EDK). Interview with LPN #11, on 01/10/2020 at 11:52 AM, revealed the facility had issues with timely delivery of medications since the pharmacy changed in September 2019. LPN #11 stated the nurse was responsible for notifying the physician if a medication was not available and request a one-time order to pull the controlled pain medication from the EDK as needed; however, she did not know why she did not notify Resident #34's physician. The nurse did not contact the physician to pull from the EDK until the medication arrived from the pharmacy. According to LPN #11, non-pharmacological pain interventions would include applying a cold/warm compress, offering fluids or diversional activities. Continued interview revealed LPN #11 should have assessed Resident #34's pain level, and implemented some non-pharmacological intervention(s). Per interview, she probably should have notified the Physician for a one-time order for pain medication as the resident was out of medication. However, she was sometimes swamped and did not document everything. Further interview revealed a resident could have been in a lot of pain if their pain medication was not administered accordingly. Interview with LPN #10, on 01/09/2020 at 11:07 AM, revealed nurses were responsible for ordering medication in the facility's electronic MAR (eMAR) and for notifying the physician for a new prescription for controlled medications. She further stated the nurse was responsible for obtaining a Physician's Order as needed to administer a narcotic from the EDK. LPN #10 stated she was not aware of any issues related to the availability of Resident #34's pain medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #12 on 01/10/2020 at 2:47 PM, revealed the facility had problems receiving medication orders from the Pharmacy. According to LPN #12, the pharmacy did not notify the facility whenever a new prescription was needed for refills. The LPN stated nurses were responsible for pulling medications from the EDK and/or notifying the Physician for a prescription if a medication was not available. Continued interview with LPN #12 revealed non-pharmacological interventions to use for residents' pain management could include deep breathing, repositioning, and positive visualization. She further stated pain assessments and interventions should be documented in the Progress Notes. According to LPN #12, Resident #34's was very upset about not having pain medication available. 2. Observation, on 01/10/2020 at 10:33 AM, revealed Resident #101 seated at the bedside. Interview during observation revealed the resident sometimes went without pain medication for days because it was not available. Review of the clinical record revealed the facility readmitted the resident on 03/25/2017 with diagnoses to include Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Primary Osteoarthritis. 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 fifteen (15) out of fifteen (15) and determined the resident was interviewable. Further review of the clinical record revealed a Physician's Order, dated 09/27/2019, for Oxycodone-APAP 10-325 mg give one (1) tablet by mouth every four (4) hours for pain. Review of the MAR, dated October 2019, revealed a total of fourteen (14) missed doses of Oxycodone-APAP on 10/02/2019, 10/04/2019, 10/07/2019, 10/09/2019, 10/11/2019, and 10/13/2019. Review of the MAR, dated November 2019, revealed a total of six (6) missed doses of Oxycodone-APAP on 11/20/2019, 11/21/2019, and 11/26/2019. Interview with Licensed Practical Nurse (LPN) #4, on 01/09/2020 at 10:38 AM, revealed the facility had issues getting medication delivered from the pharmacy. She stated sometimes the pharmacy needed a new prescription and Resident #101 would run out of pain medication. According to LPN #4, nurses were responsible for notifying the physician and pulling the narcotic from the Emergency Drug Kit (EDK) as needed. The nurse stated pain could affect a resident's activities of daily living (ADL). Interview with LPN #11, on 01/10/2020 at 11:52 AM, revealed there were constant issues with delivery of medications and stated she reported the issues to the former Administrator and the pharmacy representative. Interview with LPN #12, on 01/10/2020 at 2:47 PM, revealed the facility had problems with delivery of medications. She stated staff were not aware the pharmacy needed a new prescription until they called to find out why the medication was not delivered. Interview with LPN #15, on 01/11/2020 at 10:34 AM, revealed nurses were responsible for notifying the physician to request a one-time order to remove a narcotic from the EDK if a pain medication was not available. She stated it was important to manage pain because pain could affect the resident's mood, behavior, socialization, and mobility. