STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185090	A. Building B. Wing	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28707 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system to ensure the Physician was notified when there was a significant change in condition and a need to alter treatment for one (1) of thirty (30) sampled residents (Resident #110). The facility admitted Resident #110, on [DATE], with diagnoses to include Chronic Pain; Contracture, Thoracic, Thoracolumbar, and Lumbosacral Intervertebral Disc Disorder. Resident #110 was hospitalized , on [DATE], with Altered Mental Status, Condition Decline, and Respiratory Failure. Prior to the [DATE] acute care hospitalization , the resident was receiving Oxycodone with Acetaminophen (a narcotic opioid pain reliever given for moderate to severe pain) on a every six (6) hour schedule. Review of Resident #110 medical record revealed the resident returned from the hospital to the facility, on [DATE]. The resident's discharge medication and the Physician's Orders included the same narcotic pain medication but it was ordered every six (6) hours as needed (PRN) instead of the routine administration of every six (6) hours. Moreover, the Physician's Order was for only (3) days, to start on [DATE] and end on [DATE]. However there was no documented evidence the Physician was notified that the order expired in three (3) days. Interviews with staff revealed Resident #110 continued to complain of pain. Interview with the resident revealed he/she was in constant pain and had made staff aware of his/her pain; however, no one was addressing the resident's pain. Interviews with Resident #110's Physician and Advanced Practice Registered Nurse (APRN) revealed they were aware the resident had chronic pain and had been on the narcotic pain reliever. However, they both stated they were unaware it had been discontinued as of [DATE]. In addition, the Physician stated he would have expected staff to notify him or the APRN that the resident was complaining of pain. Resident #110 was transferred to the Hospital Emergency Department (ED) on [DATE]. Review of the Admitting Physician's Note, dated [DATE], revealed the resident arrived at the ED in pain, lethargic, did not move his/her extremities, and moaned with discomfort. Per the ED record, the resident received Morphine (an opioid narcotic). (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to have an effective system to ensure the Physician was notified when there was a significant change in condition and a need to alter treatment provided to residents who required such services has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified in the area of 42 CFR 483.10 Resident Rights, on [DATE] and were determined to exist on [DATE]. The facility provided an acceptable Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with the remaining non-compliance at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled, Change in Condition: Notification Of, revised [DATE], revealed the center must immediately inform the resident, consult with the resident's Physician, and notify, consistent with his/her authority, the resident's Health Care Decision Maker (HCDM), where there was: a need to alter treatment significantly (that was, a need to discontinue or change from an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Review of the facility's policy titled, Physician/Advanced Practice Provider (APP) Notification, revised [DATE], revealed the requirement to communicate a change in the resident's condition to the Physician/APP and initiate interventions as needed or ordered. Review of the facility's policy titled, Resident Rights and Dignity, revised [DATE], revealed each resident would be cared for in a manner that promoted an enhanced quality of life, dignity, respect, and individuality. Review of Resident #110's medical record revealed the facility admitted the resident, on [DATE], with diagnoses to include Chronic Pain; Contracture, Right Hand; Contracture, Left Hand; Contracture, Right Elbow; Thoracic, Thoracolumbar, and Lumbosacral Intervertebral Disc Disorder Review of Resident #110's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated he/she had mild cognitive impairment. Continued review revealed the facility assessed Resident #110 as having pain during this assessment period and had received scheduled or as needed (PRN) pain medication. Review of Resident #110's Comprehensive Care Plan (CCP), initiated on [DATE], revealed Resident #110 was at risk for alterations in comfort related to Osteoarthritis, muscle weakness, right upper extremity edema, contracture, hemiplegia, obesity, and polyneuropathy. The goal was the resident would achieve an acceptable level of pain control. Further, interventions included but were not limited to, administer pain medication as ordered; elevate right upper extremities with pillow; observe pain characteristics: quality, severity, location, precipitating/relieving factors; medicate resident as ordered for pain and observe for effectiveness and side effects; report to Physician as indicated. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Resident #110, on [DATE] at 9:05 AM, revealed the resident yelling for a nurse. Resident was moaning and groaning in pain. Further observation revealed, the resident was lying flat on his/her back, no pillow under the right arm. The resident's hands had contractures, and the resident was unable to use the call light related to his/her contractures. Per observation resident showed non-verbal ques of pain with grimacing. Further observation revealed no one responded to the resident until the State Survey Agency (SSA) Surveyor alerted staff that the resident needed assistance. However, there was no documented evidence the Physician was notified of the resident's complaints of pain. Interview with Resident #110, on [DATE] at 9:20 AM, revealed staff did not address his/her chronic pain, and while the resident had resided at the facility since the last readmission, on [DATE], he/she had not received pain medication as needed. Further interview revealed, the resident stated, I am miserable and I hurt all the time. Per interview the resident stated when he/she tells the nurse he/she was in pain, no one would help him/her. Review of Resident #110's Vital Sign Assessment, revealed, in the month of [DATE] the only pain assessments documented were on [DATE] at 1:00 PM, rated zero (0) out of ten (10), and on [DATE] at 10:00 PM, rated zero (0) out of ten (10), despite a diagnosis of Chronic Pain. Interview with State Registered Nurse Aide (SRNA) #11, on [DATE] at 1:50 PM, revealed Resident #110 hurt all the time, especially when he/she was moved. She stated the resident could not tolerate lying on his/her right side. Further interview revealed she would notify the nurse that the resident was in pain. Review of Resident #110's Hospital ED (emergency department) Admitting Physician Note, dated [DATE], revealed the resident arrived at the ED in pain lethargic, did not move his/her extremities, and moaned with discomfort. Per the ED record, Morphine (an opioid narcotic pain reliever for acute pain) Injection four (4) mg was ordered and given. Review of Resident #110's Hospital ED Face Sheet, dated [DATE], revealed Morphine Injection four (4) mg was added to the resident's hospital medications. Interview with Licensed Practical Nurse (LPN) #8, on [DATE] at 8:26 AM, revealed if a staff member reported to her that a resident was in pain, she would first review the orders and if a resident had unrelieved pain, the policy required the nurse to notify the Physician or APP (Advanced Practice Registered Nurse, APRN) to adjust the resident's pain medication regimen. However, she stated she could not recall notifying the Physician of the resident not having an order for his/her scheduled pain medication. Interview with Agency LPN #9, on [DATE] at 2:15 PM, revealed Resident #110 had experienced a recent change in condition (CIC) resulting in a decline. In addition, LPN #9 stated she readmitted the resident on [DATE] and recalled seeing the order for the narcotics for only three (3) days; however, she did not notify the Physician or APRN, nor reconcile orders with the medications the resident was ordered prior to the hospital admission. She stated she just assumed the Physician at the hospital did not want the resident on the pain medicaton after three (3) days. Furthermore, she did not notify the Physician that the resident was complaining of pain because she felt like that was the norm for the resident. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Unit Manager (UM), on [DATE] at 1:49 PM, revealed it was the responsibility of the nurse assigned to the resident to notify the Physician or APRN of any change of condition. Further interview revealed they should document the change on a Change of Condition form in the resident's medical record. She further stated if it was not documented, then it did not happen. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 4:40 PM, revealed she was not made aware that nursing staff failed to notify the Physician or the APRN to reorder the resident's scheduled narcotic pain medication after the three (3) day order had expired on [DATE]. Further interview revealed she was also not aware the resident was crying out in pain. She stated it was her expectation for staff to follow the policies and notify the Physician or APRN when there was a change in a resident's condition. However, there was no documented evidence the nursing staff notified the Physician that the resident was no longer on scheduled Oxycodone with Acetaminophen after returning from the hospital. Furthermore, there was no documented evidence the nursing staff notified the Physician of a CIC related to pain, according to facility policy. Interview with the Regional Clinical Quality Specialist (RCQS), on [DATE] at 3:40 PM, revealed it was her expectation that nursing staff follow the facility's policies. The RCQS stated, with Resident #110's pain management, there was a communication breakdown because there was no documented evidence the nursing staff notified the Physician or the APRN of a CIC related to pain, according to facility policy. Interview with the APRN, on [DATE] at 2:30 PM, revealed she was aware the resident had chronic pain and mobility issues, used opioid medications, and took Oxycodone ,d+[DATE] mg (milligrams), one (1) tablet by mouth every six (6) hours, scheduled, prior to his/her admission to the hospital on [DATE]. Per interview, staff did not make her aware upon readmission of the order expiring in three (3) days. Per interview, if she had been made aware she would have reordered the medication. Further interview revealed, staff failed to notify her that the resident was in pain and was experiencing a change of condition. Interview with the Physician, on [DATE] at 10:15 AM, revealed it was his expectation for staff to notify him or the APRN if the resident was having a change of condition. Per interview, he was unaware the resident was in pain, and that the resident's pain medication order had expired. Interview with the Director of Nursing (DON), on [DATE] at 9:18 AM, revealed that follow-up on admission/readmission orders was important to address and treat the resident appropriately. Per interview, the DON stated there was no documented evidence the nursing staff notified the Physician that the resident was no longer on scheduled Oxycodone, after returning from the hospital. In addition, she stated there was no documented evidence the nursing staff notified the Physician or APRN of a CIC related to pain. Per interview, it was her expectation for staff to follow the facility's policies. Interview with the Administrator, on [DATE] at 5:28 PM, revealed the Change in Condition/Notification of Change policy was expected to be followed to ensure the Physician was notified of changes in a resident's condition per policy guidelines. Additionally, she stated any significant change in a resident's condition was expected to be documented in the medical record. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility provided an acceptable credible Allegation of Compliance (AoC) on [DATE] alleging removal of the Immediate Jeopardy on [DATE]. Review of the AoC revealed the facility implemented the following: 1. An audit was conducted by the Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE), and Unit Managers (UM) between [DATE] and [DATE] to determine if residents had pain, had pain medications ordered, if pain medications were effective, and if pain was not relieved. The Physician/Advanced Registered Nurse Practitioner (ARNP) were notified of unrelieved complaints of pain with new orders obtained if applicable. 2. Nineteen (19) of nineteen (19) residents identified with pain issues were reassessed on [DATE] by the Director of Nursing (DON), UM's, and/or Licensed Nurse (LN) Nurse Practitioner and/or Physician to determine if a change in condition had occurred regarding pain. Areas of concern were corrected upon discovery. 3. The DON, UM, ADON, NPE, and/or Clinical Quality Specialist (CQS) initiated reeducation, beginning on [DATE], with all facility staff to include contracted staff on the facility's policy and procedures regarding: (A) Change in Condition; (B) Pain Management, including observations; (C) Stop and Watch Tool; (D) Physician/Mid-Level Provider Notification of Change in a Resident's condition; and (E) Person Centered Care Plan. A post-test was administered at the time of the reeducation that required a passing score of 100% that will be graded by the DON, UM, ADON, NPE, and/or CQS to validate understanding. Facility staff and agency staff not available during the reeducation and post-test were to be provided reeducation including a post-test by the DON, UM, ADON, NPE, and/or CQS upon day of return to work prior to providing care. Newly hired staff and contracted staff were to be provided education and post-test during orientation by the DON, ADON, CQS, NPE, UM, and/or Licensed Nurse (LN). 4. Starting [DATE], clinical observation rounds will be conducted every shift, including interviews of ten (10) staff and five (5) residents who receive pain medication to identify any change in condition including a change in pain by the DON, ADON, UM, NPE, or LN to determine if residents have experienced a change in condition regarding pain. The Physician/NP were notified and the plan of care was reviewed to ensure it reflected the current needs of the resident daily until the Immediate Jeopardy is abated. 5. Starting [DATE], the Center Executive Director (CED) and/or LN would conduct ten (10) employee questionnaires daily to determine if staff were aware of the Center's process of the Stop and Watch Tool and reporting a change in condition, including reporting resident pain to a licensed nurse, to ensure prompt interventions when a resident experienced a change in condition, until the Immediate Jeopardy is abated. 6. The results of the observations, interviews, and audits will be reviewed daily by the CED or DON corrective actions taken upon discovery of deficiencies. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Beginning on [DATE], the DON, UM, ADON, NPE, CQS, and/or LNs initiated reeducation with all licensed nurses and agency nurses on the facility's policy and procedures regarding: (A) Pain management to include implementing person-centered care plan with individualized person centered interventions to include monitoring pain, administering pain medications as ordered, utilizing and documenting the pain scale, and observing for non-verbal signs/symptoms of pain; (B) Pressure Ulcer prevention to include developing/implementing the care plan; (C) Person-centered care plans; and (D) Physician/Mid-Level Provider Notification of Change in a resident's condition. 8. All admissions, readmissions, and residents with changes in respiratory status since [DATE] were reviewed on [DATE] by the DON, ADON, NPE, UM, and or LNs to determine if care plans reflected patient specific interventions to include interventions to monitor respiratory status to include residents with sleep apnea, COPD, acute respiratory failure, and asthma. Areas of concern were corrected upon discovery. 9. On [DATE], the DON, UM, ADON, NPE and or CQS initiated reeducation with all licensed nurses and agency nurses on the facility's policy and procedures regarding: (A) Revision of the care plan with all admissions, readmissions, and changes in respiratory status with diagnoses to include acute respiratory failure, sleep apnea, COPD, and asthma. A post-test was administered at the time of the reeducation that required a passing score of 100% that was graded by the DON, UM, ADON, NPE, and/or CQS to validate understanding. Licensed Nursing and Agency Licensed Nursing Staff not available will be provided reeducation, including a post-test, by the DON, UM, ADON, NPE, and/or Registered Nurse upon day of return to work before providing care. New licensed nursing hires and agency licensed nurses will be provided education and post-test during orientation by the DON, ADON, NPE and/or UM. 10. Care plan audits were completed for residents with diagnoses including acute respiratory failure, sleep apnea, COPD, and/or asthma and will be completed for new admissions, readmissions, and residents with a change in condition to include a change in respiratory status to determine the care plan has resident specific interventions including respiratory assessments; and, corrective actions were taken upon discovery of deficiencies. 11. Five (5) Licensed Nursing Staff interviews were completed by the CED, DON, UM, ADON, NPE, and/or CQS to determine if staff were aware of the process of a respiratory assessment when a resident's condition warranted the assessment and per the resident's plan of care will be conducted daily until the Immediate Jeopardy is abated. 12. The DON, UM, ADON, NPE, and/or CQS completed reeducation beginning on [DATE] with facility licensed staff to include agency staff on the facility's policy and procedures regarding: (A) Pain management to include implementing person-centered care plans with individualized person-centered interventions to include monitoring pain, administering pain medications as ordered, and utilizing and documenting pain scale assessments, and observe for non-verbal signs/symptoms of pain. A medication reconciliation process is in place to review discharge orders to current orders; (B) Physician/Mid-Level Provider Notification of Change in a resident's condition; and (C) Person Centered care plans regarding resident interventions for pain. A post-test was administered at the time of reeducation that required a passing score of 100% that was graded by the DON, UM, ADON, NPE, and or CQS to validate understanding. Facility licensed staff and agency staff not available will be provided reeducation including a post-test during orientation by the DON, ADON, NPE, UM, and/or LN, before allowed to work. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. The CED and/or LN will conduct five (5) employee questionnaires daily to determine if staff were aware of the Center's process of reporting a change in condition including pain to a licensed nurse to ensure prompt intervention when a resident experienced a change in condition until Immediate Jeopardy is abated. 14. The UM's, ADON, NPE, and licensed nurses completed skin assessments on all residents on [DATE], to ensure residents, including residents with pressure ulcers, received care per Physician's orders to promote healing and prevent additional pressure ulcers with any needed corrective action taken upon discovery. 15. The CQS reeducated the Wound Nurse regarding the facility's policy, Wound Care, on [DATE]. A post-test was administered at the time of the reeducation to validate understanding. 16. The NPE, DON, UM's, and/or ADON reeducated all licensed staff, including agency staff, regarding the requirement that residents with pressure ulcers receive care to promote healing and prevent additional pressure ulcers, to include appropriate assessment of all wounds when a wound/abscess was identified, beginning on [DATE], with a posttest requiring 100% score to validate understanding. 17. The DON, ADON, NPE or UM will conduct observation rounds and treatment administration audits to ensure residents with pressure ulcers receive care to promote healing and prevent additional pressure ulcers as per Physician's Orders starting [DATE] daily until Immediate Jeopardy is abated. 18. Quality Assurance/Performance Improvement (QAPI) meetings are occurring daily (Monday-Friday) beginning [DATE] with the interdisciplinary team, which consists of the CED, DOB, ADON, NPE, UM's, MDS, Dietary Manager, Social Services, Business Office Manager, Environmental Services, Medical Records, Maintenance, Human Resources, Registered Dietician, Activities Director, Central Supply, and Director of Rehabilitation, until Immediate Jeopardy is abated. During QAPI meetings, the current status of the AoC is discussed, including review of the audit tools, findings, and any needed corrective action. The State Survey Agency validated the implementation of the facility's AoC as follows: 1. Review of the facility's audit tool revealed the audits were reviewed, with all residents present as of [DATE]. Audits were conducted to determine the presence of pain, and the effectiveness of any pain medications ordered. Record review revealed nineteen (19) residents were identified with pain concerns, with most concerns identified consisting of pain medications not being effective, or not being effective for the length of time until the next dosage of pain medication was available. All of this information was emailed to the Nurse Practitioner (NP) by the CQS. Review of residents' medical records for residents identified, revealed residents had been reassessed by either the Physician or NP, with new orders provided as appropriate. 2. Review of nineteen (19) residents with identified pain issues revealed residents identified had been reassessed on [DATE] by the DON, UMs and/or Licensed Nurse (LN) to determine if a change in condition had occurred regarding pain. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the NPE, on [DATE] at 1:30 PM, revealed, based on audits conducted by [DATE]; nineteen (19) residents were identified with pain issues. She revealed all residents had been reassessed, and staff were documenting changes in resident condition in nursing notes regarding effectiveness of pain medications. 