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with the Regional Director of Customer Success for the pharmacy used by the facility, on 01/11/2020 at 12:52 PM, revealed he was not aware of any recent issues related to orders or delivery of medications. Interview, on 01/11/2020 at 12:29 PM with the Director of Nursing (DON) revealed she had recently assumed the role as DON and had identified omissions in the medical records and was evaluating to identify a trend to put a corrective action plan in place. Interview, on 01/10/2020 at 4:55 PM, with the Administrator revealed he expected medications to be administered as ordered and the facility was still in the process of finding out if there was a trend at a certain time of day related to medication administration and availability issues. Interview with the Medical Director, on 01/11/2020 on 2:42 PM, revealed he was working with the pharmacy to resolve an issue with faxed prescriptions. The Medical Director stated he was not aware of any persistent issues with delivery of medications.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **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 ensure the correct use and maintenance of resident side rails for one (1) of thirty-two (32) sampled residents (Resident #91). Resident #91's bed rail was not securely attached to the bed and partially rested on the floor. The findings include: Review of the facility's policy regarding, Bed Safety, revised December 2007, revealed the resident's sleeping environment would be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. The policy further revealed to try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility would promote approaches including ensuring that bed side rails were properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.). When using side rails for any reason, the staff should take measures to reduce related risks. Review of the facility's policy titled, Safety and Supervision of Residents, revised July 2017, revealed the facility strived to make the environment as free from accident hazards as possible. Further review of the policy revealed employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. Observation, on 01/06/2020 at 11:22 AM, revealed Resident #91 lying in bed. Two (2) half side rails were attached to the bed and the right rail was partially resting on the floor. Further observation revealed Resident #91 attempted to move his/her legs over the broken rail. Review of the clinical record revealed the facility admitted Resident #91 on 03/18/2019 with diagnoses which included Atrial Fibrillation, Dementia without Behavioral Disturbance, and Type 2 Diabetes Mellitus. Review of the Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #91 with a Brief Interview for Mental Status (BIMS) score of 99 and determined the resident was cognitively impaired. Further review of the MDS revealed the resident required extensive assistance for transfers. Review of the Side Rail Assessment, dated 04/09/2019, revealed the resident would not utilize side rails. Review of Resident #91's Physician's Orders, dated 01/01/2020, revealed there was no order for side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #4, on 01/06/2020 at 11:28 AM, revealed Resident #91's side rail seemed to be broken and looked like a screw was missing. LPN #4 stated she noticed the broken rail when she transferred the resident back to bed; however, she had not reported the issue to maintenance because she just noticed it about fifteen (15) minutes earlier. LPN #4 stated the broken rail was a safety issue and the resident could potentially fall out of bed and get hurt. Further observation, on 01/06/2020 at 11:33 AM, revealed LPN #4 walked the Maintenance Director to Resident #91's room. Interview with Certified Nursing Assistant (CNA) #2, on 01/06/2020 at 11:36 AM, revealed she noticed the broken side rail about 10:00 AM (an hour and 36 minutes earlier) when she, LPN #4, and a therapy aide transferred the resident back to bed; however, she did not notify maintenance or submit a work order. According to CNA #2, the broken side rail was a safety issue and could cause an accident Interview with CNA #4, on 01/08/2020 at 9:08 AM, revealed she had noticed Resident #91's broken side rail for about 4 months and stated she reported the issue to the nurse and submitted work orders. She further stated the broken rail was a fall and trip hazard. Review of Completed Work Orders, for the period 10/01/2019 through 01/08/2020, revealed work order #838 was critical priority related to Resident #91's loose bed rail and had not been assigned to staff for repair. Interview with the Maintenance Director, on 01/10/2020 at 9:34 AM, revealed staff were responsible for submitting electronic work orders; however, housekeeping staff did not have access to the work order program. The Maintenance Director stated staff notified him of the broken rail during the survey. Further interview revealed the bed rails should be repaired immediately to ensure resident safety.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 28733 Based on interview, personnel record review, and facility policy review, it was determined the facility failed to ensure the Certified Nurse Aides (CNA) received and completed the required annual twelve (12) hours of continuing education for seven (7) of seven (7) sampled CNA personnel files reviewed. Personnel record review revealed the facility failed to ensure completion of annual evaluations for CNAs #15, #16, #17, #18, #19, #20, and #21. In addition, the facility failed to ensure CNAs #15, #16, #17, #18, #19, #20, and #21 had documented evidence of continuing education (CE) based on their annual evaluations present in the employee's personnel record. The findings include: Review of the facility's policy, In-Services Training Program, Nurse Aide revised October 2017, revealed all Nurse Aide personnel should participate in regularly scheduled in-service training classes. Per the policy, all personnel were required to attend regularly scheduled in-service training classes. Continued review revealed in-service training would be based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews. The policy revealed annual in-services were to ensure the continuing competence of the Nurse Aides. The policy noted Nurse Aides were to have no less than twelve (12) hours per employment year of annual in-servicing which was to include training which addressed the care of residents with cognitive impairment, Dementia management and abuse prevention. Further review revealed all in-service training classes attended by the Nurse Aides should be entered on the respective employee's Record of In-Service, by the department supervisor or other person as designated by the supervisor. The policy further revealed records should be filed in the employee's personnel file or were to be maintained by the department supervisor. The Surveyor (State Survey Agency) requested the annual evaluations/performance reviews for CNAs #15, #16, #17, #18, #19, #20, and #21 regarding their work performance for the past year. However, the facility was unable to provide documented evidence of the seven (7) CNAs' annual evaluations, as per policy and regulation. 1. Review of CNA #15's personnel file revealed her date of hire was 06/03/2015. Continued review revealed zero (0) hours of CE documented for the time frame of 06/03/2018 through 06/03/2019. 2. Review of CNA #16's personnel file revealed his date of hire was 09/27/2010. Continued review revealed only one (1) hour of CE documented for the time frame of 09/27/2018 through 09/27/2019. 3. Review of CNA #17's personnel file revealed his date of hire was 01/10/1994. Continued review revealed only one half (0.5) hour of CE documented for the period of 01/10/2019 through 01/10/2020. 4. Review of CNA #18's personnel file revealed his date of hire was 03/20/2018. Continued review revealed only one and one half (1.5) hours of CE documented for the period of 03/20/2018 through 03/20/2019. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Review of CNA #19's personnel file revealed his date of hire was 12/30/2008. Continue review revealed only one (1) hour of CE documented for the period of 12/30/2018 through 12/30/2019. 6. Review of CNA #20's personnel file revealed his date of hire was 04/24/2015. Continued review revealed zero (0) hours of CE documented for the period of 04/24/2018 through 04/24/2019. 7. Review of CNA #21's personnel file revealed his date of hire was 10/10/2016. Continued review revealed zero (0) hours of CE documented for the period of 10/10/2018 through 10/10/2019. Interview with the Staff Development Coordinator (SDC), on 01/11/2020 at 12:42 PM, revealed she had been newly hired as of 01/07/2020. She stated she had attended the facility's general orientation program on Tuesday, 01/07/2020 and Wednesday, 01/08/2020, and had continued her orientation with the Assistant Director of Nursing (ADON). Review of the Assistant Director of Nursing Services (ADON) job description, dated August, 2019, revealed essential responsibilities included participate in orientation, and in-service training education training. In addition, participate in performance review and personnel files, and enforce the personnel policies of the community. Interview with the ADON, on 01/11/2020 at 12:57 PM, revealed she had only started being involved in the orientation of newly hired staff during the last couple of weeks since the resignation of the prior Staff Development Coordinator (SDC). She stated the prior SDC had not provided her any of the continuing education information for staff or for the ongoing audits. Interview with the Director of Nursing (DON), on 01/10/2020 at 2:45 PM, revealed she was not aware the CNAs' CE hours were incomplete for the previous year. She stated she was not aware of any annual evaluations not having been completed. Per interview, she stated she had not been involved in any of the evaluations since her arrival in the last month or so. Although she was ultimately responsible for staff development, she stated she did not have any audits on personnel files in progress. Interview with the Human