3. Review of the facility's In-Service Sign In Sheets, dated [DATE] through [DATE], revealed all facility staff were educated in person or over the phone regarding: (A) Change in condition; (B) Pain management; (C) Stop and Watch Tool; (D) Provider notification of change; and (E) Person-centered care plans. Review of documents titled Post Test, revealed staff completed testing covering all identified areas, to include changes in resident condition, management of resident pain, Stop and Watch Tool, provider notification of change, and person-centered care plans. Interview with Admissions personnel, on [DATE] at 8:20 AM, revealed she had been educated to monitor residents for any new or worsening pain or any change in activity or changes in resident condition, the resident care plan. Admissions personnel was to report to the nurse and DON. She stated she was in-serviced on the use of the Stop and Watch tool. Interview with Laundry personnel, on [DATE] at 8:30 AM, revealed Laundry staff had been educated to monitor residents for pain or change in condition and to notify the nurse if any occurs. Laundry staff was to observe for any lack of care for the residents. Per interview Laundry personnel were in-serviced on the Stop and Watch tool. Interview with Physical Therapy Assistant (PTA) #1, on [DATE] at 8:15 AM, revealed PTA#1 had been educated to monitor for new or worsening pain and if a resident was participating less in activities or had a change in condition to report this to the nurse. Per interview, they had been in-serviced on the Stop and Watch tool. PTA #1 completed a posttest after the training. Interview with SRNA #8, on [DATE] at 8:35 AM and SRNA #27 at 8:45 AM, SRNA #25 at 8:50 AM and SRNA #28 at 9:00 AM revealed education was provided to monitor for any new or worsening pain, change in condition and the appropriate use of the resident's care plan. Any change was to be reported immediately to the nurse. Per interview, they had been in-serviced on the Stop and Watch tool and had taken a posttest after the education. Interview with the Activities Director on [DATE] at 3:40 PM revealed she had been educated in the Stop and Watch tool and the importance of the resident's care plan. She stated she was to watch for any new or worsening pain, or if a resident was participating less in activities. She stated she was to document and notify the nurse. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of AoC Audit Tool - [DATE], dated [DATE] through [DATE], revealed the facility was conducting observation rounds of ten (10) staff and five (5) residents every shift. Continued review revealed residents were interviewed to ensure they were receiving pain medications, with any changes in condition noted, assessments completed, notifications made as appropriate, and care plans updated as appropriate. Review of the staff portion for licensed staff revealed licensed staff were interviewed regarding the process for respiratory treatment, the process for reporting changes in condition, awareness of notification of the Physician or NP regarding resident pain issues and awareness of the care plan reflecting resident needs. Review of the staff portion for non-licensed staff revealed they were interviewed regarding awareness of the Stop and Watch Tool reporting of changes in resident condition regarding pain, respiratory status, or skin issues. Interview with RN #4 on [DATE] at 12:00 PM revealed she had audited nineteen (19) residents with pain. A tool called 'Stop and Watch' was used to educate staff on pain. All staff were educated and all tours of duty were included to assure no staff were missed. Interview with SRNA #8, on [DATE] at 8:35 AM, revealed education was done to monitor for any new or worsening pain or change in condition. Any change was to be reported immediately to the nurse. Per interview, she had been questioned during management rounds related to monitoring for pain and reporting to nursing staff. Interview with the Activities Director, on [DATE] at 3:40 PM, revealed she had been educated in the 'Stop and Watch' tool. She stated she was to watch for any new or worsening pain, or if a resident was participating less in activities. She stated she was to document and notify the nurse. Per interview, she had been asked during management rounds regarding awareness of the Stop and Watch Tool. 5. Review of the facility's AoC binders revealed completed documentation labeled F580 Test 2 All Staff except LN, completed by facility staff covering topics such as the Stop and Watch Tool, changes in resident condition, and person-centered resident care. 6. Interview with the DON, on [DATE] at 9:18 AM, revealed she reviewed the results of observations, interviews, and audits daily, and she ensured there was additional follow-up as needed. She stated audits had increased staff education and were helping management ensure staff followed-up with everything. She stated management had identified a need for staff improvement on documentation. 7. Review of the facility's In-Service Sign In Sheets, dated [DATE] through [DATE], revealed Licensed Nurses attended or were educated in person or over the phone regarding: (A) Pain management to include implementing person-centered care plan with individualized person centered interventions to include monitoring pain, administering pain medications as ordered, utilizing and documenting the pain scale, and observing for non-verbal signs/symptoms of pain; (B) Pressure Ulcer prevention to include developing/implementing the care plan; (C) Person-centered care plans; and (D) Physician/Mid-Level Provider Notification of Change in a resident's condition, Review of documents titled Post Test revealed licensed nursing staff completed testing covering all identified areas, to include changes in residents' condition, management of resident pain, Stop and Watch Tool, provider notification of change, and person-centered care plans. (continued on next page)

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	185090	A. Building B. Wing	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #17, on [DATE] at 8:49 AM and with LPN #10 on [DATE] at 8:05 AM, LPN #3 at 9:05 AM and LPN #6 at 9:10 AM, revealed they had been educated to watch for any new or worsening pain, to implement a person centered care plan with individualized interventions, administer pain medications as ordered using the pain scale, pressure ulcers monitor and treatment and to notify the practitioner with all changes in resident conditions. Per interviews, a posttest to acknowledge understanding of the education was given. Interview with RN #4 on [DATE] at 12:00 PM revealed a tool called 'Stop and Watch' was used to educate staff on pain. All staff were educated and all tours of duty were included to assure no staff were missed. The education is to be ongoing. Staff were educated to be transparent and use open communication. RN#4 reported all staff were educated on notifying the practitioner if a resident was experiencing pain. For chronic pain, interventions were to be implemented. 8. Review of the facility's documentation revealed the NPE reviewed all residents on [DATE] that had been admitted , readmitted , or that had been identified with changes in respiratory status. The NPE identified any changes since [DATE], and ensured care plan changes were implemented as necessary. Interview with the NPE, on [DATE] at 1:30 PM, revealed she did review all residents on [DATE] that had been admitted , readmitted or identified with changes in respiratory status. 9. Review of the facility's In-Service Sign In Sheets, dated [DATE] through [DATE], revealed all licensed nurses, to include agency nurses, were educated in person or over the phone regarding revision of resident care plans for all admissions, readmissions, and changes in respiratory status for residents with diagnoses to include acute respiratory failure, sleep apnea, COPD, and asthma. Review of Clinical Competency Validation Respiratory Assessment, revealed licensed nursing staff completed testing following education. Interview with RN #4 on [DATE], LPN #17, on [DATE] at 8:49 AM and with LPN #10 on [DATE] at 8:05 AM, LPN #3 at 9:05 AM and LPN #6 at 9:10 AM, revealed they had been educated related to the revision of the resident care plan for all admissions, readmissions and changes in respiratory status for residents. Per interviews, a posttest to acknowledge understanding of the education was given. 10. Review of the AoC Audit Tool - [DATE], revealed care plan audits were conducted on new admissions, readmissions, and change in condition residents, to include a change in respiratory status, and were ongoing as of [DATE]. 11. Continued review of the AoC Audit Tool - [DATE], revealed five (5) licensed staff were intervie [TRUNCATED]

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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** 32635 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide a comfortable homelike environment for four (4) of thirty (30) sampled residents (Residents #84, #88, #108, and #114) and three (3) unsampled residents (Residents #41, #59, and #96). Observations conducted, on 04/12/2021 through 04/15/2021; 04/22/2021 through 04/28/2021; and 05/11/2021 through 05/14/2021, revealed strong urine and fecal odors were present upon entering the facility and throughout the areas of the facility where residents resided. Interviews with staff and residents revealed concerns had been voiced to Administration related to odors in the facility. The findings include: Review of the facility's policy titled, Resident Rights, dated 03/01/2018, revealed residents had the fundamental right to considerate care that safeguarded their personal dignity along with respecting cultural, social, and spiritual values. Further review of the policy revealed the facility complied with and communicated those rights to residents in a language and/or by a means of communication that ensured understanding. On 05/13/2021 at 1:00 PM, a request was made for the facility's policy related to providing residents with a comfortable homelike environment. The Administrator stated the facility did not have a policy related to providing residents with a comfortable homelike environment. Observations on 04/12/2021 at 11:45 AM, 12:30 PM, 4:05 PM, and 5:10 PM revealed strong odors on the 200 and 300 Units, with less pronounced odors present in the lobby and on the 100 Unit. Observations on 04/13/2021 at 9:00 AM, 1:42 PM, and 4:45 PM revealed strong fecal odors on the 200 Unit. Observations on 04/14/2021 at 8:02 AM, 9:37 AM, 11:10 AM, 12:26 AM, and 2:23 PM revealed strong fecal odors on the 200 and 300 Units. Observations on 04/15/2021 at 7:50 AM and 8:50 AM revealed extremely overpowering urine and fecal odors on the 200 Unit. Observations on 04/22/2021 at 9:10 AM, 11:30 AM, and 1:50 PM revealed strong odors on the 200 Unit. Observation on 04/27/2021 at 9:50 AM revealed strong foul odors on the 200 and 300 Units. In addition, observation, on 04/27/2021 at 4:45 PM, revealed strong odors on the 100 Unit. Observations on 04/28/2021 at 8:00 AM during the tour revealed foul odors on the 200 and 300 Units. In addition, on 04/28/2021 at 9:25 AM, when in the conference room on the 200 Unit, State Survey Agency Surveyors smelled foul odors when the door was opened to the hallway. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Observation on 04/14/2021 at 8:35 AM with Resident #59 who resided on the 200 Unit revealed a twelve (12) inch area on the bottom sheet that was stained with dried feces. The top sheet had large dark dried areas. Interview with Resident #59, on 04/14/2021 at 8:35 AM, revealed there were foul odors all the time. Resident #59 stated the sheets were last changed two (2) days ago. Resident #59 further stated, I don't like this. It smells and makes me feel dirty. I'm leaving here soon. I just cover it up so I don't look at it until they change it. When I ask them to change the linen they will if they have linen, but they are out of linen frequently. 2. Observation of Resident #114's room, on 04/14/2021 at 9:00 AM, revealed a strong odor coming from his/her side of the room. Interview with Resident #114, on 04/14/2021 at 9:00 AM, revealed he/she did not like the odors, and they made him/her feel dirty. 3. Observation of Resident #84's room, on 04/13/2021 at 4:50 PM, revealed the resident was calm and clean, but there was a strong odor present in the room. Interview with Resident #84, on 04/13/2021 at 4:50 PM, who resided on the 100 Unit, revealed he/she had concerns about the shared bathroom and with the continuous daily unpleasant odors. 4. Observation of Resident #88's room, on 04/12/2021 at 11:14 AM, revealed a strong odor was present in his/her room. Interview with Resident #88, on 04/12/2021 at 11:14 AM, revealed the resident wore a face mask when going to therapy to help him/her not smell the odors in the hallway. 5. Observation of Resident #108's room, on 04/12/2021 at 12:45 PM, revealed odor was present in his/her room. Interview with Resident #108, on 04/12/2021 at 12:45 PM, revealed the resident had to keep his/her door shut due to the unpleasant odors in the hallway. 6. Observation of Resident #41's room, on 04/14/2021 at 8:40 AM, revealed unpleasant odors were present in his/her room. Interview with Resident #41, on 04/14/2021 at 8:40 AM, revealed he/she was bothered by the smell. 7. Observation of Resident #96's room, on 04/14/2021 at 8:45 AM, revealed there was a foul odor in the resident's room. Interview with Resident #96, on 04/14/2021 at 8:45 AM, revealed foul odors were present all the time, and he/she was bothered by the smell. Resident #96 stated he/she attempted to keep the door shut to keep the odors out of the room, but the odors were still present. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with an Emergency Medical Services (EMS) worker, on 04/26/2021 at 5:33 PM, revealed he had come to the facility on several occasions and each time there was a foul odor, and the residents looked unkempt. Interview with the Assistant Director of Nursing (ADON), on 04/13/2021 at 10:49 AM, revealed foul odors were present in the facility. The ADON stated she was not aware of the reason for the odors and did not know how or if the facility was addressing the odors. Interview with the Director of Nursing (DON), on 05/14/2021 at 10:43 AM, revealed the facility had had several issues with plumbing. She stated on 04/19/2021 maintenance from the facility repaired the toilets in rooms [ROOM NUMBERS] on the 300 Unit; on 05/12/2021 maintenance from the facility repaired a sink in room [ROOM NUMBER] on the 100 Unit. Furthermore, she stated an outside plumber replaced eighty (80) feet of drain lines in the basement under the 300 Unit on 05/12/2021. The DON reported housekeeping rounds had been increased. In addition, she stated nursing staff had included monitoring for appropriate disposal of soiled materials during every two (2) hour rounds. Interview with the Administrator, on 04/27/2021 at 5:45 PM, revealed she was aware there was a foul odor in the facility, and it could be coming from a toilet that was currently not in use on the 200 Unit. Additional interview with the Administrator, on 05/12/2021 at 2:25 PM, revealed there was a generalized foul odor in the facility. Moreover, the Administrator stated she took responsibility for it because her position mandated that she had oversight of the facility. 44000 44001

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28707 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to protect residents from resident-to-resident abuse for four (4) of thirty (30) sampled residents (Residents #24, #68, #71, and #235). On 02/28/2021, Resident #24 slapped Resident #71 for inviting someone into their shared room, and Resident #71 slapped Resident #24 back. On 02/20/2021, Resident #65 struck Resident #235 in their shared room, as Resident #235 was in the room going through Resident #65's possessions. On 03/29/2021, Resident #334 observed Resident #68 taking food from a tray at the nurse's station. Resident #334 thought Resident #68 was stealing his/her food and stabbed Resident #68 with a fork. The findings include: Review of the facility's policy titled, Abuse Prohibition, dated 04/09/2021, revealed physical abuse was prohibited and included hitting, slapping, pinching, kicking, as well as controlling behavior through corporal punishment. 1. Review of Resident #71's medical record revealed the facility admitted the resident, on 12/10/2020 with diagnoses of Atrial Fibrillation, Hypertension, Diabetes Mellitus Type 2, and Arthritis. Review of Resident #71's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility had assessed the resident to have a Brief Interview for Mental status (BIMS) score of five (5) out of fifteen (15), indicating the resident had severe cognitive impairment. Review of the facility's Incident Report revealed, on 02/28/2021, Resident #24 slapped Resident #71 for inviting someone into their shared room. Resident #71 slapped Resident #24 back. Interview with Resident #71, on 04/13/2021 at 10:45 AM, revealed he/she denied hitting or being hit by Resident #24, and denied ever being hurt by anyone. Resident #71 stated he/she felt safe in the facility. Review of Resident #24 medical record revealed the facility admitted the resident, on 07/30/2020 with diagnoses of Anemia, Cirrhosis, Asthma, and Malnutrition. Review of Resident #24's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility had assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #24, on 04/13/2021 at 10:30 AM, revealed Resident #71 was touching his/her table and then he/she smacked Resident #24 on the face. Resident #24 stated the smack did not hurt Resident #71, but he/she did not remember the incident. Per interview, Resident #24 denied hitting Resident #71 first, even though this was reported in the incident report. Resident #24 stated there were no problems between the two (2) residents, but Resident #71 was relocated to another room. Interview with Social Services (SS) #2, on 04/13/2021 at 2:35 PM, revealed she worked on the 200 Unit and 300 Unit, and investigated the altercation between Resident #71 and Resident #24, which occurred on 02/28/2021. SS #2 stated, in her interview with Resident #24, the resident stated he/she slapped Resident #71 for inviting another resident into the room. SS #2 stated she visited Resident #71, who denied being hit at all. Interview with the Administrator, on 04/14/2021 at 4:00 PM, revealed the facility conducted an investigation of the altercation between Resident #24 and Resident #71, on 02/28/2021, when the residents were roommates. She stated it started because Resident #71 wanted to invite a friend into the room, and Resident #24 did not want the friend to enter the room. In addition, she stated, after the altercation, Resident #71 was moved to another room. Per interview, prior to this incident, there had been no issues between the two (2) residents, and there had not been any further issues between the residents. 2. Record review revealed the facility admitted Resident #65, on 07/22/2020 with diagnoses to include Dementia without Behavior Disturbance, Disorientation, HTN, and Osteoarthritis. Review of Resident #65's Quarterly Minimum Data Set Assessment, dated 03/21/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), indicating the resident was severely cognitively impaired. Review of the facility's incident report, dated 02/24/2021, revealed that on the weekend of 02/21/2021, Resident #65 struck Resident #235 when Resident #235 was in the shared room going through Resident #65's possessions. Continued review of Resident #65's medical record revealed a visit from the Social Services (SS) following the incident, for a Psychosocial visit with Resident #65. Per the Psychosocial progress note, dated 02/22/2021, the resident recalled no specifics as to why or what happened and he/she did not recall the event. However, the note stated Resident #65 did recall an altercation with someone. In addition, the note stated the resident believed that he/she was punched in the face and that he/she punched someone else in the face. Interview with Resident #65, on 04/13/2021 at 11:00 AM, revealed the resident did not remember hitting Resident #235. However, Resident #65 recalled someone had gone through his/her stuff. Review of Resident #235's medical record revealed he/she was admitted on [DATE] with diagnoses to include Dementia, Adult Failure to Thrive, and Cognitive Communication Deficit. Review of Resident #235's Quarterly Minimum Data Set Assessment, dated 03/03/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), indicating the resident was severely cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with SS #1, on 04/13/2021 at 2:55 PM, revealed she worked on the 100 Unit and investigated the event. She stated this was an isolated incident without previous issues. Resident #65 hit Resident #235 in the back of the head with a closed fist, after Resident #235 accidentally went to the wrong closet, Resident #65's closet, and started going through his/her belongings. Review of State Registered Nurse Aide (SRNA) #23's written statement, dated 02/21/2021, revealed Resident #235 had been going through Resident #65 things and said it all belonged to him/her. Interview with SRNA #23, on 04/27/2021 at 8:56 AM, revealed Resident #65 hit Resident #235 in the back of the head. She stated Resident #65 thought Resident #235 was stealing his/her things. In addition, SRNA #23 separated the two (2) residents and alerted the nurse. Review of Licensed Practical Nurse (LPN) #18's written statement, dated 02/20/2021, revealed SRNA #23 was alerted to Resident #65 and Resident #235 fighting. Further review of the statement revealed Resident #235 was found by Resident #65 going through his/her things, and Resident #65 told the other resident he/she was not going to be robbed. In addition, the statement documented Resident #65 was observed hitting Resident #235 three (3) times in the back of the head with a closed fist, and the physical exam of Resident #235's head showed a pink scratch to the neck. Interview with LPN #18, on 04/27/2021 at 9:05 AM, revealed she was sitting at the nurse's station, when SRNA #23 informed her of the altercation between Resident #65 and Resident #235. She stated SRNA #23 separated Resident #65 and Resident #235. In addition, she stated she checked both residents for injury and found a pink spot on the back of Resident #235's head. Interview with the Administrator, on 04/14/2021 at 4:00 PM, revealed Resident #235, on 02/20/2021 was very confused and would pilfer through other residents' belongings. She stated staff witnessed the punching by Resident #65, with a closed fist, to Resident #235's head. Per interview, the Administrator said Resident #235 received a scratch on the back of the neck. In addition, she stated both residents were immediately separated, rooms were changed, and there was increased staff supervision of the residents. 3. Review of Resident #334's medical record revealed the facility admitted the resident, on 02/25/2021, with diagnoses to include Dementia without Behavioral Disturbance, Cognitive Communication Deficit, Macular Degeneration, and Reduced Mobility. Review of Resident #334's Admission Minimum Data Set (MDS) Assessment, dated 03/04/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (MDS) score of seven (7) of out of fifteen (15), indicating the resident had cognitive impairment. Review of the facility's Final Investigation Report, dated 04/01/2021, revealed, on 03/29/2021, Resident #334 saw Resident #68 near the nurse's station taking food off a tray, which Resident #334 believed contained his/her food. Resident #334 poked Resident #68 in the back with a fork, and both were immediately separated. In addition, the report stated staff walked with Resident #334, around until he/she was calm. The report stated the skin assessment of Resident #334 revealed no areas of concern; however, Resident #68's skin assessment, on 03/29/2021, revealed abrasions to the upper mid-back and right scapula. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's medical record revealed the facility admitted the resident, on 01/15/2021, with diagnoses to include Traumatic Subdural Hemorrhage, Difficulty in Walking, Cognitive Communication Deficit, and Encephalopathy. Review of Resident #68's Quarterly MDS Assessment, dated 03/16/2021, revealed the facility assessed the resident as severely cognitively impaired. Interview with the Assistant Director of Nursing (ADON), on 04/13/2021 at 11:06 AM, revealed Resident #334 had poked Resident # 68 in the back with a fork. She stated the two (2) residents were separated, and Resident #68's back was examined. Further, the ADON stated Resident #68's back had the appearance of small abrasions. Per interview, the ADON stated Resident #68 told her he/she was okay. Interview with Social Services #1, on 04/13/2020 at 2:57 PM, revealed she had visited with Resident #334 and Resident #68 after the incident. She stated both residents did not recall the incident, and the incident occurred because Resident #334 thought he/she saw Resident #68 take food off of his/her tray at the nurse's station. Per interview, she stated Resident #334 was not happy Resident #68 was taking his/her food, so he/she struck Resident #68 with a fork to the back. In addition, Social Services #1 stated this was an isolated incident, Resident #68 was very confused, and since the incident, both residents had been separated from each other without further incident. Interview with the Administrator, on 04/22/2021 at 8:55 AM, revealed Resident #334 was walking by and thought Resident #68 was taking, stealing his/her food, so Resident #334 poked Resident #68 with a fork. She stated staff removed Resident #334 from the area and walked the halls with him/her until calm. In addition, the Administrator said Resident #68's skin assessment revealed scratches to his/her back from the fork. Continued interview with the Administrator, on 04/22/2021 at 8:55 AM, revealed the facility has an abuse policy that prohibits abuse of any type to include resident-to-resident abuse. She stated staff were trained upon hire, yearly and as needed on the facility's abuse policy that included all types of abuse. Per interview, the facility monitors residents for behaviors and implements actions per the behaviors. 32635