Resources (HR) Director, on 01/10/2020 at 3:45 PM, revealed the facility had not completed annual evaluations for any of the staff. Interview with the Administrator, on 01/10/2020 at 3:34 PM, revealed he recently assumed the role of Administrator days ago. He stated the former Clinical Educator/SDC had provided or tracked the CE's for the CNAs in the facility. However, the former Clinical Educator/SDC had resigned from employment two (2) weeks prior to the survey. Per interview, the new SDC had started on 01/07/2020. He stated staff have access to an online education program; however, it was not utilized. Continued interview revealed the manually entered CNA hours present in the personnel records were inaccurate. The Administrator stated the current process for the CE for staff was not effective for the monitoring of the CE program. He stated the facility was unable to locate the ongoing CE hours for the seven (7) CNAs reviewed. Further interview revealed none of the seven (7) CNAs reviewed had completed their required annual twelve (12) hours of CE. The Administrator further stated he was not sure, if any of the evaluations had been completed. However, the HR Director was responsible for ensuring the evaluations were filed in the personnel files. He stated he briefly reviewed the facility's most recent Quality Assurance meeting minutes and did not see that the committee had identified any issues related to CE for staff.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41851 Based on observation, interview, record review, and the facility's policy review, it was determined the facility failed to ensure nursing administered medications according to physician's orders for one (1) of thirty-two (32) sampled residents (Resident #110). Licensed Practical Nurse (LPN) #2 failed to obtain orders for Intravenous (IV) Heparin flush per a Peripherally Inserted Central Catheter (PICC) line. Observation of LPN #2, on 01/10/2020, revealed the LPN was unable to flush Resident #110 PICC line with Normal Saline Intravenously (IV). Instead, LPN #2 flushed Resident #110 PICC line with 2.5 cubic centimeter (cc) of Heparin 100 units/milliliters (ml) without a physician's order. The findings include: Review of the facility's policy, Administering Medications, revised April 2019, stated medications are administered in accordance with prescriber orders, including any time frame. The individual administering the medication, checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. Review of Resident #110's clinical record revealed the facility admitted the resident on 12/10/2019 with the diagnoses of Partial Traumatic Amputation of Left Great Toe, Local Infection of the Skin and Subcutaneous Tissue, Type 2 Diabetes Mellitus with other diabetic neurological complication. In addition, the physician ordered Normal Saline flush ten (10) milliliters (ml) every eight (8) hours and flush with ten (10) ml of Normal Saline after administration of intravenous medication. Further review revealed no order for a Heparin flush. Observation and interview with Licensed Practical Nurse (LPN) #2, on 01/10/2020 at 10:00 AM, during medication pass, revealed she was unable to flush Resident #110's peripherally inserted central catheter (PICC) line with Normal Saline before giving the intravenous (IV) antibiotic. She then was observed to flush the resident's PICC line with two point five (2.5) ml of Heparin 100 units/ml without a physician's order. LPN #2 stated he/she did not check to verify if Resident #110 had orders for Heparin flush via PICC line and should have checked the orders before administering the Heparin flush. She stated she should have called the physician for an order before giving the medication. In addition, she should have checked the resident's allergies, because he/she could have had an allergic reaction from the medication. Interview with Assistant Director of Nursing (ADON), on 01/10/2020 at 2:57 PM, revealed nursing staff should always obtain an order for a medication before administrating the medication to a resident. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON), on 01/10/2020 at 3:30 PM, revealed she recently assumed the role of DON and had only begun to audit nursing services provided. She stated she completed real time education with nursing staff when she identified learning opportunities. However, she had not audited medication administration. In addition, the contracted Pharmacy Services did not audit medication pass either. She stated the nursing staff should obtain an order for any medication administered to a resident. The DON stated administrating Heparin IV without and order could cause bleeding to the resident. Interview with Administrator, on 01/10/2020 at 3:58 PM, revealed his expectation was for nursing staff to obtain an order for a medication before the nurses gave the medication. He stated the resident could experience an adverse effect such as an allergic reaction or overdose by giving too much medication.

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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, and facility policy review it was determined the facility failed to ensure medications were stored securely in one (1) of four (4) medication rooms, 2B Unit and two (2) of eight (8) medication carts. Observations revealed medication carts and medication rooms unlocked and unattended. The findings include: Review of the facility's policy Security of Medication Cart, revised April 2007, revealed the nurse must secure the medication cart during medication pass to prevent unauthorized entry and carts must be securely locked at all times when out of the nurse's view. The policy further revealed when the medication cart was not being used, it must be locked and parked at the nurses' station or inside the medication room. Review of the facility's policy Administering Medications, revised April 2019, revealed during administration of medications, the medication cart was kept closed and locked when out of sight of the medication nurse or aide. The policy stated no medications should be kept on the top of the cart. Observation, on 01/09/2020 at 10:22 AM, revealed the 2B Unit medication room door was open. Further observation revealed the lab and medication refrigerators inside the room were unlocked. Interview with Licensed Practical Nurse (LPN) #13 during observation revealed the medication room should remain locked to prevent resident access because a confused resident could take a medication and get sick. LPN #13 stated she may not have pushed the door all the way shut when she came out of the room. Observation of the medication cart on 1B Unit, on 01/06/2020 at 1:06 PM revealed both medication carts were unlocked and unattended by staff. Observation, on 01/06/2020 at 3:27 PM, revealed Licensed Practical Nurse (LPN) #1 was seated at the nurse's station on 1B with his back to his unlocked medication cart. In addition, the Administrator walked past the unlocked medication cart without observation or intervention. Observation, on 01/10/2020 at 3:28 PM, revealed a medication cart (Rooms 235 - 249) located in front of the nurse's station was unlocked and unattended. Further observation of the medication cart, on 01/10/2020 at 3:31 PM, revealed Certified Medication Technician (CMT) #2 returned and locked the cart. Observation, on 01/10/2020 at 3:34 PM, revealed CMT #2 was logging in new medications on the medication cart (Rooms 223 - 230). Further observation revealed CMT #2 walked away from the cart to the 2B nurse's station, stood with her back to the cart, and left two (2) cards of Hydrocodone and one (1) card of Nitrofurantoin (Antibiotic) tablets lying on top of the cart unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CMT #2, on 01/11/2020 at 11:12 AM, revealed medication should always be locked up, and controlled medications should be double-locked, to prevent them from getting stolen. CMT #2 stated a resident or someone passing by the cart could take the medication and a resident could ingest the medication and get sick or overdose. Interview with Licensed Practical Nurse (LPN) #15, on 01/11/2020 at 10:34 AM, revealed all medications should be stored inside a locked medication cart/room and controlled medication should be double locked. LPN #15 stated it was important to secure controlled medication to maintain accountability. The nurse stated a resident or staff could take the medication if it was left unattended on top of the cart. According to LPN #15, a resident could potentially ingest the medication and have an allergic reaction or overdose. Interview with the Administrator, on 01/11/20 at 2:03 PM, revealed he came to his current role in the last six (6) days. He stated he was not aware of the medications issues. He stated he had become aware of some of the issues during this survey process. However, he became aware of the medication issues on Tuesday of the past week during survey. He stated he did have expectation the staff followed the policies, and there were concerns to address moving forward.

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	185039	A. Building B. Wing	01/11/2020

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure food was stored, prepared, served and distributed under sanitary conditions. Observations revealed food stored open to air and undated, the dish machine failed to meet the required temperature for sanitization and the facility failed to calibrate the thermometer used to ensure safe food temperatures. In addition, the facility failed to cover food items on meal trays served to resident rooms on four (4) of four (4) nursing units, 1B, 1C, 2B, and 2C. The findings include: 1. Review of the facility's policy, Labeling and Dating, dated October 2018, revealed all packaged foods removed from original packing (original case) would be dated with the date received and the date opened if opened (i.e. bags of frozen vegetables removed from the original case). Review of the facility's job description for the Dietary Cook, dated August 2019, revealed the Cook was responsible for labeling/dating foods, rotating foods properly, and checking foods for proper storage. Observation of the walk-in freezer, on 01/06/2020 at 10:10 AM, revealed two (2) boxes of frozen ground beef patties and one (1) box of crinkle cut carrots stored in open plastic bags. Further observation revealed the bags of beef patties and carrots were open to air, and had not been labeled with an opened date as per facility policy. Interview, with the Dietary Manager during the observation, revealed the Cook was responsible for ensuring opened packages were properly closed and labeled with the opened date. He stated it was important to date and store food in properly closed packages to ensure the quality of the food. The Manager further stated he conducted daily walk through audits to ensure food stored in the freezer was labeled and dated. 