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28707 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to protect residents from abuse related to Misappropriation of resident property for one (1) of thirty (30) sampled residents (Resident #93). On 01/17/2021, Resident #93 reported that he/she did not receive a bag with two (2) candy bars and two hundred forty dollars ($240) which was left for him/her at the front door when staff was not available to receive the items. The findings include: Review of the facility's policy titled, Abuse Prohibition, dated 04/09/2021, revealed misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Review of Resident #93's medical record revealed the facility admitted the resident, on 12/18/2021, with diagnoses of Atrial Fibrillation, Hypertension, and Diabetes Mellitus Type 2. Review of Resident #93's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the Brief Interview for Mental Status (BIMS) score was fifteen (15) of fifteen (15), indicating the resident was cognitively intact. Review of the facility's Incident Report, dated 01/18/2021, revealed, on 01/17/2021, Resident #93 reported he/she never received a brown bag with two (2) candy bars and two hundred forty dollars ($240) which was left for him/her at the front door when staff was not available to receive the items. Resident #93 subsequently found his/her wallet and credit/debit cards missing from the brown paper bag in a [NAME] Dog Box. Interview with Resident #93, on 04/14/2021 at 10:30 AM, revealed he/she had a missing wallet with credit cards, debit cards, and two hundred twenty-six dollars ($266). This amount was different from the initial facility investigation of two hundred forty dollars ($240). The resident stated he/she asked the spouse of a good friend to withdraw three hundred dollars ($300) from his/her bank account and buy some items, including lunch. The resident stated he/she had paid the friend's spouse forty dollars ($40) dollars to do this. Per interview, Resident #93 stated the spouse delivered his/her wallet, and the money/cash was to be placed into a brown paper bag and put into a cardboard box that held the resident's meal, a [NAME] hot dog. The resident stated he/she did not remember which staff member delivered the meal to him/her and did not know if the police were contacted. Review of the facility's Investigation Report related to Resident #93 revealed a bank receipt, dated 01/16/2021 at 5:43 PM, which showed a three hundred forty dollar ($340) withdrawal. Review of the Police Report Incident, revealed the Director of Nursing (DON) reported the incident on 01/21/2021, the incident remained open, and the spouse of the good friend refused to be interviewed. (continued on next page)

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	185090	A. Building B. Wing	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with State Registered Nurse Aide (SRNA #9), on 04/14/2021 at 3:22 PM, revealed she heard the alarm going off at the front door, and she checked to see if a resident was trying to exit the facility. She stated she saw a person at the front door, and the person had brought in a box of stuff and was looking for Resident #93. SRNA #9 stated she instructed the person to leave the package between the doors, and she would take it to Resident #93. Per interview, SRNA #9 stated she returned to assisting smokers back into the facility, and after she finished this, she went up front and picked up the box that was between the doors. She stated she did not open the box but noticed the box had pictures of [NAME] Dogs on top. SRNA #9 further stated she took the box straight to Resident #93 and then returned to the 200 Unit. Interview with the Director of Nursing (DON), on 05/14/2021 at 9:18 AM, revealed she notified the police of the incident, and the police spoke with Resident #93. Per interview, during the COVID - 19 lockdown, visitors were not allowed inside the building and any packages were to be dropped off and left at the main entrance between the front doors. Per interview, it was her expectation that all items that were brought to the facility by resident's family and friends would be delivered to that resident. Interview with the Administrator, on 04/17/2021 at 4:00 PM, revealed, during the COVID -19 lockdown, packages and items for the residents were delivered to the main entrance, between the front doors. She stated Resident #93 reported his/her brown bag was found in the package; however, the resident was missing his/her wallet, money, and credits cards. The Administrator stated, during the facility's investigation, the spouse of Resident #93's friend did not want to be contacted concerning the missing money. Per interview, she stated SRNA #9 told her she was bringing residents back into the facility from a smoke break and told the visitor to leave the package between the front doors, and she would be back to pick-up the item and deliver it to Resident #93. Per interview, the items were left at the front door unattended to by staff. The Administrator stated, during the course of the investigation, SRNA #9 stated she did not look into the box, and the police were contacted. Continued interview revealed it was her expectation that all items left at the front door for residents would be delivered to the residents. Per interview, the facility has a policy related to abuse and misappropriation of a resident's property and it was her expectation that all staff would follow the facility's policy.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41721 44001 Based on observation, interview, record review, review of the facility's policy, and review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual Version 3.0, it was determined the facility failed to ensure Comprehensive Care Plans (CCP) for chronic pain and pressure risk with individualized person-centered interventions were followed for four (1) of thirty (30) sampled residents, Resident #110, #114, #36 and #102. The facility identified Resident #110 as at risk for alterations in comfort related to osteoarthritis (OA), muscle weakness, right upper extremity edema, contracture, hemiplegia, obesity, and polyneuropathy. Observation of Resident #110, on [DATE] at 9:05 AM, revealed the resident yelled for a nurse for appoximately two (2) minutes. No one responded to the resident until the State Survey Agency (SSA) Surveyor alerted staff that the resident needed assistance. Interview with Resident #110, on [DATE] at 9:20 AM, revealed staff did not address his/her chronic pain, and while the resident had resided at the facility since the last readmission, he/she had not received pain medication as needed. Resident #110's care plan, revised on [DATE], identified the resident as being at risk for pressure injuries. Interviews and record review revealed the facility failed to implement pressure sore interventions. Resident #110 developed an open right gluteal abscess 2.0 cm (length) by 3.0 cm (width) by 0.4 cm (depth), with hard surrounding tissue and moderate amounts of purulent drainage. In addition, there was development of an unstageable sacral decubitus ulcer measuring 8.0 cm (length) by 2.0 cm (width). Furthermore, a Computed Tomography (CT) of the pelvis showed a chronic calcified posterior right gluteal region hematoma in the surrounding soft tissue infiltration indicating possible soft tissue infection from the right buttock ulcer. The facility's failure to have an effective system to ensure the facility developed care plans and implemented interventions in the care plans to address the resident's assessed needs, related to pain management and pressure ulcers, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE], in the area of 42 CFR 483.21(b)(1) Comprehensive Resident Centered Care Plans, Develop and Implement Care Plans, and was determined to exist on [DATE]. The facility provided an acceptable Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with the remaining non-compliance at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Person-Centered Care Plan, revised [DATE], revealed Comprehensive Care Plans were developed to help the resident attain or maintain his/her highest practicable physical, mental and psychosocial well-being and included measurable objectives and timetables to meet a resident's medical, nursing, nutrition, and mental and psychosocial needs that were identified in the comprehensive assessments. Review of the Centers for Medicare and Medicaid Services, Resident Assessment Instrument (RAI) Manual 3.0, dated [DATE], revealed the care plan was driven, not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths, and needs. Furthermore, a care plan, based on a thorough assessment and effective clinical decision making, was compatible with current standards of clinical practice that provided a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. The manual stated a well-developed and executed assessment and care plan re-evaluated the resident's status at prescribed intervals (quarterly, annually, or if a significant change in status occurred) using the RAI and then modified the individualized care plan as appropriate and necessary. 1. Review of Resident #110's medical record revealed the resident was admitted by the facility, on [DATE]. The resident had current diagnoses of Obstructive Sleep Apnea (OSA), Chronic Obstructive Pulmonary Disease (COPD), Asthma, Dysphagia, Heart Failure (HF), and Chronic Kidney Disease (CKD). Further review revealed Resident #110 had been hospitalized , from [DATE] to [DATE], with Sepsis and Acute Respiratory Failure. Review of Resident #110's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated he/she had mild cognitive impairment. Continued review revealed the facility assessed Resident #110 as having pain during this assessment period and had received scheduled or as needed (PRN) pain medication. Review of Resident #110's Comprehensive Care Plan (CCP), initiated on [DATE] and last reviewed on [DATE], revealed Resident #110 was at risk for alterations in comfort related to osteoarthritis (OA), muscle weakness, right upper extremity edema, contracture, hemiplegia, obesity, and polyneuropathy. The goal was the resident would achieve an acceptable level of pain control. Further, interventions included but were not limited to, administer pain medication as ordered; elevate right upper extremities with pillow; observe pain characteristics: quality, severity, location, precipitating/relieving factors, medicate resident as ordered for pain, observe for effectiveness and side effects, and report to the Physician as indicated. Observation of Resident #110, on [DATE] at 9:05 AM, revealed the resident yelled for appoximately two (2) minutes. Resident was heard to moan and groan and observation of resident showed non-verbal ques of pain with grimacing. No one responded to the resident until the State Survey Agency (SSA) Surveyor alerted staff that the resident needed assistance. This surveyor went to the nursing station and made SRNA #11, aware that Resident needed assistance. SRNA #11 got up and went into the room. Interview with Resident #110, on [DATE] at 9:20 AM, revealed staff did not address his/her chronic pain, and while the resident had resided at the facility since the last readmission, he/she had not received pain medication as needed. Interview with the resident revealed that he/she was in pain. The resident stated, I'm miserable and I hurt. I hurt all the time. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Agency LPN #9, on [DATE] at 2:15 PM and [DATE] at 8:15 AM, revealed all staff was to follow and implement the residents' CCP to ensure they were receiving ordered care. LPN #9 stated Resident #110 was uncomfortable with positioning and would not tolerate it well. She stated the resident would cry out in pain when turned. LPN #9's interview revealed the resident verbalization pain, but stated if the resident had pain it was Only when moved. Further stated, She/he says she's in pain but she isn't. She stated the resident was incontinent, obese, and needed frequent skin assessments. Review of the facility's Roster Matrix (a cumulative record of residents on the census, their care needs, and identified health conditions), dated [DATE], revealed no indication Resident #110 had any pressure ulcers. Further review of the Comprehensive Care Plan, last reviewed [DATE], revealed Resident #110 was at risk for skin breakdown as evidenced by moisture/excessive perspiration, limited mobility, diabetes mellitus, peripheral vascular disease, incontinence of bowel and bladder, medications, history of pressure ulcers, obesity, hemiplegia, anemia, and an arterial ulcer to the right second digit. The goal was for the resident to show no signs of further skin breakdown. Further review revealed interventions were to apply barrier cream with each cleansing, assist with methods of reducing friction and shear, assist the resident with turning and repositioning every two (2) hours as tolerated, float heels while in bed as tolerated, provide a low air loss (LAL) mattress to the bed, perform [NAME]/Braden assessments per policy, observe skin risk factors per protocol, and observe for localized skin problems. Further review of the Comprehensive Care Plan, last reviewed [DATE], revealed Resident #110 was at risk for skin breakdown or had actual skin breakdown. The healing goals were: 1) the resident would remain free of skin tear and bruising; 2) show no signs of skin breakdown; 3) the skin tear/bruise would heal; and 4) the wound/skin impairment would heal. Further review revealed interventions were to pat skin when drying, provide treatment to skin tear per Physician order, observe for signs of infection, assist resident with turning and repositioning, observe skin for signs/symptoms of skin breakdown, evaluate localized skin problems, utilize devices to assist with turning/positioning to reduce friction and shear, weekly skin assessments by a licensed nurse, weekly wound assessment to include measurements and description of the wound, and provide wound related pain management intervention (i.e. premedicate before wound care). Further review of the Comprehensive Care Plan, last reviewed [DATE], revealed Resident #110 was incontinent of urine and was unable to participate cognitively or physically in a retraining program. The goals were to have incontinence care needs met by staff to maintain dignity and comfort, and to prevent incontinence related complications. Further review revealed interventions were to check and change every two (2) hours and as needed (PRN) and to observe for skin redness/irritation and report as indicated. Interview with Agency LPN #9, [DATE] at 8:15 AM, stated the wound on the hip was an abscess with drainage, and she performed a culture and sensitivity on the drainage during a dressing change. She stated the wound abscess was tiny. LPN #9 stated the area on the right buttocks was healed. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review Resident #110's medical record revealed, on [DATE], Resident #110 was transferred to the hospital Emergency Department (ED) by Emergency Medical Services (EMS), and during the triage period, hospital staff and EMS identified a sacral wound. The hospital assessed the resident to have an open right gluteal abscess, 2.0 cm (length) by 3.0 cm (width) by 0.4 cm (depth), with hard surrounding tissue and moderate amounts of purulent drainage. In addition, the record stated staff identified an unstageable sacral decubitus ulcer measuring 8.0 cm (length) by 2.0 cm (width). Furthermore, a Computed Tomography (CT) of the pelvis showed a chronic calcified posterior right gluteal region hematoma in the surrounding soft tissue infiltration indicating possible soft tissue infection from the right buttocks ulcer. Further review revealed a surgical consult revealed the abscess and sacral ulcer would require surgical debridement of necrotic tissue. Then, a palliative care (care primarily focused on alleviating pain) consult was requested by the provider because the patient has no quality of life. The resident was transferred back to the facility under Hospice Care on [DATE] and expired on [DATE]. Review of a Braden Scale (a scale used to determine the degree of risk a resident had for developing pressure ulcers) Assessment and Skin Check dated, [DATE] at 5:27 PM, revealed Resident #110's score as ten (10), which indicated high risk. Review of the Skin Check, dated [DATE], revealed the nurse identified wounds to the right, second toe; right buttocks; and forehead. Review of a CIC follow-up Progress Note, dated [DATE] at 9:43 AM, revealed Resident #110's skin was warm with one-plus (1+) pitting edema in bilateral feet. Review of the Skin Check, performed on [DATE] at 5:27 PM, revealed no documented assessment, skin injuries, or wounds. Review of the Skin Assessment Grid, dated [DATE], revealed the only remaining wounds documented as assessed, was the buttocks/right hip abscess. There was no documentation of the right first toe, second toe, or third toe. There was no documentation of the medial forehead wound. There was no documentation or description of an unstageable sacral decubitus ulcer. Interview with SRNA #18, on on [DATE] at 8:20 AM, revealed when aides found a skin issue on a resident, the process was to document the finding on the Skin Assessment sheet and make the nurse aware. She further stated it was important to follow the resident's CCP. Interview with SRNA #26, on [DATE] at 5:15 PM, revealed Resident #110 was a total assist, but not bedridden. She stated the resident did not refuse care, but she would have to be very gentle when providing care. She used a pillow for elevation of the right arm. However, the SSA Surveyor observations, on [DATE], revealed no pillow under the resident's right arm as directed by the resident's CCP. SRNA #26 further stated it was important to follow the resident's CCP so that residents' needs were met. She stated she had performed incontinent care for Resident #110, but she did not recall seeing a wound. Interview with Agency LPN #15, on [DATE] at 5:05 PM, revealed she cared for Resident #110. She stated he/she was bedridden and had skin breakdown in abdominal folds. She did not recall any other skin breakdown. She stated Resident #110 would occasionally not want to be changed. LPN #15 stated her focus was on acute residents, so the SRNA's were her eyes and ears to alert her to potential problems. She stated person-centered care plans should be implemented. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional interview with LPN #9, on [DATE] at 11:13 AM, revealed Resident #110's right buttocks area had purulent drainage like an abscess. She stated she notified the Wound Care Nurse (WCN), obtained a wound culture and sensitivity, and notified the Physician for treatment orders. She stated she did not measure the wound and estimated it to be the size of a nickel. She stated no other skin issues were present. LPN #9 stated, on [DATE], the abscess was open and draining, and she had to pack it. She recalled the resident flinched during treatment and stated it was uncomfortable. She further stated that Resident #110 did not want to be disturbed. LPN #9 stated she did not document the resident's care or his/her verbal or non-verbal reactions to treatment. Interview with Registered Nurse (RN) #3, on [DATE] at 8:30 AM, revealed Resident #110's had an abscess to the right buttock. Per interview, RN #3 stated SRNA's only changed the resident two (2) times or less a shift because it was too uncomfortable for the resident. RN #3 stated the resident's CCP should have be implemented. Interview with RN #2, Nurse Educator/Wound Care Nurse (WCN), on [DATE] at 9:00 AM, revealed she was following Resident #110 for a wound on the toe, forehead, and shearing on the right buttock; however, she was not following the resident's abdominal fold wounds. RN #2 stated the shearing wound on the right buttock was healed, but a new wound abscess was found on the right hip area. She stated that LPN #9 did culture and dress the wound. In addition, the WCN stated the resident would grimace and moan when touched, and staff had to be gentle and procede slowing during the resident's wound care treatments. She stated she did not document Resident #110's pain level or non-verbal cues. She further stated if there was an order to do so, she would generally premedicate residents prior to wound care. Per interview, she stated it was important to follow the resident's CCP. Furthermore, she stated she should have premedicated Resident #110, per the CCP. She stated it would have been important to prevent any additional discomfort to the resident. Continued interview with the WCN, on [DATE] at 9:00 AM, revealed it was her expectation that staff assessed skin, bathed, checked and changed, and turned the resident per the CCP. She stated the importance of CCP was to ensure the Resident #110 was turned a minimum of every two (2) hours, and if he/she required, more frequently to prevent pressure injuries. She stated CCP's should be personalized and updated. Further interview revealed there was currently no widespread education on newly identified skin issues. The WCN stated the facility process was to let Unit Managers know about new skin issues. She stated not all staff had been educated on Pressure Ulcer Prevention (PUP) and PUP protocols were not in place. The WCN stated the plan was to implement new training regarding the turn schedule so nursing staff and SRNA's were educated on the importance of turning residents. Additional interview with the WCN, on [DATE] at 4:35 PM, revealed Agency staff was trained prior to coming to the facility on basic resident care. She stated the facility had processes to ensure competencies, which were not yet in place, for new hires, but new hires were paired with a trainer for one (1) to two (2) days, which she did not think was an adequate period of time. In addition, the WCN stated, during orientation, new staff was educated about using the CCP to personalize care, and trainers reported if there were any issues with competencies. Per interview, she stated she relied on other staff to check that agency staff was competent. Furthermore, she stated there was no follow-up from the Educator to assure competent care was provided according to the CCP and facility policies. She stated her goal was to spend one-on-one time with all staff, but for right now the process is broken. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional interview with the WCN, on [DATE] at 11:52 AM, revealed during the last treatment she did on Resident #110, she only concentrated on the abscess to the hip. She recalled documenting assessment findings on a piece of paper. She stated she received an order to pack the wound with Silvadene covered gauze. Per interview, she stated the wound was an abscess and not something that could be staged. She stated she did not measure the wound, and per policy, no photographs were obtained. The WCN stated a full skin assessment was not done. Further interviewed revealed she focused on the acute areas of skin breakdown, and nurses did a weekly skin assessment. Interview with the Regional Clinical Quality Specialist (RCQS), on [DATE] at 03:40 PM, revealed it was her expectation that nursing staff utilize skilled charting to document She stated, If it was not charted, it didn't happen. RCQS stated, Stated there is a breakdown in communication. here was no documented evidence the nursing followed the resident's care plan, according to facility policy. Interview with the Director of Nursing (DON), on [DATE] at 9:18 AM, revealed it was her expectation staff followed the resident's CCP, and if a resident had a pressure injury, it should be addressed in the CPC. She stated she expected nursing staff to provide the correct level of care per the person-centered care plan and as ordered by the Physician. Further interview revealed full skin assessments should be completed by nursing staff when weekly skin assessments were due. Per interview, the DON stated all residents at risk for skin breakdown should be checked, changed, and turned every two (2) hours. The DON stated SRNA's should notify the nurse of any change in the resident's condition. 2. Based on observation, interview, and record review, it was determined the facility failed to follow the individualized care plan relating to bathing and grooming of Resident #114. Record review revealed the facility admitted Resident #114 on [DATE] with multiple diagnoses to include Hemiplegia Affecting the Left Dominant Side, Dysphagia, History of TIA, Cognitive-Communication Deficit, Epilepsy, Vascular Dementia with Behavioral Disturbance, Major Depressive Disorder, Generalized Anxiety Disorder, Unspecified Mood Disorder, Congestive Heart Failure (CHF), Acquired Absence of Left Leg Above Knee (LAKA), Repeated Falls, etc. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) exam score of eight (8) of fifteen (15), and determined the resident to be moderately cognitively impaired. Review of Resident #114 Comprehensive Care Plan, last reviewed on [DATE], revealed the resident required assistance with, and was dependent for Activities of Daily Living (ADL) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to Limited Mobility, Cognitive Loss and Behaviors, Hemiplegia, and Left Above-Knee Amputation (LAKA), with the goal that ADL care needs will be anticipated and met throughout the next review period. Target date was [DATE]. Interventions included providing Resident #114 with extensive assist for toileting, dressing, and bathing. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Resident #114, on [DATE] at around 2:00 PM, revealed Resident #114 lying in bed with a urinal containing urine hanging on his bed rail. There was an odor detected coming from the resident's side of the room. Resident #114 also had a full beard, and his clothes and hair were disheveled. Attempts to have a conversation with Resident #114 regarding his care needs were unsuccessful. He commented that he liked pretty women. Interview with the Manager on 200 Hall (LPN #1), on [DATE] at 2:15 PM, revealed residents received showers on a routine assigned schedule and as often as staff deemed necessary. In addition, the manager stated the nurse aides complete shower sheets when showers were given to their assigned residents. The shower sheets were placed in a shower book at the nurses' station. Resident #114 was assigned to receive a shower on Tuesdays and Fridays during the evening shift. Continued interview with LPN #1 (Unit Manager), revealed that based on the shower sheets in the book, she could not determine when the last time Resident #114 received a shower, or that ADL care needs were being provided as per care plan. Observation of the Shower Binder, on [DATE] at 2:30 PM, located at the nurses' station, revealed Resident #114 did not have any shower sheets in the book for April. Interview with the manager again revealed she did not know why the sheets were not in the book. She stated that this was a new process, and she realized the process needed improvement. Continued interview revealed that perhaps the sheets were removed and sent to medical records already, and she would check to find out. However, no sheets were located in medical records. Interview with SRNA #22, on [DATE] at 9:00 AM, employed sixteen (16) years, revealed she usually worked weekends from 7 AM-11 PM on the 200 Hall. On a good day, staffing was four (4) nurse aides; today, there were three aides working the 200 Hall. Continued interview revealed each aide was assigned two to three showers each. During the shower, the nurse aide noted any skin issues and reported any findings to the nurse. Afterward, a shower sheet was completed, and placed in the shower binder located at the nurses' station. If the shower sheet was not found in the shower book, either the nurse aide did not do the shower, or the aide failed to complete the sheet; The nurse was supposed to verify that the nurse aide conducted the shower by checking the shower sheets. She stated that the facility has been in a staffing crisis lately, and most of the staff are Agency. Interview with SRNA #19 on [DATE] at 9:30 AM, employed [AGE] years at the facility, revealed she primarily works weekends on the 300 Hall and works typically with three to four aides. She revealed she normally was assigned two showers on her shift. She said the aides completed the shower sheets and reported any skin issues to the nurse; they then put the sheets in the shower book. Continued interview revealed that she would assume it was not done if she did not see the shower sheet in the book. Interview with LPN #11, on [DATE] at 8:49 AM, employed seventeen (17) years, revealed that aides were responsible for performing resident's showers on the days the showers were due. Aides bring the shower sheets to the nurse upon completion. The aides were supposed to inform nurses if the resident refuses their shower. The nurse would then go to the resident and try to convince the resident to take a shower. If the resident continued to refuse a shower, it should be documented in the medical record. Interview again with LPN #1, on [DATE] at approximately 10:00 AM, revealed Resident #114 received a good shower last evening. She revealed more attention would be given to make sure resident's care plans were implemented as outlined in their individualized care plan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Record review revealed the facility admitted Resident #36 on [DATE] with diagnoses to include Anoxic Brain Damage, Hemiplegia Affecting Unspecified Side, Chronic Obstructive Pulmonary Disease, Encephalopathy, Unspecified Convulsions, Dysphagia, Hypothyroidism, Congenital Deformities, Irritability and Anger, Mood Disorder, Bipolar Disorder, Unspecified Psychosis, etc. Review of the Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) exam score of three (3) of fifteen (15), and determined the resident to be moderately cognitively impaired. The resident required one person physical assist with mobility and extensive assistance with transfers due to impairment on one side. In addition, the resident was dependent for toileting, hygiene, and requires substantial/maximum assistance with shower/bath. Resident #36 was incontinent of urine. Review of Resident #36's Comprehensive Care Plan (CCP), last reviewed on [DATE], revealed the resident required extensive to dependent care for all Activities of Daily Living (ADL) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to Anoxia and Hemiplegia. Review of Resident #36's CCP, last reviewed on [DATE], revealed the resident required extensive to dependent care for all Activities of Daily Living (ADL) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to Anoxia and Hemiplegia. The goal of Resident #36 ADL care was to maintain the highest capable level of ADL ability throughout the next review period. Initiated date was [DATE]. Target date was [DATE]. Interventions included providing extensive assist for personal hygiene (grooming), and bathing. Review of Resident #36's CCP, last reviewed on [DATE], revealed the resident was at risk for skin breakdown as evidenced by incontinence, limited mobility, hemiplegia, and cognitive loss and decreased safety awareness, convulsions, diagnosis of herpes labialis. The goal of Resident #36 interventions were the resident would not show signs of skin breakdown for the next ninety (90) days. Initiated date was [DATE]. Target date was [DATE]. Interventions included applying barrier cream with each cleansing, assist resident with repositioning, observe for localized skin problems, observe for skin risk factors per protocol, observe skin conditions with ADL care, observe skin for signs/symptoms of skin breakdown, provide pericare/incontinence care as needed, perform a weekly skin assessment by a licensed nurse. Observation of Resident #36, on [DATE] at 9:30 AM, revealed the resident to have greasy, uncombed hair. The Resident's had food stuck between his/her teeth and they appeared dirty. Resident #36 reported to SSA Surveyor that he/she was in pain. Resident #36 pointed to the groin area and stated, It hurts and burns. Observation noted a strong smell of urine. Resident stated he/she was wet, and the brief under slacks appeared saturated. When asked how often he/she was changed during the day, Resident #36 replied, he/she sat in the wheelchair and was not changed until he/she was put back to bed. SSA Surveyor reported Resident #36's condition to the Unit Manager, LPN #6. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Medical Records review, on [DATE] at 11:10 AM, revealed a Skin Assessment was performed after SSA Surveyor alerted nursing staff that the resident was wet and uncomfortable. On [DATE] at 2:12 PM, LPN #9 documented a red fungal rash to vaginal folds. Continued review of medical records revealed a Nursing Note, dated [DATE] at 2:25 PM, for a change in condition (CIC). Review of the CIC notes revealed, LPN #9 assessed Resident #36 as having a rash area covering vaginal labias. The physician was notified and new orders received. Observation, on [DATE] at 4:00 PM, of perineal care on Resident #36, revealed labial area was excoriated with a small amount of thick, white drainage note. Observation on [DATE] at 8:30 AM, revealed Resident #36 sitting in his/her in room in a wheelchair. Resident #36 pointed to his/her groin. Per interview, Resident stated he/she had not been changed. Resident stated he/she was wet. Observation revealed a strong smell of urine and briefs were full. SSA Surveyor asked if the staff changed his/her briefs when asked, he/she replied, Not very much. When asked if staff takes him/her to the bathroom during the day, he/she stated, No. I sit all day. The resident began to cry. Staff came in and changed the resident. Review of the 300 Hall Shower Binder, on [DATE] at 2:50 PM, located at the nurses' station, revealed Resident #36 had only two (2) document shower sheets, dated [DATE] and [DATE]. There was no document evidence Resident #36 received his/her showers as care planned and per facility policy for resident to receive a bath/shower at least twice weekly. Interview with the Unit Clerk, SRNA #11, on [DATE] at 1:50 PM, revealed she did not know why the sheets were not in the book. She stated the nurse was responsible for making sure the shower or bed bath was completed, and should sign each shower sheet when the shower wa completed. She stated aides do a skin check with each change. Continued interview revealed Resident #36 was changed in the morning, per the Care Plan, then changed and repositioned every two (2) hours thereafter on even hours. However, further interview revealed, Resident #36 was placed in his/her wheelchair after breakfast and not changed until after lunch. Interview with SRNA #19, on [DATE] at 3:43 PM, revealed she worked the 300 Unit. She stated the facility was frequently short staffed. Per interview, SRNA #19 stated she did not have enough time on some days to do job. On days when there were not enough aides, she revealed she tried to check and change each residents every two (2) hours. SRNA #19 stated, however, check and change were usually done every three (3) hours. She state aides completed shower sheets, documented skin issues, and reported to the nurse to sign. Continued interview revealed that she would assume it was not done if shower sheet were not in the shower binder. On [DATE] at 2:15 PM,Interview with LPN #9, revealed showers were given every two (2) days. The policy was for the aide to report to the nurse, if a resident refused a shower so the nurse could talk with the resident. If the resident refused a second time, the Unit Manager would speak to and educate the resident on the benefits of taking regular showers. If after a third refusal, the nurse was to document the refusal on the shower sheet, and as a nursing note. LPN #9 stated that was not always the case, and shower sheets were not always completed. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #2, Nurse Educator/Wound Care Nurse, on [DATE] at 9:00 AM revealed incontinent residents should be checked and changed every two (2) hours. RN #2 stated the importance of following the Care Plan (CP) was to ensure the Resident was turned minimally every two (2) hours, and if they require, [TRUNCATED]

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41355 Based on interview, record review, review of the facility's policy, and review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual Version 3.0, it was determined the facility failed to ensure Comprehensive Care Plans (CCP) were reviewed and revised to address the need for additional interventions to monitor and maintain sufficient respiratory status for one (1) of thirty (30) sampled residents (Resident #110). The facility admitted Resident #110, on [DATE] with current diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Asthma, Dysphasia, Heart Failure (HF), and Chronic Kidney Disease (CKD). Resident #110 had been hospitalized , from [DATE] to [DATE] with Sepsis and Acute Respiratory Failure. In addition, Resident #110 had been sent to the hospital Emergency Department (ED), on [DATE], for edema and was returned to the facility five (5) hours later, on [DATE]. However, there was no documented evidence the facility identified the resident's risks and revised the Comprehensive Care Plan (CCP) to give direction for staff to monitor and maintain sufficient respiratory status for the resident. On [DATE], Resident #110 experienced a change in condition (CIC) with his/her respiratory status. Resident #110 was transferred to the hospital's ED (Emergency Department), on [DATE] at 5:52 PM, via Emergency Medical Services (EMS) and was admitted . Resident #110 presented to the ED in pain, lethargic and moaning with diminished lung sounds bilaterally (both sides), bilateral upper and lower extremity swelling and edema, febrile, and with an altered mental status. Resident #110 returned to the facility under Hospice Care, on [DATE], and expired on [DATE]. The facility's failure to revise the resident's care plan to address the resident's respiratory status has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE] in the area of 42 CFR 483.21(b)(2) Comprehensive Resident Centered Care Plans, Timing and Revision of Care Plans, and was determined to exist on [DATE]. The facility provided an acceptable Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with the remaining non-compliance at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Refer to F695 The findings include: Review of the facility's policy titled, Person-Centered Care Plan, revised [DATE], revealed Comprehensive Care Plans were developed to help the resident attain or maintain his/her highest practicable physical, mental and psychosocial well-being and included measurable objectives and timetables to meet a resident's medical, nursing, nutrition, and mental and psychosocial needs that were identified in the comprehensive assessments. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Centers for Medicare and Medicaid Services, Resident Assessment Instrument (RAI) Manual 3.0, dated [DATE], revealed the care plan must be reviewed and revised periodically, and the services provided or arranged should be consistent with each resident's written plan of care. Continued review of the manual, revealed the care plan was driven, not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths, and needs. Furthermore, a care plan, based on a thorough assessment and effective clinical decision making, was compatible with current standards of clinical practice that provided a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. The manual stated a well-developed and executed assessment and care plan re-evaluated the resident's status at prescribed intervals (quarterly, annually, or if a significant change in status occurred) using the RAI and then modified the individualized care plan as appropriate and necessary. Record review revealed the facility admitted Resident #110 on [DATE]. The resident had diagnoses of Obstructive Sleep Apnea (OSA), Chronic Obstructive Pulmonary Disease (COPD), Asthma, Dysphagia, Heart Failure (HF), and Chronic Kidney Disease (CKD). Further review revealed, Resident #110 had been hospitalized , from [DATE] to [DATE], with Sepsis and Acute Respiratory Failure. Review of Resident #110's CCP, initiated on [DATE], revealed a focus of the resident was at risk for the potential alteration in fluid balance and he/she was at risk for fluid volume excess because of Heart Failure and Chronic Kidney Disease. The goal revealed the resident would not experience any signs/symptoms of fluid overload as evidenced by the absence of peripheral edema and dyspnea. Continued review of the CCP revealed interventions, initiated on [DATE], included staff was to observe for symptoms of edema, shortness of air (SOA) and weight gain. Further review revealed the CCP was not revised when the resident experienced a change in condition on [DATE]. Continued review of Resident #110's CCP, initiated on [DATE], revealed the resident was at risk for complications related to OSA, COPD, Asthma, and Dysphagia. The goal stated the resident would not have sign/symptoms of respiratory distress or aspiration. Further review of the CCP revealed some interventions were to administer aerosol medications as ordered/indicated; administer BiPAP as ordered; observe and report SpO2 (blood oxygen saturation) levels via pulse oximetry as ordered and as needed; and observe respiratory rate, signs/symptoms of dyspnea, abnormal breath sounds, cyanosis, and use of accessory muscles. Review of Resident #110's hospital records, dated [DATE], revealed the resident was admitted to the hospital, on [DATE], for sepsis and acute respiratory failure. Resident #110 was discharged from the hospital and returned to the facility on [DATE]. However, there was no documented evidence the CCP was revised to address the resident's respiratory status. Further review of Resident #110's medical record revealed a Physician's Order, with a start date of [DATE], to use a BiPAP machine with two (2) liters of oxygen at bedtime. In addition, the record showed an order for two (2) liters of oxygen, via nasal cannula, every shift to keep oxygen saturation levels above ninety (90) percent. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview with Resident #110, on [DATE] at 9:20 AM, revealed the resident in bed lying on his/her left side with his/her heels pressed against the mattress. There was generalized edema observed over the lower extremities, bilateral hands, and upper extremities; the left hand had an indentation where it rested against the bed. Further observation revealed the resident was on two (2) liters/minute of oxygen via nasal cannula, but the oxygen tubing was not labeled with a date or initialed. Additional observation showed the resident's BIPAP mask and tubing were on the floor. Interview with Registered Nurse (RN) #3, on [DATE] at 8:30 AM, revealed Resident #110 was in no respiratory distress throughout the evening of [DATE], until about 5:30 AM on [DATE]. Continued interview revealed at 6:30 AM, a State Registered Nurse Aide (SRNA) observed the resident with thick phlegm coming from the mouth. RN #3 stated she notified the Physician. Per interview, the Physician examined the resident that morning and ordered lab work and a chest x-ray. Further interview revealed she did not update the care plan, and she left for the day. However, she stated any licensed nurse could update care plans. RN #3 stated the care plan should have been revised to include increased monitoring for Resident #110 when he/she had the change of condition. Interview with the Physician, on [DATE] at 10:12 AM, revealed he examined Resident #110 on the morning of [DATE]. Per interview, he assessed the resident with fluid overload caused by his/her recent intravenous (IV) antibiotic therapy, and it was his intent to diurese (remove fluid) the resident. The Physician stated he gave a verbal order to the Director of Nursing (DON) directly to place an indwelling catheter, give one (1) dose of Furosemide (a diuretic used to remove excess fluid from the body) sixty (60) mg IV (intravenous), monitor lung sounds, and document strict I&O's (fluid intake and output). The Physician stated he gave the order specifically to the DON because, as an RN (Registered Nurse), she was the only nurse in the building, who could push IV Furosemide. Additionally, he stated he ordered strict I&O's and the monitoring of the resident's lung sounds to assess the resident's response to the treatment. However review of the resident's CCP revealed no documented evidence the care plan was revised to reflect these new orders. Continued review of Resident #110's Nursing Progress Note, dated [DATE] at 3:09 PM, revealed the first CIC follow-up note by LPN #9. The note stated the resident's condition had declined, and the Physician was notified. Furthermore, the note stated new orders were received to continue to hold PO (oral) medications, insert a Foley catheter for strict I&O's, and provide comfort care; there was not a specific time given for receipt of the orders. However, the resident's CCP was not revised to reflect these changes to the resident's plan of care. Interview with Agency State Registered Nurse Aide (SRNA) #21, on [DATE] at 3:04 PM, revealed she was assigned to Resident #110 on [DATE]. Per interview, she stated that when she cared for the resident, he/she was crying and complained of having no air (SOA). Per interview, SRNA #21 stated she reported this to the nurse, but did not recall if the nurse assessed the resident. She further stated no one made her aware of any revisions to the resident's care plan. She stated all she knew was the resident was sent to the hospital later that day. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #110's Hospital ED Admitting Physician Note, dated [DATE], revealed the resident arrived at the ED in pain, lethargic, did not move his/her extremities, and moaned with discomfort. Resident #110 was admitted to the hospital with diminished lung sounds bilaterally (both sides), bilateral upper and lower extremity swelling and edema, febrile, and with an altered mental status. Resident #110 returned to the facility under Hospice Care, on [DATE], and expired on [DATE]. Interview with LPN #9, on [DATE] at 8:15 AM, revealed she was assigned to Resident #110, on [DATE] from 6:00 AM to 6:00 PM. She stated the resident was noted to have a CIC during the night shift, which was documented and reported to her at shift change. LPN # 9 stated she was up and down the hall ensuring the resident was responsive, and she monitored his/her vital signs throughout the day. However, she stated she did not revise the care plan to include increased monitoring and to include strict intake and outputs, as ordered by the Physician. She further stated she should have updated the care plan, so Resident #110 could obtain the best possible outcome and so all staff would know how to care for the resident. Telephone Interview with the Minimum Data Set (MDS) Coordinator, [DATE] at 4:20 PM, revealed every nurse had the ability to access and update the CCP, and she would expect to see updates on acute changes as they happened. Interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), on [DATE] at 10:00 AM, revealed she was made aware of the change of condition with Resident #110 on the morning of [DATE]. She stated she expected the care plans to be revised according to the resident's condition to prevent further decline. She further stated the care plans must be accurate in order for all staff to know what care needs were to be provided. Interview with the DON, on [DATE] at 9:15 AM, revealed it was her expectation that nursing staff provide the correct level of care per the care plan and as ordered by the Physician. Per interview, it was the DON's expectation that nurses did resident assessments and charted accordingly. She further stated it was her expectation for the care plans to be revised to reflect the resident's plan of care. Interview with the Regional Clinical Quality Specialist (RCQS), on [DATE] at 3:40 PM, revealed it was her expectation that care plans were updated, when there was a CIC. Furthermore, nursing staff was to assess the resident as ordered and as in the CCP. Interview with the Administrator, on [DATE] at 2:15 PM, revealed it was her expectation for care plans to be revised when there was a change of condition. The facility provided an acceptable credible Allegation of Compliance (AoC) on [DATE] alleging removal of the Immediate Jeopardy on [DATE]. Review of the AoC revealed the facility implemented the following: 1. An audit was conducted by the Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE), and Unit Managers (UM) between [DATE] and [DATE] to determine if residents had pain, had pain medications ordered, if pain medications were effective, and if pain was not relieved. The Physician/Advanced Registered Nurse Practitioner (ARNP) were notified of unrelieved complaints of pain with new orders obtained if applicable. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Nineteen (19) of nineteen (19) residents identified with pain issues were reassessed on [DATE] by the Director of Nursing (DON), UM's, and/or Licensed Nurse (LN) Nurse Practitioner and/or Physician to determine if a change in condition had occurred regarding pain. Areas of concern were corrected upon discovery. 3. The DON, UM, ADON, NPE, and/or Clinical Quality Specialist (CQS) initiated reeducation, beginning on [DATE], with all facility staff to include contracted staff on the facility's policy and procedures regarding: (A) Change in Condition; (B) Pain Management, including observations; (C) Stop and Watch Tool; (D) Physician/Mid-Level Provider Notification of Change in a Resident's condition; and (E) Person Centered Care Plan. A post-test was administered at the time of the reeducation that required a passing score of 100% that will be graded by the DON, UM, ADON, NPE, and/or CQS to validate understanding. Facility staff and agency staff not available during the reeducation and post-test were to be provided reeducation including a post-test by the DON, UM, ADON, NPE, and/or CQS upon day of return to work prior to providing care. Newly hired staff and contracted staff were to be provided education and post-test during orientation by the DON, ADON, CQS, NPE, UM, and/or Licensed Nurse (LN). 4. Starting [DATE], clinical observation rounds will be conducted every shift, including interviews of ten (10) staff and five (5) residents who receive pain medication to identify any change in condition including a change in pain by the DON, ADON, UM, NPE, or LN to determine if residents have experienced a change in condition regarding pain. The Physician/NP were notified and the plan of care was reviewed to ensure it reflected the current needs of the resident daily until the Immediate Jeopardy is abated. 5. Starting [DATE], the Center Executive Director (CED) and/or LN would conduct ten (10) employee questionnaires daily to determine if staff were aware of the Center's process of the Stop and Watch Tool and reporting a change in condition, including reporting resident pain to a licensed nurse, to ensure prompt interventions when a resident experienced a change in condition, until the Immediate Jeopardy is abated. 6. The results of the observations, interviews, and audits will be reviewed daily by the CED or DON corrective actions taken upon discovery of deficiencies. 7. Beginning on [DATE], the DON, UM, ADON, NPE, CQS, and/or LNs initiated reeducation with all licensed nurses and agency nurses on the facility's policy and procedures regarding: (A) Pain management to include implementing person-centered care plan with individualized person centered interventions to include monitoring pain, administering pain medications as ordered, utilizing and documenting the pain scale, and observing for non-verbal signs/symptoms of pain; (B) Pressure Ulcer prevention to include developing/implementing the care plan; (C) Person-centered care plans; and (D) Physician/Mid-Level Provider Notification of Change in a resident's condition. 8. All admissions, readmissions, and residents with changes in respiratory status since [DATE] were reviewed on [DATE] by the DON, ADON, NPE, UM, and or LNs to determine if care plans reflected patient specific interventions to include interventions to monitor respiratory status to include residents with sleep apnea, COPD, acute respiratory failure, and asthma. Areas of concern were corrected upon discovery. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. On [DATE], the DON, UM, ADON, NPE and or CQS initiated reeducation with all licensed nurses and agency nurses on the facility's policy and procedures regarding: (A) Revision of the care plan with all admissions, readmissions, and changes in respiratory status with diagnoses to include acute respiratory failure, sleep apnea, COPD, and asthma. A post-test was administered at the time of the reeducation that required a passing score of 100% that was graded by the DON, UM, ADON, NPE, and/or CQS to validate understanding. Licensed Nursing and Agency Licensed Nursing Staff not available will be provided reeducation, including a post-test, by the DON, UM, ADON, NPE, and/or Registered Nurse upon day of return to work before providing care. New licensed nursing hires and agency licensed nurses will be provided education and post-test during orientation by the DON, ADON, NPE and/or UM. 10. Care plan audits were completed for residents with diagnoses including acute respiratory failure, sleep apnea, COPD, and/or asthma and will be completed for new admissions, readmissions, and residents with a change in condition to include a change in respiratory status to determine the care plan has resident specific interventions including respiratory assessments; and, corrective actions were taken upon discovery of deficiencies. 11. Five (5) Licensed Nursing Staff interviews were completed by the CED, DON, UM, ADON, NPE, and/or CQS to determine if staff were aware of the process of a respiratory assessment when a resident's condition warranted the assessment and per the resident's plan of care will be conducted daily until the Immediate Jeopardy is abated. 12. The DON, UM, ADON, NPE, and/or CQS completed reeducation beginning on [DATE] with facility licensed staff to include agency staff on the facility's policy and procedures regarding: (A) Pain management to include implementing person-centered care plans with individualized person-centered interventions to include monitoring pain, administering pain medications as ordered, and utilizing and documenting pain scale assessments, and observe for non-verbal signs/symptoms of pain. A medication reconciliation process is in place to review discharge orders to current orders; (B) Physician/Mid-Level Provider Notification of Change in a resident's condition; and (C) Person Centered care plans regarding resident interventions for pain. A post-test was administered at the time of reeducation that required a passing score of 100% that was graded by the DON, UM, ADON, NPE, and or CQS to validate understanding. Facility licensed staff and agency staff not available will be provided reeducation including a post-test during orientation by the DON, ADON, NPE, UM, and/or LN, before allowed to work. 13. The CED and/or LN will conduct five (5) employee questionnaires daily to determine if staff were aware of the Center's process of reporting a change in condition including pain to a licensed nurse to ensure prompt intervention when a resident experienced a change in condition until Immediate Jeopardy is abated. 14. The UM's, ADON, NPE, and licensed nurses completed skin assessments on all residents on [DATE], to ensure residents, including residents with pressure ulcers, received care per Physician's orders to promote healing and prevent additional pressure ulcers with any needed corrective action taken upon discovery. 15. The CQS reeducated the Wound Nurse regarding the facility's policy, Wound Care, on [DATE]. A post-test was administered at the time of the reeducation to validate understanding. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	16. The NPE, DON, UM's, and/or ADON reeducated all licensed staff, including agency staff, regarding the requirement that residents with pressure ulcers receive care to promote healing and prevent additional pressure ulcers, to include appropriate assessment of all wounds when a wound/abscess was identified, beginning on [DATE], with a posttest requiring 100% score to validate understanding. 17. The DON, ADON, NPE or UM will conduct observation rounds and treatment administration audits to ensure residents with pressure ulcers receive care to promote healing and prevent additional pressure ulcers as per Physician's Orders starting [DATE] daily until Immediate Jeopardy is abated. 18. Quality Assurance/Performance Improvement (QAPI) meetings are occurring daily (Monday-Friday) beginning [DATE] with the interdisciplinary team, which consists of the CED, DOB, ADON, NPE, UM's, MDS, Dietary Manager, Social Services, Business Office Manager, Environmental Services, Medical Records, Maintenance, Human Resources, Registered Dietician, Activities Director, Central Supply, and Director of Rehabilitation, until Immediate Jeopardy is abated. During QAPI meetings, the current status of the AoC is discussed, including review of the audit tools, findings, and any needed corrective action. The State Survey Agency validated the implementation of the facility's AoC as follows: 1. Review of the facility's audit tool revealed the audits were reviewed, with all residents present as of [DATE]. Audits were conducted to determine the presence of pain, and the effectiveness of any pain medications ordered. Record review revealed nineteen (19) residents were identified with pain concerns, with most concerns identified consisting of pain medications not being effective, or not being effective for the length of time until the next dosage of pain medication was available. All of this information was emailed to the Nurse Practitioner (NP) by the CQS. Review of residents' medical records for residents identified, revealed residents had been reassessed by either the Physician or NP, with new orders provided as appropriate. 2. Review of nineteen (19) residents with identified pain issues revealed residents identified had been reassessed on [DATE] by the DON, UMs and/or Licensed Nurse (LN) to determine if a change in condition had occurred regarding pain. Interview with the NPE, on [DATE] at 1:30 PM, revealed, based on audits conducted by [DATE]; nineteen (19) residents were identified with pain issues. She revealed all residents had been reassessed, and staff were documenting changes in resident condition in nursing notes regarding effectiveness of pain medications. 3. Review of the facility's In-Service Sign In Sheets, dated [DATE] through [DATE], revealed all facility staff were educated in person or over the phone regarding: (A) Change in condition; (B) Pain management; (C) Stop and Watch Tool; (D) Provider notification of change; and (E) Person-centered care plans. Review of documents titled Post Test, revealed staff completed testing covering all identified areas, to include changes in resident condition, management of resident pain, Stop and Watch Tool, provider notification of change, and person-centered care plans. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Admissions personnel, on [DATE] at 8:20 AM, revealed she had been educated to monitor residents for any new or worsening pain or any change in activity or changes in resident condition, the resident care plan. Admissions personnel was to report to the nurse and DON. She stated she was in-serviced on the use of the Stop and Watch tool. Interview with Laundry personnel, on [DATE] at 8:30 AM, revealed Laundry staff had been educated to monitor residents for pain or change in condition and to notify the nurse if any occurs. Laundry staff was to observe for any lack of care for the residents. Per interview Laundry personnel were in-serviced on the Stop and Watch tool. Interview with Physical Therapy Assistant (PTA) #1, on [DATE] at 8:15 AM, revealed PTA#1 had been educated to monitor for new or worsening pain and if a resident was participating less in activities or had a change in condition to report this to the nurse. Per interview, they had been in-serviced on the Stop and Watch tool. PTA #1 completed a posttest after the training. Interview with SRNA #8, on [DATE] at 8:35 AM and SRNA #27 at 8:45 AM, SRNA #25 at 8:50 AM and SRNA #28 at 9:00 AM revealed education was provided to monitor for any new or worsening pain, change in condition and the appropriate use of the resident's care plan. Any change was to be reported immediately to the nurse. Per interview, they had been in-serviced on the Stop and Watch tool and had taken a posttest after the education. Interview with the Activities Director on [DATE] at 3:40 PM revealed she had been educated in the Stop and Watch tool and the importance of the resident's care plan. She stated she was to watch for any new or worsening pain, or if a resident was participating less in activities. She stated she was to document and notify the nurse. 4. Review of AoC Audit Tool - [DATE], dated [DATE] through [DATE], revealed the facility was conducting observation rounds of ten (10) staff and five (5) residents every shift. Continued review revealed residents were interviewed to ensure they were receiving pain medications, with any changes in condition noted, assessments completed, notifications made as appropriate, and care plans updated as appropriate. Review of the staff portion for licensed staff revealed licensed staff were interviewed regarding the process for respiratory treatment, the process for reporting changes in condition, awareness of notification of the Physician or NP regarding resident pain issues and awareness of the care plan reflecting resident needs. Review of the staff portion for non-licensed staff revealed they were interviewed regarding awareness of the Stop and Watch Tool reporting of changes in resident condition regarding pain, respiratory status, or skin issues. Interview with RN #4 on [DATE] at 12:00 PM revealed she had audited nineteen (19) residents with pain. A tool called 'Stop and Watch' was used to educate staff on pain. All staff were educated and all tours of duty were included to assure no staff were missed. Interview with SRNA #8, on [DATE] at 8:35 AM, revealed education was done to monitor for any new or worsening pain or change in condition. Any change was to be reported immediately to the nurse. Per interview, she had been questioned during management rounds related to monitoring for pain and reporting to nursing staff. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Activities Director, on [DATE] at 3:40 PM, revealed she had been educated in the 'Stop and Watch' tool. She stated she was to watch for any new or worsening pain, or if a resident was participating less in activities. She stated she was to document and notify the nurse. Per interview, she had been asked during management rounds regarding awareness of the Stop and Watch Tool. 5. Review of the facility's AoC binders revealed completed documentation labeled F580 Test 2 All Staff except LN, completed by facility staff covering topics such as the Stop and Watch Tool, changes in resident condition, and person-centered resident care. 6. Interview with the DON, on [DATE] at 9:18 AM, revealed she reviewed the results of observations, interviews, and audits daily, and she ensured there was additional follow-up as needed. She stated audits had increased staff education and were helping management ensure staff followed-up with everything. She stated management had identified a need for staff improvement on documentation. 7. Review of the facility's In-Service Sign In Sheets, dated [DATE] through [DATE], revealed Licensed Nurses attended or were educated in person or over the phone regarding: (A) Pain management to include implementing person-centered care plan with individualized person centered interventions to include monitoring pain, administering pain medications as ordered, utilizing and documenting the pain scale, and observing for non-verbal signs/symptoms of pain; (B) Pressure Ulcer prevention to include developing/implementing the care plan; (C) Person-centered care plans; and (D) Physician/Mid-Level Provider Notification of Change in a resident's condition, Review of documents titled Post Test revealed licensed nursing staff completed testing covering all identified areas, to include changes in residents' condition, management of resident pain, Stop and Watch Tool, provider notification of change, and person-centered care plans. Interview with LPN #17, on [DATE] at 8:49 AM and with LPN #10 on [DATE] at 8:05 AM, LPN #3 at 9:05 AM and LPN #6 at 9:10 AM, revealed they had been educated to watch for any new or worsening pain, to implement a person centered care plan with individualized interventions, administer pain medications as ordered using the pain scale, pressure ulcers monitor and treatment and to notify the practitioner with all changes in resident conditions. Per interviews, a posttest to acknowledge understanding of the education was given. Interview with RN #4 on [DATE] at 12:00 PM revealed a tool called 'Stop and Watch' was used to educate staff on pain. All staff were educated and all tours of duty were included to assure no staff were missed. The education is to be ongoing. Staff were educated to be transparent and use open communication. RN#4 reported all staff were educated on notifying the practitioner if a resident was experiencing pain. For chronic pain, interventions were to be implemented. 8. Review of the facility's documentation revealed the NPE reviewed all residents on [DATE] that had been admitted , readmitted , or that had been identified with changes in respiratory status. The NPE identified any changes since [DATE], and ensured care plan changes were implemented as necessary. Interview with the NPE, on [DATE] at 1:30 PM, revealed she did review all residents on [DATE] that had been admitted , readmitted or identified with changes in respiratory status. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. Review of the facility's In-Service Sign In Sheets, dated [DATE] through [DATE], revealed all licensed nurses, to include agency nurses, were educated in person or over the phone regarding revision of resident care plans for all admissions, readmissions, and changes in respiratory status for residents with diagnoses to include acute respiratory failure, sleep apnea, COPD, and asthma. Review of Clinical Competency Validation Respiratory Assessment, revealed licensed nursing staff completed testing following education. Interview with RN #4 on [DATE], LPN #17, on [DATE] at 8:49 AM and with LPN #10 on [DATE] at 8:05 AM, LPN #3 at 9:05 AM and LPN #6 at 9:10 AM, revealed they had been educated related to the revision of the resident care plan for all admissions, readmissions and changes in respiratory status for residents. Per interviews, a posttest to acknowledge understanding of the education was given. 10. Review of the AoC Audit Tool - [DATE], revealed care plan audits were conducted on new admissions, readmissions, and change in conditio [TRUNCATED]