2. Review of the facility's policy, Calibrating Food Thermometers, dated March 2019, revealed the purpose of the policy was to ensure thermometers, used for obtaining food temperatures, were in accurate working order. The policy revealed probe thermometers were to be calibrated weekly or as needed. Further review revealed the information obtained was to be recorded on the Weekly Food Temperature Log. Observation of the facility's food service, on 01/07/2020 at 11:35 AM, revealed the Dietary Manager failed to calibrate the thermometer prior to obtaining temperatures of the food on the steam table. Interview, during the observation, revealed thermometers were calibrated quarterly and as needed. Interview with the Cook, on 01/09/2020 at 3:13 PM, revealed thermometers were calibrated once a week; however, the calibration was not documented. The Cook stated it was important to calibrate thermometers to ensure food reached appropriate temperatures to prevent potential food borne illness. The Surveyor (State Survey Agency) requested the log of weekly thermometer calibrations; however, the facility did not provide documented evidence of a log containing the weekly thermometer calibrations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the facility's policy, Dish Machine Monitoring, dated October 2018, revealed the temperatures of the dish machine's wash/rinse cycles and/or parts per million (PPM) of chemical sanitizing was to be monitored throughout the day. The policy revealed Dietary staff were to be provided a log to record the temperature and sanitizer readings of the mechanical dish machine. Further review revealed the temperatures and sanitizer levers would meet the manufacturer's recommendations, as indicated on the facility's dish machine. Review of the Auto-Chlor System D2 Watersaver Dishmachine specifications revealed a one hundred twenty (120) degree Fahrenheit (F) Minimum Water Temperature. Observation of the facility's dish machine, on 01/08/2020 at 10:43 AM, with the Dietary Aide, revealed no temperature registered on the thermometer gauge. Interview with the Dietary Aide, during the observation revealed he was responsible for checking the temperature. Further interview revealed he stated the temperature was one hundred eighty (180) degrees F when he checked the temperature earlier. Review of the Dish Machine - PPM Sanitizer Record Log, dated 01/08/2020, revealed staff logged the morning water temperature as one hundred twenty-eight (128) degrees F. Further observation of the facility's dish machine, on 01/08/2020 at 10:48 AM, with the Dietary Manager revealed the water temperature was only ninety-two (92) degrees F using a handheld thermometer. Interview with the Dietary Manager, during the observation, revealed the dish machine temperature was to reach one hundred twenty (120) degrees F for sanitizing dishes. Further interview with the Dietary Aide, on 01/09/2020 at 3:23 PM, revealed the temperature of the dish machine should reach one hundred twenty (120) degrees F. He stated he was responsible for notifying the Supervisor of any issues with the dish machine temperature. According to the Aide, it was important to ensure the machine reached the correct temperature to remove bacteria from the dishes because residents could get sick otherwise. Interview with the Cook, on 01/09/2020 at 3:13 PM, revealed the Dietary Aides were responsible for monitoring the temperature of the dish machine and for reporting any issues to the Supervisor as needed. Additional interview with the Dietary Manager, on 01/09/2020 at 3:33 PM, revealed the dish machine temperature was to be at one hundred twenty-five (125) degrees F to prevent bacterial growth and potential foodborne illness. The Manager stated he monitored the temperature logs daily and had not identified any issues. Interview with the Administrator, on 01/11/2020 at 1:53 PM, revealed it was essential for the Dietary Staff to ensure the dish temperature was correct for sanitation to prevent food borne illness in the elderly population. He stated that storage and labeling prevented the potential contamination of food and prevention of foodborne illnesses. He stated his expectation was for the Dietary Staff to follow the policies and maintain the temperatures. The Administrator stated he was not aware if any of the food concerns were reviewed in Quality Assurance (QA) prior to his arrival. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of the facility's policy Food Production, dated March 2019, revealed prepared food would be transported to other areas either covered or in covered containers/enclosed carts. The policy further revealed any utensils or dishware transported to other areas would either be covered or placed in covered containers/enclosed carts. Observation of the 2B Unit dining, on 01/06/2020 at 12:45 PM, revealed a dining cart located in the corridor outside room [ROOM NUMBER]. Further observation of the cart revealed the slices of cake served on the lunch trays were not covered and were exposed to air. Certified Nursing Assistant (CNA) #1 removed a tray from the cart, walked down the hall with the uncovered cake, and served it to the resident in room [ROOM NUMBER]-1. The CNA returned to the cart, removed a tray, left the door to the cart open, and walked the tray down the hall to room [ROOM NUMBER]-2. CNA #1 continued to carry the lunch trays down the hall and served the uncovered cake to Rooms 228-2 and 223-2. Further observation of 2B dining revealed CNA #2 removed a tray from the cart and walked to room [ROOM NUMBER]-2 with the cake uncovered. Interview with CNA #13, on 01/10/2020 at 10:06 AM, revealed staff should push the dining cart down the hall as they served the meal trays. The CNA further revealed it was not acceptable to carry uncovered food down the hall and stated food should be covered at all times to prevent contamination. Interview with CNA #11, on 01/10/2020 at 10:16 AM, revealed staff should not walk down the hall with uncovered food because dust or something else could get in the food. Interview with Licensed Practical Nurse (LPN) #11, on 01/10/2020 at 11:52 AM, revealed staff should not carry uncovered food down the hall because germs in the air could get on the food. Interview with the Cook, on 01/09/2020 at 3:13 PM, revealed food on the meal tray should be covered because dust could get in the food if staff carried the tray down the hall. Interview with the Dietary Aide, on 01/09/2020 at 3:23 PM, revealed food transported from the kitchen should be wrapped and covered to prevent contamination. Interview with the Dietary Manager, on 01/09/2020 at 3:33 PM, revealed food transported inside the dining cart did not have to be covered. He stated staff were supposed to close the door of the cart between each tray pass and deliver the trays one at a time, moving the cart as they served. The Dietary Manager stated there was a potential for contamination of uncovered food if the meal trays were carried down the hall. Interview with the Administrator, on 01/11/2020 at 1:53 PM, revealed there was a lot of work for the facility moving forward as he had identified multiple areas of need during his first week onsite. He stated the lack of covering the trays, food items and leaving the meal cart doors open provided opportunity for the food to become contaminated. He stated the act of carrying trays down the hall uncovered allowed opportunity for the food to get dust particles, or environmental containments. Continued interview revealed covering the food items would prevents the opportunity for foodborne illness. In addition, keeping the food carts closed helps to maintain the food at the appropriate serving temperatures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41851 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to implement an effective infection control program related to staff not washing their hands between glove changes during the medication administration observation. The findings include: Review of the facility's policy Handwashing and Hand Hygiene, revised August 2015, revealed the facility considered hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the hand washing and hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. Use of alcohol based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: Before and after handling an invasive device (IV {intravenous} access sites). Review of Resident #110's clinical record revealed the facility admitted the resident on 12/10/2019, with the diagnoses of Partial Traumatic Amputation of Left Great Toe, local Infection of the Skin and Subcutaneous Tissue. Type two (2) diabetes mellitus with other Diabetic Neurological Complication. Review of Resident #110's medication record dated 12/10/2019-12/31/2019, revealed the resident had a peripherally inserted central catheter (PICC) for administration of intravenous antibiotic with start date 12/11/2019. Interview with Licensed Practical Nurse (LPN) #2, on 01/10/2020 at 11:23 AM, revealed that you must wash your hands between glove changes to prevent the spread of infection. LPN #2 stated she had failed to wash her hands between glove changes which could potentially result in cross contamination. The LPN stated this created an increased risk for infection for the residents. Interview with the Assistant Director of Nursing (ADON), on 01/10/2020 at 2:57 PM, revealed she expected staff to perform hand washing between glove changes. The ADON stated the effect on the resident could be a potential for infection. Interview with the Director of Nursing (DON), on 01/10/2020 at 3:30 PM, revealed she expected staff to perform hand washing between glove changes. She stated the infection was a potential risk to the resident when staff failed to practice hand washing before and after glove changes. Interview with the Administrator, on 01/10/2020 at 3:58 PM, revealed, he was not aware of any problems with hand washing in the facility. He stated the staff were supposed to wash their hands as needed when required, and in-between caring for one resident to another resident. He stated the effect to the resident could result in the spread of infection, and lead to sickness and dehydration.