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F 0661 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 44396 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the discharge summary process included reconciliation of all pre-discharge medications with the resident's post-discharge medications, both prescription and over-the-counter, and the resident was discharged with the correct medications for one (1) of thirty (30) sampled residents (Resident #81). The facility admitted Resident #81, on 03/12/2021, for short-term rehabilitation. On 05/05/2021, the Physician ordered to discharge Resident #81 home with medications. Licensed Practical Nurse (LPN) #3, Resident #81's nurse, reviewed the Discharge Instructions/Summary with Resident #81, and sent his/her medications from the medication cart home with the resident on 05/05/2021. On 05/07/2021, Resident #81 informed a family member that the medications he/she received from the facility at discharge included a medication that he/she did not take, Risperdal (an antipsychotic used to treat schizophrenia and other psychiatric disorders). The resident sent the family member a picture of a medication box that was labeled Risperdal 0.25 milligram (mg), with Resident #80's name on it. Resident #81 stated he/she took two (2) doses of Risperdal 0.25 mg and experienced lethargy, mental status changes, dizziness, and difficulty with memory after taking the medication. The facility's Pharmacist stated the medication, Risperdal (generic name Risperidone) could pose a moderate risk of interaction with the other prescribed medications for Resident #81. Resident #81's Attending Physician stated Resident #81 was a high-risk resident, and if the Risperdal had been taken at a higher dosage than 0.25 milligrams per day, it could cause increased sedation and a heart arrhythmia. The facility's failure to have an effective system in place to ensure each resident received the correct medications during medication reconciliation in the discharge summary process has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified, in the area of 42 CFR 483.21(c)(2) Comprehensive Resident Centered Care Plan, Discharge Summary, on 05/14/2021 and was determined to exist on 05/05/2021 and is ongoing. The findings include: Review of the facility's policy titled, Discharge Planning Process, review date 02/01/2019, revealed the discharge summary should include a reconciliation of all pre-discharge medications with the patient's (resident's) post-discharge medications (both prescription and over-the-counter). No further details were found in the policy regarding medication reconciliation. Review of Resident #81's medical record revealed the resident was admitted to the facility, on 03/12/2021, for short-term rehabilitation upon discharge from an acute care hospital episode for Alcoholic Hepatitis with Ascites, Generalized Weakness, Difficulty with Walking, and Chronic Pancreatitis. (continued on next page)

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F 0661 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #81's initial Minimum Data Set (MDS) Assessment, dated 03/18/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Review of Resident #81's initial care plan indicated the need for assistance with Activities of Daily Living (ADLs) including bathing, grooming, personal hygiene, dressing, transfers, locomotion and toileting related to a recent hospitalization resulting in fatigue. Discharge documents showed the need for a rolling walker for ambulation and independence in all ADLs. Further review of the record revealed initial medication orders, dated 03/12/2021, as well as changes to the orders, as indicated, throughout the course of Resident #81's stay at the facility. However, the record revealed no order for Risperidone at any time during the course of care for Resident #81. In addition, the record revealed the Physician ordered Resident #81 to be discharged home with medications, on 05/05/2021. Continued review revealed the resident was discharged per the order by LPN #3. However, there was no documented evidence of specific reconciliation of medications on the Order Summary, which was supposed to include all discharge medications and directions for administration. Further, the paper copies of Resident #81's record, kept in the hardback chart at the Nurse's Station revealed an Order Summary, including the form Medication List, but the form was blank. There was no documented list of Resident #81's discharge medications for review. Interview with Resident #81's Family Member, on 05/11/2021 at 2:12 PM, revealed, on 05/07/2021, Resident #81 called to inform her that he/she had discovered a medication box that was given to him/her from the facility. The Family Member stated Resident #81 told her the box contained a medication that was not ordered for him/her. She stated the box had thirty (30) pills of Risperdal 0.25 mg, take one (1) tablet daily. In addition, the resident told the Family Member the box was labeled with Resident #80's name, and he/she had taken two (2) doses. She stated Resident #81 reported to her that after taking the Risperdal tablets, he/she was feeling lethargic, had mental status changes, dizziness, difficulty with memory, some disorientation, and was very upset because he/she could not process thoughts or finish a sentence. The Family Member stated Resident #81 felt so bad that he/she was not able to visit with her, on 05/07/2021 or 05/08/2021; and, the resident was scheduled to see his/her primary care provider, on 05/11/2021 or 05/12/2021. Per interview, Resident #81 took photos of the medication box labeled with Resident #80's name and forwarded it to her. The Family Member stated she verified the picture of the medication box in Resident #81's possession that had Resident #80's name and was labeled Risperdal 0.25 mg, take one (1) tablet daily. Review of Resident #80's medical record revealed an order for Risperidone, 0.25 mg, with instructions to be administered by mouth one (1) time a day. Interview with LPN #3, on 05/12/2021 at 10:20 AM, revealed when a nurse discharged a resident, they sent what was in the resident's medication drawer with the resident. LPN #3 stated the actual medication boxes were sent home with the resident. Further interview revealed the face sheet and medication list were printed, and the nurse used them to instruct the resident on the discharge medications prior to his/her departure. (continued on next page)

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F 0661 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional interview with LPN #3, on 05/12/2021 at 4:00 PM, revealed she discharged Resident #81, sometime after 10:00 AM on 05/05/2021. LPN #3 stated she and Resident #81 went over the medication list together with education on his/her medications. She stated, for Resident #81, she printed the facesheet and the order summary, which included all of the resident's medications and how to take them. LPN #3 stated she had been over the whole process in her memory and did not know how Resident #81 received Resident #80's medication, other than human error. She also stated that prior to Covid, the Pharmacy came through at regular intervals and reviewed all medications and stocked the medication carts. However, with current Covid restrictions, LPN #3 stated Pharmacy depended on nursing to report medication needs. Continued interview on 05/12/2021 at 4:00 PM, with LPN #3 revealed since Resident #80 was transferred from another unit in the facility, there initially must have been enough medications from his/her previous order to provide the Risperdal he/she was ordered. Review of the medication cart showed a newly delivered box of Risperidone (Risperdal) as of 05/12/2021 for Resident #80. Interview with LPN #2, on 05/12/2021 at 10:00 AM, revealed that a resident who was to be discharged received a discharge summary with upcoming appointments, a printed medication list, and a summary of care at the facility. He/she stated, We are allowed to send any non-narcotic medications home with the resident and, narcotics if there was a specific order for it. The resident would be asked about pain medication availability already at home. Residents are discharged with medications in the original boxes. Telephone interview with the Pharmacist in charge, on 05/13/2021 at 9:09 AM, revealed that the Pharmacy was not involved with discharge medications. The Pharmacist stated additional drowsiness, lethargy, and inability to concentrate would be likely side effects of Risperidone use, in combination with Resident #81's own medication regimen and/or heavy alcohol use. Interview with Resident #81's Attending Physician, on 05/13/2021 at 1:20 PM, revealed he was not knowledgeable of the discharge process, but he expected the process to be managed safely, which included sending the correct discharge medications home with the resident. The Physician stated Resident #81 was a high risk for medication administration due to potential side effects; consequently, he stated he always weighed the risk of the medication versus the benefit before prescribing medications for Resident #81. In addition, the Physician stated there would probably be no serious adverse reactions from Resident #81 taking Risperidone, with his/her other medications, if he/she only took it for two (2) days as reported, but if it were taken longer or abused, there could be increased lethargy and even a heart arrhythmia (abnormal heart rhythm). Interview with the Director of Nursing (DON), on 05/14/2021 at 9:18 AM, revealed with a resident to be discharged , the nurse would go over information about his/her care needs and what medications went home with the resident; the resident would receive whatever medications the doctor ordered. In addition, the resident signed the care summary and a copy went in the hard chart. Per interview, with medication reconciliation, she expected the nurse to compare the written list, prescription by prescription, with the actual medications to be sent home. She stated the facility followed these recommendations from Pharmacy about how the nursing staff should manage the discharge process for medications. The DON stated, in the incident with Resident #81 where an incorrect medication was sent home with the resident, the only answer she had was it involved human error. Furthermore, she stated the discharge education given to a resident was computer generated and was based on previously entered information for the resident. (continued on next page)

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F 0661 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator, on 05/12/2021 at 2:20 PM, revealed she expected at discharge, the nurse would provide a list of medications and would go over those with the resident prior to discharge. She stated there should be printed copies, one (1) given to the resident, and one (1) placed in the resident's hard copy chart. The Administrator stated the nurse would gather the resident's medications and give them to the resident at departure. She further stated that medications were supposed to be in order in the medication cart by resident room, and she expected each resident's medications to be in the correct slot. In addition, the Administrator stated she expected nurses to reconcile the physical medication with the printed list.

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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. 41721 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents who were unable to carry out Activities of Daily Living (ADLs) received the necessary services to maintain good grooming, personal and oral hygiene for three (3) of thirty (30) sampled residents (Resident #114, Resident #36, and Resident #102). Resident #114 was observed to be unshaven with full facial hair, unclean and messy clothing, and an unpleasant body odor. Observation of Resident #36, on 04/21/2021, revealed the resident had greasy uncombed hair. The resident had food stuck between his/her teeth, and they appeared dirty. Further observation noted a strong smell of urine, and the resident stated he/she was wet, with the brief under his/her slacks appearing saturated. Observation of Resident #102, on 04/20/2021, revealed his/her hair was greasy, and the resident smelled of urine. Interview with Resident #102, revealed he/she had issues with the ability of staff to help residents take showers and clean up. The findings include: On 04/20/2021 at 10:00 AM, a request was made for the facility's policy related to nursing staff providing residents with personal care, grooming, and oral hygiene. The Regional Clinical Director and Administrator stated the facility did not have a policy related to providing residents with personal care, grooming, and oral hygiene. They followed the standards of care in the Gerontological Standards of Practice guidelines. Review of the facility's Federal Resident Rights under Federal Law and Facility Responsibilities Policy, effective date, 06/11/1996, reviewed 01/25/2018, and revised 03/01/2018, revealed residents have the right to be treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her self-esteem and self-worth; recognizing each resident's individuality, as well as honor and value his/her input. Further review revealed it was the facility's responsibility to incorporate the patient's (resident's) goals, preferences, and choices into care. Review of the facility's Kentucky Resident Rights and Facility Responsibilities policy, undated, revealed residents have a right to be treated with consideration, respect, and full recognition of his/her dignity and individuality. Further review revealed residents have the right to be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming. 1. Review of Resident #114's medical record revealed the facility admitted the resident, on 08/10/2021 with diagnoses to include Hemiplegia Affecting the Left Dominant Side, Dysphagia, History of Transient Ischemic Attack (TIA), Cognitive-Communication Deficit, Epilepsy, Vascular Dementia with Behavioral Disturbance, Major Depressive Disorder, Generalized Anxiety Disorder, Unspecified Mood Disorder, Congestive Heart Failure (CHF), Acquired Absence of Left Leg Above Knee, and Repeated Falls. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #114's Annual Minimum Data Set (MDS) Assessment, dated 04/09/2021, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of eight (8) and determined the resident to be moderately cognitively impaired. The assessment revealed the resident required a two (2) person physical assist with mobility and extensive assistance with weight-bearing due to impairment on one (1) side. In addition, the assessment revealed the resident was dependent for toileting, hygiene and required substantial/maximum assistance with shower/bath. Per the assessment, Resident #114 was occasionally incontinent of urine and always incontinent of bowel. Review of Resident #114's Comprehensive Care Plan (CCP), initiated on 07/11/2018 and last reviewed on 04/13/2021, revealed the resident required assistance with and was dependent for, Activities of Daily Living (ADL), care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to limited mobility, cognitive loss and behaviors, Hemiplegia, and left above-knee amputation (LAKA). A review of the Goal initiated on 07/16/2018 and revised 06/17/2020, revealed the resident's ADL care needs would be anticipated and met throughout the next period-target date 07/12/2020. Interventions included providing Resident #114 with extensive assist for dressing, bathing, and toileting. Observation of Resident #114, on 04/21/2021 around 3:25 PM, revealed Resident #114 lying in bed with a urinal containing urine hanging on his/her bed rail, and a strong unpleasant odor detected from the resident's side of the room. Per the observation, Resident #114 also had a full beard that looked unclean, and his/her clothes and hair were disheveled. Attempts to interview Resident #114, on 04/21/2021 at 3:25 PM, concerning his/her care needs were unsuccessful. He/she did not answer the questions, only responding that staff helped him/her with care needs. Interview with the Unit Manager on the 200 Unit, Licensed Practical Nurse (LPN) #1, on 04/21/2021 at 3:45 PM, revealed residents received showers on a routine assigned schedule and as often as staff deemed necessary. In addition, the Manager said the State Registered Nurse Aides (SRNA) completed shower sheets when showers were given to their assigned residents. Then, the shower sheets were placed in a shower book at the nurse's station. LPN #1 stated Resident #114 was assigned to receive a shower on Observation of the shower binder, on 04/21/2021 at 3:50 PM, located at the nurse's station, revealed Resident #114 did not have any shower sheets in the book for April. Further interview with the Manager on 04/21/2021 at 3:50 PM, revealed she did not know why the sheets were not in the book. She stated this was a new process, and she realized the process needed improvement. In addition, she said that perhaps the sheets were already removed and sent to medical records, and she would check to find out. However, she did not locate any shower sheets belonging to Resident #114 in the Medical Records department. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SRNA #22, on 04/24/2021 at 9:00 AM, employed sixteen (16) years at the facility, revealed she usually worked weekends, from 7:00 AM to 11:00 PM, on the 200 Unit. She stated, on a good day, staffing was four (4) nurse aides; today, there were three (3) aides working the 200 Unit. Continued interview revealed each aide was assigned two (2) to three (3) showers, and during the shower, the SRNA noted any skin issues and reported any findings to the nurse. In addition, she stated afterward, a shower sheet was completed and placed in the shower binder located at the nurse's station. Furthermore, she said if the shower sheet was not found in the shower book, either the SRNA did not do the shower, or the aide failed to complete the sheet. Per interview, she stated the nurse was supposed to verify that the nurse aide conducted the shower by checking the shower sheets. SRNA #22 stated the facility had been in a staffing crisis lately, and there was currently a lot of Agency staff. Interview with SRNA #19, on 04/24/2021 at 9:30 AM, employed twenty-five (25) years at the facility, revealed she primarily worked weekends on the 300 Unit and worked typically with three (3) to four (4) aides. She revealed she usually was assigned two (2) showers on her shift. She said the aides completed the shower sheets and reported any skin issues to the nurse; they then put the sheets in the shower book. Continued interview revealed that she would assume the shower was not done if she did not see the completed shower sheet in the book. 44001 2. Review of Resident #36's medical record revealed the facility admitted the resident, on 02/27/2019, with diagnoses to include Anoxic Brain Damage, Hemiplegia Affecting Unspecified Side, Chronic Obstructive Pulmonary Disease (COPD), Encephalopathy, Unspecified Convulsions, Dysphagia, Hypothyroidism, Congenital Deformities, Irritability and Anger, Mood Disorder, Bipolar Disorder, and Unspecified Psychosis. Review of Resident #36's Annual Minimum Data Set (MDS) Assessment, dated 02/17/2021, revealed the facility assessed the resident with a BIMS score of three (3) of ten (10) and determined the resident to be severely cognitively impaired. Per the assessment, the resident required a one (1) person physical assist with mobility and extensive assistance with transfers due to impairment on one (1) side. In addition, the resident was dependent for toileting, hygiene and required substantial/maximum assistance with shower/bath; Resident #36 was incontinent of urine. Review of Resident #36's Comprehensive Care Plan (CCP), last reviewed on 03/09/2021, revealed the resident required extensive to dependent care for all Activities of Daily Living (ADL) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to Anoxia and Hemiplegia. Observation of Resident #36, on 04/21/2021 at 9:30 AM, revealed the resident to have greasy, uncombed hair. The resident had food stuck between his/her teeth, and they appeared dirty. Resident #36 reported to the State Survey Agency (SSA) Surveyor that he/she was in pain, pointed to the groin area, and stated it hurt and burned. Further observation noted a strong smell of urine, and the resident said he/she was wet, with the brief under his/her slacks appearing saturated. When asked how often he/she was changed during the day, Resident #36 replied that he/she sat in the wheelchair and was not changed until he/she was put back to bed. The SSA Surveyor reported Resident #36's condition to the Unit Manager, LPN #6. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of Resident #36's medical records revealed a Skin Assessment, dated 04/20/2021 at 2:12 PM. Per the assessment, LPN #9 documented a red fungal rash to vaginal folds. In addition, a Nurse's Note, dated 04/20/2021 at 2:25 PM, for a change in condition (CIC) revealed LPN #9 assessed Resident #36 as having a rash area covering vaginal labia. Further, the record revealed a Skin Check, completed on 04/20/2021 at 2:12 PM, which documented a red fungal rash to vaginal folds. Per the record, the Physician was notified, and new orders were received. Observation, on 5/11/2021 at 4:00 PM, of perineal care on Resident #36, revealed the labial area was excoriated with a small amount of thick, white drainage noted. On 5/13/2021 at 8:30 AM, observation and interview revealed Resident #36 sitting in his/her room in a wheelchair; Resident #36 pointed to his/her groin. Per interview, the resident stated he/she had not been changed, and he/she was wet. Observation revealed a strong smell of urine, and his/her brief was full of urine. In addition, the resident stated his/her briefs were not changed very often, and he/she sat all day. Review of the 300 Unit Shower Binder, on 04/21/2021 at 2:50 PM, located at the nurse's station, revealed Resident #36 had only two (2) documented shower sheets, dated 03/28/2021 and 04/21/2021. Interview with the Unit Clerk, SRNA #11, on 04/28/2021 at 1:50 PM, revealed she did not know why the sheets were not in the book. Per the interview, the nurse was responsible for making sure the shower or bed bath was completed and signed when the shower was completed. Continued interview revealed Resident #36 was changed in the morning, per policy, then changed and repositioned every two (2) hours, after that he/she was changed on even hours. She stated SRNA's did a skin check with each change. In addition, she said Resident #36 was placed in his/her wheelchair after breakfast and changed after lunch. 3. Review of Resident #102's medical record revealed the facility admitted the resident, on 12/16/2020, with diagnoses to include Anoxic Brain Damage, Hemiplegia Affecting Unspecified Side, Chronic Obstructive Pulmonary Disease (COPD), Spinal Stenosis, Hypertension, Hypothyroidism, Anxiety Disorder, Major Depressive Disorder, Schizoaffective Disorder, Bipolar Disorder, and Muscle Weakness. Review of Resident #102's Annual Minimum Data Set (MDS) Assessment, dated 02/17/2021, revealed the facility assessed the resident with a BIMS score of zero-zero (00) and determined the resident to be severely cognitively impaired. The assessment documented the resident required a one (1) person physical assist with mobility. Per the assessment, the resident needed extensive assistance with personal hygiene and was incontinent of bowel and bladder. Review of Resident #102's Comprehensive Care Plan, last reviewed on 03/09/2021, revealed that the resident required assistance with Activities of Daily Living (ADL) for bathing, grooming, personal hygiene, dressing, transfer, and toileting to muscle weakness and chronic disease, compromising functional ability. Observation of Resident #102, on 04/20/2021 at 4:20 PM, revealed his/her hair was greasy, and the resident smelled of urine. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #102, on 04/20/2021 around 4:25 PM, revealed he/she had issues with the ability of staff to help residents take showers and clean up. The resident states he/she was trying to get staff to help him/her take a bath because he/she smelled. He/she further reported waiting for over thirty (30) minutes for linen. Per interview, Resident #102 stated, There were never any washcloths when you need them. And by the time the towels get here, there isn't enough staff to help us. Further interview revealed he/she was scheduled to receive two (2) showers a week, but resident #102 stated that never happened. Observation of the linen cart on the 300 Unit, on 04/20/2021 at 4:40 PM, revealed no wash clothes or towels on the cart. Review of the 300 Unit Shower Binder located at the nurse's station for Resident #102's completed shower sheets revealed three (3) completed shower sheets for March, dated 03/16/2021, 03/29/2021, and 03/30/2021. Further review revealed four (4) completed shower sheets for April, dated 04/06/2021, 04/13/2021, 04/16/2021, and 04/20/2021. Resident #102 was scheduled to receive showers on Tuesday and Friday during the evening shift. Interview with the Director of Nursing (DON) on 05/15/2021 at 9:18 AM, revealed Resident #102 would frequently refuse to take his/her showers. Interview with LPN #9, on 04/24/2021 at 2:15 PM, revealed showers were given per schedule every two (2) days. If the resident refused a shower, the aide must report to the nurse, who would talk with the resident. If the resident refused a second time, the Unit Manager would speak to them and educate the resident on the benefits of taking regular showers. If after a third refusal, the nurse was to document the refusal on the shower sheet and as a nursing note. LPN #9 stated that was not always the case, and shower sheets were not always completed. Interview with LPN #11, on 04/25/2021 at 8:49 AM, employed seventeen (17) years at the facility, revealed that SRNA's were responsible for performing residents' showers on the days the showers were due. She stated they bring the shower sheets to the nurse upon completion. LPN #11 stated SRNA's were supposed to inform nurses if the resident refused his/her shower, so the nurse could go to the resident and try to convince him/her to take a shower. LPN #11 stated that it should be documented in the medical record if the resident continued to refuse a shower. Continued interview with the Director of Nursing (DON) on 05/15/2021 at 9:18 AM, revealed resident personal care was to be completed every day. She stated it was her expectation that residents get their showers as scheduled and as needed, and personal hygiene was to be performed. Per the interview, the DON stated she was unaware of the concerns expressed by the residents.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure skin assessments were completed to identify/monitor for skin breakdown along pressure ulcer prevention interventions according to standards of practice to prevent further decline for one (1) of thirty (30) sampled residents, Resident #110. On [DATE], Resident #110 was transferred to the hospital by Emergency Medical Services (EMS) and during the triage period hospital staff and EMS identified a sacral wound. The hospital assessed the resident to have an open right gluteal abscess measuring three (3.0) centimeters (cm) and draining copious amounts of purulent material. There was an unstageable sacral decubitus ulcer measuring eight (8.0) cm (length) by two (2.0) cm (width). Surgical consult revealed the abscess and sacral ulcer would require surgical debridement of necrotic tissue. Review of Infectious Disease (ID) Consult, on [DATE], revealed ID was consulted for evaluation of sepsis and antibiotic management. Possible causes for the infectious etiology included Bacteremia and soft tissue infection from right buttocks ulcer. A Computed Tomography (CT) of the pelvis showed a chronic calcified posterior right gluteal region hematoma in the surrounding soft tissue infiltration indicating possible soft tissue infections. Wound culture of right buttock showing gram negative rods. Review of the facility's Skin Assessment Grids, revealed the Wound Nurse assessed Resident #110's wounds on [DATE] and identified a new Right Hip/Buttock Abscess that measured 2.0 cm (length) by 3.0 cm (width) by 0.4 cm (depth), with hard surrounding tissue and moderate amounts of purulent drainage. However, interview and record review revealed the Wound Nurse nor other nursing staff had not identified the unstageable sacral decubitus ulcer that was assessed and identified during hospital triage. Review of the Acute Care Hospital record, dated [DATE], revealed a palliative care (treatment focused on prevention of suffering and improving quality of life) consult was requested on [DATE]. Continued review revealed the provider noted, Patient has no quality of life. Review of the Nurses Notes, dated [DATE], revealed the resident was readmitted back to the facility under Hospice Care, on [DATE], and later expired on [DATE]. The facility's failure to provide care consistent with professional standards of practice, to care for and prevent pressure ulcers has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on [DATE], in the area of 42 CFR 483.25(b)(1) Quality of Care, Treatment/Services to Prevent/Heal Pressure Ulcers, and were determined to exist on [DATE]. The facility provided an acceptable Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with the remaining non-compliance at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Skin Integrity Management revised on [DATE], revealed the purpose was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. Per the policy, staff was to continually observe and monitor residents for changes and implement revisions to the plan of care. Nursing staff was to follow Standards of Practice, which included: 1) Review pre-admission information to plan for resident's needs; 2) Complete comprehensive evaluation of the resident upon admission/readmission; 3) Identify resident's skin integrity status and need for prevention interventions or treatment modalities through review of all assessment information; 4) Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated; 5) Review co-morbid conditions that may affect healing; 6) Notify Dietician and Rehabilitation Services as indicated; 7) Notify Physician/Advance Practice Provider (APP); Review care plan weekly and revise as indicated; 8) Document daily monitoring of ulcer site, with or without dressing. Daily monitoring should include status of dressing, status of tissue surrounding dressing, and adequate control of wound pain. On [DATE] at 9:05 AM, observation of Resident #110, revealed the resident yelled for a nurse, moaned and groaned as if in pain. Further observation revealed the resident was lying flat on his/her back, no pillow under the right arm, as per the care plan. In addition, the resident did not have the care planned boots on his/her feet, the residents' hands had contractures, and the resident was unable to use the call light related to his/her contractures. Per observation, the resident showed non-verbal cues of pain with grimacing. No one responded to the resident until the State Survey Agency (SSA) Surveyor alerted staff that the resident needed assistance. Further observation revealed the resident smelled of the strong odor of urine. Observation of Resident #110, on [DATE] at 1:15 PM, approximately four (4) hours later, revealed the resident lying in the same position as earlier, however there was a pillow under his/her right arm. Interview with Resident #110, on [DATE] at 9:20 AM, revealed staff did not address his/her chronic pain, and while the resident had resided at the facility since the last readmission, on [DATE], he/she had not received pain medication as needed. Further interview revealed, the resident stated I am miserable and I hurt all the time. Per interview, the resident stated when he/she told the nurse he/she was in pain, no one would help him/her. Resident #110 stated he/she was unable to turn and reposition related to the amount of pain he/she was experiencing. He/she was unaware of the last time he/she had been changed and stated he/she was wet and smelled. The resident further stated it hurt to be touched. Interview with Registered Nurse (RN) #3, on [DATE] at 8:30 AM, revealed Resident #110 used to get showers, and now, she was unaware of the last shower the resident had taken. She stated the resident refused showers because he/she was in too much pain to move. Interview with LPN #13, on [DATE] at 3:55 PM, revealed she cared for Resident #110. She stated the facility policy was to check User Defined Assessments (UDA) in the Electronic Health Record (EHR), which directed/prompted nursing staff when to assess residents. LPN #13 stated nurses charted by exception, except with change in condition. She stated UDA had a Change in Condition/Situation, Background, Assessment, and Recommendation (CIC/SBAR) alert, which prompted the user to follow-up. She stated some sections of the EHR would not allow for free-hand charting, but nursing could use the progress note section. LPN #13 stated it was important to do resident assessments and document to ensure quality care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #11, on [DATE] at 8:49 AM, revealed resident weekly skin assessments were assigned to each nurse. She stated the nurses routinely has two (2) to three (3) assessments per shift. Skin assessments were documented in the medical record. Further interview revealed, the Wound Care physician came weekly and reviewed findings. She stated staff looked for skin issues during routine care and showers/baths. Further interview revealed Resident #110 was being followed by Wound Care every week for skin issues. Record review revealed the facility admitted Resident #110 on [DATE], with diagnoses to include Chronic Pain; Contracture, Right Hand; Contracture, Left Hand; Contracture, Right Elbow; Thoracic, Thoracolumbar, and Lumbosacral Intervertebral Disc Disorder. Review of the Social Services Assessment, dated [DATE], revealed Resident #110 scored an eleven (11) on the Brief Interview for Mental Status (BIMS) evaluation. Further review revealed the resident was able to express ideas and wants and was able to understand verbal content. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #110's Functional Abilities as needing substantial/maximal assistance. Resident was dependent on staff to roll left and right in the bed. Further review revealed the resident had one (1) Stage 2 ulcer, one (1) venous and arterial ulcer, and was receiving pressure ulcer/injury care. Review of the Braden Scale for Predicting Pressure Sore Risk, dated [DATE], revealed the facility assessed Resident #110 to be a severe risk for skin breakdown, with a score of eight (8). Review of the Comprehensive Care Plan (CCP), last updated [DATE], revealed Resident #110 was at risk for skin breakdown as evidenced by moisture/excessive perspiration limited mobility, Diabetes, Peripheral Vascular Disease, incontinence of bowel and bladder, medications, history of pressure ulcers, obesity, hemiplegia, arterial ulcer to right second digit. The goals were to show no signs of further skin breakdown. Further review revealed interventions directed staff to apply barrier cream with each cleansing, assist with methods of reducing friction and shear, assist the resident with turning and repositioning every two (2) hours as tolerated. In addition, staff were to float resident's heels while in bed as tolerated, provide a low air loss (LAL) mattress to bed, perform [NAME]/Braden assessments per policy, observe skin risk factors per protocol, and observe for localized skin problems. Further review revealed, Resident #110 was at risk for skin breakdown or had actual skin breakdown. The healing goals were: 1) the resident would remain free of skin tear and bruising; 3) show no signs of skin breakdown; 3) the skin tear/bruise would heal; and 4) the wound/skin impairment would heal. Further review revealed interventions to pat skin when drying, provide treatment to skin tear per physician order, observe for signs of infection, assist resident with turning and repositioning, observe skin for signs/symptoms of skin breakdown, evaluate localized skin problems, utilize devices to assist with turning/positioning to reduce friction and shear, weekly skin assessments by licensed nurse, weekly wound assessment to include measurements and description of wound, and provide wound related pain management intervention (i.e. pre-medicate). Continued review of the CCP, last updated [DATE], revealed Resident #110 was incontinent of urine and was unable to participate cognitively or physically in a retraining program. The goals were to have incontinence care needs met by staff to maintain dignity and comfort, and to prevent incontinence related complications. Further review revealed interventions were to check and change every two (2) hours and as needed (PRN), observe for skin redness/irritation and report as indicated, observe for odor, color, consistency, and amount, use absorbent products PRN. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Specialty Physician's Wound Evaluation and Management Summary, revealed the Wound Physician assessed Resident #110's wounds, on [DATE], and it identified a shear wound to the Right Buttock which measured 0.2 cm (length) by 0.3 cm (width) by 0.2 cm (depth), with light serous exudate, twenty percent (20%) slough, one hundred percent (100%) granulation tissue. Abnormal granulation present within wound margins. Wound progress improved. The summary stated to apply a Primary dressing and Silver Sulfadiazine once daily for thirty (30) days; Secondary dressing - apply gauze island once daily for sixteen (16) days; Apply House barrier cream to Peri-wound three (3) times daily for twenty-three (23) days. Off-load wound; reposition per facility protocol; turn side to side and front to back in bed every one to two hours if able. Review of the Specialty Physician's Wound Evaluation and Management Summary, revealed the Wound Physician assessed Resident #110's wounds, on [DATE], and it identified a shear wound to the Right Buttock - 0.4 cm (length) by 0.6 cm (width) by 0.2 cm (depth), with light serous exudate, twenty percent (20%) slough, eighty percent (80%) granulation tissue. Wound progress deteriorated. Treatment: Primary dressing - Silver Sulfadiazine apply once daily for twenty (23) days; Secondary dressing - apply gauze island once daily for nine (9) days; Apply House barrier cream to Peri-wound three (3) times daily for sixteen (16) days. Off-load wound; reposition per facility protocol; turn side to side and front to back in bed every , d+[DATE] hours if able. Review of the Specialty Physician's Wound Evaluation and Progress Note, revealed the [DATE] visit was rescheduled. Review of the Specialty Physician's Progress Note, revealed the [DATE] visit was rescheduled due to Resident #110 hospitalization unrelated to wounds. Review of a Nursing Note, dated [DATE] at 5:27 PM, revealed Resident #110 was readmitted to the facility after a hospitalization for Sepsis and Acute Respiratory Failure, from [DATE] to [DATE]. Review of skin check, dated [DATE], revealed the nurse identified the following skin injury/wounds: Mild bruising from intravenous (IV) to right upper chest and hands from hospital stay. Other wounds included an old, healed right buttocks scar; and scab areas to toes on right foot. No further descriptions were documented. Review of a Change in Condition (CIC) note, dated [DATE] at 1:35 AM, revealed a skin check was performed and noted the previously identified right buttock wound with treatment in place. The note did not include a description of the wound or surrounding tissue. However, the CIC note did include new orders to apply Z-Guard. Review of the Specialty Physician's Wound Evaluation and Management Summary, revealed the Wound Physician assessed Resident #110's wounds, on [DATE], and it stated the shear wound to the Right Buttock was resolved. The summary directed staff to continue to off-load wound; reposition per facility protocol; turn side to side and front to back in bed every ,d+[DATE] hours if able. A Braden Scale Assessment and Skin Check dated, [DATE] at 5:27 PM, revealed Resident #110's score as ten (10), indicating the resident was at high risk for pressure ulcer development. Review of Skin Check revealed the nurse identified wounds, including one to the Right Buttock. Review of the Specialty Physician's Progress Note, revealed the [DATE] visit was rescheduled. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nursing Progress Notes, dated [DATE] at 7:00 PM, revealed Resident #110 was sent to the local emergency room for evaluation related to generalized peripheral edema and inability to obtain a blood pressure. Review of CIC follow-up Progress Note, dated [DATE] at 9:43 AM, revealed Resident #110's skin was warm with one-plus (1+) pitting edema in bilateral feet. Review revealed no evidence nursing assessed the resident for pressure wounds after identification of CIC. Interview with Licensed Practical Nurse (LPN) #9, on [DATE] at 8:15 AM, revealed she readmitted the resident on [DATE], however she failed to assess the residents skin as per policy. Review of Nursing Skin Assessment Note, dated [DATE], revealed nursing failed to assess Resident #110's skin, per policy, as evidenced by the form/document being blank. Interview with LPN #9, on [DATE] at 8:15 AM, revealed she could not recall not documenting skin assessments for Resident #110 that she was assigned to perform. She stated there were times she was unable to get assessments completed on her shifts. Review of the facility's Skin Assessment Grids, revealed the Wound Nurse assessed Resident #110's wounds on [DATE] and identified a new Buttocks Right/Hip Abscess that measured 2.0 cm (length) by 3.0 cm (width) by 0.4 cm (depth), with hard surrounding tissue and moderate amounts of purulent drainage. The Skin Assessment Grid had no identification or assessment of the sacral area. Review of the Physician's Order revealed, staff were to treat the abscess with Silvadene covered packing gauze with dry dressing daily and PRN. Review of the [DATE] TAR, revealed staff continued to cleanse Right Buttocks area with wound wash, pat dry, and apply Medihoney Wound/Burn Dressing Gel every day shift, except for [DATE] and [DATE], for shearing from start date of [DATE] until the end date of the order on [DATE], even though the wound was documented as resolved from the Specialty Physician's Wound Evaluation and Management Summary, dated [DATE]. Review of Late Entry Progress Note, dated [DATE] at 3:00 PM, revealed a change in condition (CIC) related to a skin wound or ulcer. Resident #110's vital signs were obtained and were the following: oral temperature was 97.8 degrees Fahrenheit (F), respirations 18 breaths per minute; pulse was 62 beats per minute and regular; blood pressure was ,d+[DATE], and oxygen saturation 98%. The resident's blood sugar was 190. The CIC note did not contain an assessment or identfication of a sacral wound. Review of Late Entry Progress Note, dated [DATE] at 11:45 PM, revealed nursing performed a skin check and identified the previous right buttock wound. However, there was no description of the wound or surrounding tissue. Review of the Nurses Progress note, dated [DATE], revealed a nickel size wound abscess to right buttocks with thick white exudate. Further review revealed there were no measurements obtained. Additional review of the note revealed new orders received to: obtain wound culture; clean site with wound cleanser; pack opening with non-medicated Iodoform gauze with Silvadene; and dry dressing BID. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #9, on [DATE] at 8:15 AM, revealed she assessed the resident's hip wound as an abscess, on [DATE]. She stated she did not measure the abscess; she only performed a swab of the abscess to send for culture and sensitivity. Further interview revealed the facility's policy prohibited her from taking pictures of the wound. Review of Progress Notes, dated [DATE] at 3:09 PM, revealed a decline in Resident #110's health. Resident #110's vital signs were obtained and were the following: oral temperature: 99.3 F; respirations 22; pulse 59 and regular; blood pressure ,d+[DATE], and oxygen saturation: 98%. Per the note, the Physician was notified and new orders were received to hold oral medications. Further review of the Progress Notes, dated [DATE] at 7:31 PM, revealed after further monitoring and review of Resident #110's declining condition, a new order was received to transport the resident to the Emergency Department (ED). Emergency Medical Services (EMS) was dispatched at 5:52 PM. Review of the EMS Run Sheet, dated [DATE] at 6:04 PM, revealed that no nurse was present in the resident's room, and no transfer information was available from the facility when Resident #110 was picked up for transport to the hospital ED. Further review revealed EMS crew stated the resident was alert to pain and felt warm. A temperature of 103.0 degrees Fahrenheit (F) was obtained while still in the facility. Review of ED Notes, dated [DATE] at 6:19 PM, revealed Resident #110 presented to the ED with atrial fibrillation (A-fib), generalized swelling, a fever of 101.6 degrees Fahrenheit, altered mental status, diminished lung sounds bilaterally, and faint heart tones. Lab results revealed an elevated [NAME] Blood Count (WBC) at 15.7 (reference range is 3.7 - 10.3 x 10(3)/mcl. X-ray results were positive for bilateral parenchymal opacities, which could represent edema or infection and computed tomography (CT) results showed bilateral pleural effusion. Further review revealed, Resident #110 was admitted to the hospital, on [DATE], with diagnoses, which included Sepsis, Unstageable Pressure Ulcer of Sacral Region and Right Gluteal Abscess, Morbid Obesity, and Healthcare Associated Pneumonia (HCAP). Continued review of ED Physician notes, dated [DATE], revealed Resident #110 met the criteria for Sepsis. Wound cultures were obtained from the sacral decubitus ulcer and the right gluteal abscess. Review of Surgical Consult, dated [DATE], revealed a stat consult was requested to evaluate Resident #110's wounds. Per the notes, the resident's right gluteal abscess was actively draining, likely with necrotic tissue in the base, which could use further opening and debridement. Further review of the progress note revealed the resident had an unstageable sacral decubitus ulcer measuring 8 cm (length) by 2 cm (width), which required surgical debridement. The provider wrote, Patient has no quality of life. Review of Infectious Disease (ID) Consult, on [DATE], revealed ID was consulted for evaluation of Sepsis and antibiotic management; possible causes for the infectious etiology included Bacteremia, HCAP, and soft tissue infection from right buttock ulcer. A Computed Tomography (CT) of the pelvis showed a chronic calcified posterior right gluteal region hematoma in the surrounding soft tissue infiltration indicating possible soft tissue infections. Wound culture of right buttock showing gram negative rods. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with State Registered Nurse Aide (SRNA) #18, on [DATE] at 8:20 AM, revealed when aides found a skin issue on a resident, the process was to document the findings on the Skin Assessment sheet, and make the nurse aware. She further stated residents were assessed every Friday by the Wound Care Nurse. She further stated Resident #110 had some areas on her toes, abdominal folds and right buttock. She stated the resident was being followed by wound care. Interview with Licensed Practical Nurse (LPN) #9, on [DATE] at 8:15 AM, revealed she was assigned to Resident #110, on [DATE]. She stated Registered Nurse (RN) #3 observed a CIC in the resident during the night shift. RN #3 documented the CIC and reported the resident's condition to her at shift change. LPN # 9 stated she was up and down the hall insuring he/she was responsive, and monitored vital signs throughout the day. LPN #9 stated vital signs were within normal limits, and the plan was to wait for labs to see what to do next; however, she added Resident #110 did not improve, was not verbally responsive, and his/her temperature was elevated. The Physician was notified, and new orders were received to send the Resident to the ED. EMS was dispatched and Resident was transferred to the hospital's ED via EMS at 5:52 PM. Interview with SRNA #19, on [DATE] at 3:43 PM, revealed she cared for Resident #110 and stated, I try to check and change residents every two hours, but it's usually more like every three hours. Further interview revealed when she was providing care to the resident on [DATE] she noticed the area to the residents right hip she notified the nurse on duty. She stated the area was red and open with white drainage coming out of area. SRNA #19 stated she did not observe the resident's buttocks, because once she identified the right hip wound she stopped providing care and got the nurse. Interview with Agency LPN #9, on [DATE] at 8:15 AM, revealed Resident #110 was incontinent, obese, and needed frequent skin assessments. LPN #9 identified the wound on the hip as an, abscess with drainage, on [DATE], and stated she performed a culture and sensitivity on the drainage during a dressing change. She stated the wound abscess was tiny. She stated she did not perform an additional skin assessment once the area to right hip was located, she only assessed that area, she did not look any further on the resident's sacral area. She stated the plan was to wait for labs to see what to do next; however, she added Resident #110 did not improve, was not verbally responsive, and his/her temperature was elevated. LPN #9 stated the resident was uncomfortable with positioning and would not tolerate it well. She stated the resident would cry out in pain when turned. The Physician was notified, and new orders were received to send the resident to the ED. Further interview with LPN #9, on [DATE] at 11:13 AM, revealed Resident #110's right buttock area had purulent drainage like an abscess. She stated she notified the Wound Care Nurse, obtained a wound culture, and notified the Physician for treatment orders. She stated she did not measure the wound and estimated it to be the size of a nickel. Further interview revealed she monitored the wound for drainage and checked for further deterioration during dressing changes, and charted when care was completed. Per interview, she stated no other skin issues were present. LPN #9 stated, on [DATE], the abscess was open and draining, and she had to pack it. She recalled that he/she flinched during treatment and stated it was uncomfortable. She further stated, Resident #110 didn't want to be bothered. LPN #9 stated she did not the document care or the resident's verbal or non-verbal reactions to treatment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Agency LPN #15, on [DATE] at 5:05 PM, revealed she cared for Resident #110. She stated he/she was bedridden and had skin breakdown in abdominal folds. She did not recall Resident #110 having any other skin breakdown and stated the SRNA's were her eyes and ears regarding identifying new skin issues. Interview with RN #3, on [DATE] at 8:30 AM, revealed wound shear on Resident #110's right buttock had healed; however, the resident did have an abscess to right buttock. RN #3 stated she did not do a full skin assessment because she only treated the wound areas she was assigned. RN #3 stated, Aides changed Resident #110 no more than two times a shift due to it being too uncomfortable for the resident. Interview with RN #2, Nurse Educator/Wound Care Nurse, on [DATE] at 9:00 AM, revealed nursing had identified a new wound abscess to Resident #110's right hip area. She stated, LPN #9 did the culture and dressing. She stated resident would, grimace and moan when touched, and staff had to go very slowly, and gently during the resident's wound care treatments. She stated staff nurses would follow-up with Resident #110's weekly skin checks and he/she was followed by the Wound Care Physician. She stated Wound Care Physician rescheduled in-house appointments with Resident #110 due to his/her hospitalization . She could not recall why the wound consult visit on [DATE] was rescheduled. RN #2 stated she notified the physician about the new abscess. RN #2 was not aware Resident was refusing care. Per interview, he/she was care planned (CP) to be turned per facility schedule. She stated it was her expectation that staff assess skin and turn resident per the CP. Further interview revealed there was currently no widespread education on newly identified skin issues. She stated the facility process was to let Unit Managers know about new skin issues. She stated not all staff had been education on Pressure Ulcer Prevention (PUP) and PUP protocols were not in place. RN #2 stated the plan was to implement new education regarding turn schedule. Subsequent interview with RN #2, on [DATE] at 4:35 PM revealed that Agency staff was trained prior to coming to facility on basic resident care. She stated the facility had processes to ensure competencies, which were not yet in place, for new hires. New hires were paired with a trainer for one to two days, which she stated, Personally, I don't believe that was enough time. Trainers report if there were any issues with competencies. She relied on other staff to check that staff was competent. There was no follow-up from the Educator to assure competent care was provided according facility policies. She stated that her goal was to spend one-on-one time with all staff, but for right now, The process is broken. Additional interview with RN #2, on [DATE] at 11:52 AM, revealed during Resident #110's last treatment, done on [DATE], she only concentrated on the abscess to the hip. She recalled documenting her assessment on a piece of paper and was did not recall she failed to document her assessment in the chart. She received an order to pack with Silvadene covered gauze. She stated the wound was an abscess and not something that could be staged. She stated she did not measure the wound, as directed per the policy. RN #2 stated, We didn't do a full skin assessment. Further interview revealed it was her process to focus on the acute area, and nurses did a weekly skin assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Assistant Director of Nursing (ADON), on [DATE] at 4:40 PM, revealed it was her expectation that nurses assess and document what they did. She stated, If you didn't document, it didn't happen. She further stated nursing staff should fully assess using the CIC Tool. She stated she was aware of Resident #110's abscess and knew it was assessed by the Wound Care Nurse. ADON stated it was not an expectation that nursing did a full skin assessment when made aware of a new skin condition; however, she stated it would be important to fully exam the entire area to determine full extent of wound. Interview with the Director of Nursing (DON), on [DATE] at 9:18 AM, revealed it was her expectation staff followed the resident's comprehensive care plan, and care plans should be updated if any type of pressure injury was found. It was the DON's expectation that nursing staff provide the correct level of care per the care plan and as ordered by the physician Further interview revealed it was her expectation that full skin assessments were completed by nursing staff when weekly skin assessment were due. Interview with the Regional Clinical Quality Specialist (RCQS), on [DATE] at 3:40 PM, revealed it was her expectation that staff followed care plans, and updated as needed, when there was a CIC or a new pressure/wound was identified. Furthermore, nursing staff was to assess the resident and chart findings. She stated, If it was not charted, it didn't happen. The facility provided an acceptable credible Allegation of Compliance (AoC) on [DATE] alleging removal of the Immediate Jeopardy on [DATE]. Review of the AoC revealed the facility implemented the following: 1. An audit was conducted by the Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE), and Unit Managers (UM) between [DATE] and [DATE] to determine if residents had pain, had pain medications ordered, if pain medications were effective, and if pain was not relieved. The Physician/Advanced Registered Nurse Practitioner (ARNP) were notified of unrelieved complaints of pain with new orders obtained if applicable. 2. Nineteen (19) of nineteen (19) residents identified with pain issues were reassessed on [DATE] by the Director of Nursing (DON), UM's, and/or Licensed Nurse (LN) Nurse Practitioner and/or Physician to determine if a change in condition had occurred regarding pain. Areas of concern were corrected upon discovery. 3. The DON, UM, ADON, NPE, and/or Clinical Quality Specialist (CQS) initiated reeducation, beginning on [DATE], with all facility staff to include contracted staff on the facility's policy and procedures regarding: (A) Change in Condition; (B) Pain Management, including observations; (C) Stop and Watch Tool; (D) Physician/Mid-Level Provider Notification of Change in a Resident's condition; and (E) Person Centered Care Plan. A post-test was administered at the time of the reeducation that required a passing score of 100% that will be graded by the DON, UM, ADON, NPE, and/or CQS to validate understanding. Facility staff and agency staff not available during the reeducation and post-test were to be provided reeducation including a post-test by the DON, UM, ADON, NPE, and/or CQS upon day of return to work prior to providing care. Newly hired staff and contracted staff were to be provided education and post [TRUNCATED]

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system to ensure residents' respiratory care needs were consistently met for one (1) of thirty (30) sampled residents (Resident #110). The facility admitted Resident #110 on [DATE]. The resident had current diagnoses of Obstructive Sleep Apnea (OSA), Chronic Obstructive Pulmonary Disease (COPD), Asthma, Dysphagia, Heart Failure (HF), and Chronic Kidney Disease (CKD). Resident #110 had been hospitalized , from [DATE] to [DATE] with Sepsis and Acute Respiratory Failure. In addition, Resident #110 had been sent to the hospital Emergency Department (ED), on [DATE], for edema and returned to the facility five (5) hours later, on [DATE]. On [DATE], Resident #110 experienced a change in condition (CIC) with his/her respiratory status. Interview and record review revealed nursing staff did not implement respiratory care interventions for the resident on [DATE], as ordered by the Physician. Nursing staff failed to administer the resident's ordered Furosemide (a diuretic used to remove excess fluid from the body) sixty (60) mg intravenously (IV), monitor lung sounds; failed to perform strict fluid intake and output (I&O), and, failed to monitor the resident for his/her deteriorating condition. Record review and interview revealed staff failed to notify the Physician that Resident #110 refused to wear his/her mask that delivered Bi-level Positive Airway Pressure (BiPAP), a mask with tubing attached to a machine that delivered bi-level positive airway pressure while sleeping to keep the airway open and improve oxygenation, used to treat OSA) at night. Resident #110 was transferred to the hospital's ED (Emergency Department), on [DATE] at 5:52 PM, via Emergency Medical Services (EMS) and was admitted . According to the hospital ED records, the resident arrived lethargic and moaning with diminished lung sounds bilaterally (both sides), bilateral upper and lower extremity swelling and edema, febrile, and with an altered mental status. Resident #110 returned to the facility under Hospice Care, on [DATE], and expired on [DATE]. The facility's failure to provide respiratory care to meet the needs of the resident, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on [DATE], in the area of 42 CFR 483.25(i) Quality of Care, Respiratory Care, and determined to exist on [DATE]. The facility provided an acceptable Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with the remaining non-compliance at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Respiratory Management, revised on [DATE], revealed the purpose of the policy was to provide appropriate respiratory services. Further review revealed residents would be assessed for the need for respiratory services as part of the nursing assessment process. If respiratory care was needed it would be performed by a licensed nurse who had been trained. Furthermore, the nurse would consult with the Physician/Advanced Practice Provider (APP) when a resident was not responding to treatment provided by nursing; or, a resident's condition worsened. Review of the facility's policy titled, Bi-level Positive Airway Pressure, revised [DATE], revealed this treatment was used and provided via a mask connected to a machine that delivered positive airway pressure therapy for the treatment of OSA and to augment ventilation as a non-invasive positive pressure ventilator (NIPPV). Review of the facility's policy titled, Change in Condition (CIC): Notification Of, revised on [DATE], revealed the facility must immediately consult with the resident's Physician and notify him/her when there was a need to change an existing form of treatment or start a new form of treatment. Review of the facility's policy titled, Physician/Advanced Practice Provider (APP) Notification, revised on [DATE], revealed if the resident had a CIC, the Physician or APP must be notified to address new or changed interventions as needed. Per policy, if a resident had a CIC, a licensed nurse must observe and collect information about the resident's condition and report these findings to the Physician or APP (Advanced Practice Registered Nurse/APRN). Review of the facility's policy titled, Nursing Documentation, revised on [DATE], revealed the purpose of nursing documentation was to communicate the resident's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. Further review revealed the resident's record would specify what nursing interventions were performed. Review of the facility's policy titled, Assessment: Nursing, revised on [DATE], revealed the purpose of a nursing assessment was to determine the resident's condition and clinical needs. Further review revealed the assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff on all shifts. Per facility policy, the Physician or APRN was to be notified of all CIC assessment results. Review of the facility's policy titled, Intake and Output, revised on [DATE], revealed the purpose was to ensure nursing staff recorded total fluid intake and output to track the resident's fluid balance. Per policy, nursing staff was to record all intake amounts including fluids taken by mouth and the amount of IV (intravenous) fluids infused; and nursing staff was to record all output amounts including urine in milliliters (ml). Further review of the policy revealed intake and output (I&O) totals were to be recorded in the resident's medical record. Review of the facility's policy titled, Taking Medication and Treatment Orders, revised on [DATE], revealed verbal orders were given face-to-face to a nurse by a practitioner who was in the facility, and verbal orders were not an accepted standard of practice and could only be used in an emergency situation. Continued review revealed the person taking the orders could only take the order from a credentialed physician or other authorized practitioner, as allowed by state regulations. Further review of the policy revealed the person obtaining orders must document verbal orders, with the prescriber's name and title, name and title of the person receiving the order, date, month, year, and time. The prescriber's signature must be obtained per state regulation. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #110's medical record revealed the facility admitted the resident, on [DATE]. Further review revealed the resident had current diagnoses, which included Obstructive Sleep Apnea (OSA), Chronic Obstructive Pulmonary Disease (COPD), Asthma, Dysphagia, Heart Failure (HF), and Chronic Kidney Disease (CKD). Review of Resident #110's Social Services Assessment, dated [DATE], revealed the resident scored an eleven (11) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) evaluation, indicating the resident was cognitively intact. Further review revealed the resident was able to express ideas and wants, and was able to understand verbal content. Review of Resident #110's Plan of Care (POC), initiated on [DATE], revealed the resident was at risk for complications related to OSA, COPD, Asthma, and Dysphagia. The goal stated the resident would not have signs/symptoms of respiratory distress or aspiration. Further review of the POC revealed interventions included to administer aerosol medications as ordered/indicated; administer BiPAP as ordered; observe and report SpO2 (blood oxygen saturation) levels via pulse oximetry as ordered and as needed; and observe respiratory rate, signs/symptoms of dyspnea, abnormal breath sounds, cyanosis, and use of accessory muscles. Continued review of the care plan revealed the resident had the potential for alteration in fluid balance and impaired renal function with interventions to include observing for symptoms of edema, shortness of air (SOA), and weight gain. Review of Resident #110's Nursing Notes, dated [DATE] at 8:59 AM, revealed the resident was tachycardia, pulse one-hundred eighty (180) beats/minute; 02 sat 89% with 02/NC at two (2) liters per minute. Further review revealed Resident #110 complained of left sided chest pain. Resident denied nausea/vomiting, his/her skin was warm and dry to touch. But the resident stated he/she was feeling hot during night hours. Continued review revealed the resident was alert, oriented, and verbally responsive x 2; with no difficulty in breathing; and, the resident denied shortness of breath. The APRN was notified with new orders to send the resident to the emergency room . Review of Resident #110's hospital records, dated [DATE], revealed the resident was admitted to the hospital, on [DATE], for sepsis (widespread infection) and acute respiratory failure. Resident #110 was discharged from the hospital and returned to the facility on [DATE]. Review of Resident #110's Physician's Orders, dated [DATE], revealed orders for the use of a BiPAP machine with two (2) liters of oxygen at bedtime. In addition, the order stated for the resident to use two (2) liters of oxygen, via nasal cannula, every shift to keep oxygen levels above ninety (90) percent. Continued review revealed a Physician's Order for Advair Diskus Aerosol Powder Breath, Activated (an inhaler used to treat COPD, Asthma) ,d+[DATE] micrograms (mcg) per dose, inhale one (1) puff orally two (2) times a day for Asthma, with a start date of [DATE]. Further review of Resident #110's medical record revealed a Treatment Order, dated [DATE], to change oxygen tubing weekly, and label each component with date and initials, every day shift, every Thursday. Review of Resident #110's Nursing Notes, dated [DATE] at 7:00 PM, revealed the on call APRN was notifie of resident's generalized peripheral edema and not being able to obtain a blood pressure on the resident. Further review revealed new orders obtain to send the resident to the emergency room for furrther evaluation. (continued on next page)

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	185090	A. Building B. Wing	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #110's hospital records, dated [DATE], revealed the resident was sent to the ED, on [DATE], for edema and lab tests. The resident returned to the facility on [DATE], after spending approximately five (5) hours in the ED as an outpatient. Observation and interview with Resident #110, on [DATE] at 9:20 AM, revealed the resident in bed lying on his/her left side with his/her legs crossed, one over the other, with his/her heels pressed against the mattress. There was generalized edema observed over the lower extremities, bilateral hands, and upper extremities; the left hand had an indentation where it rested against the bed. Further observation revealed the resident was on two (2) liters/minute of oxygen via nasal cannula, but the oxygen tubing was not labeled with a date or initialed, which was not according to the treatment order. Additional observation revealed the resident's BIPAP mask and tubing were on the floor, and the resident stated, My life is miserable. Record review revealed Resident #110's lung sounds were assessed on [DATE] at 6:00 AM. However, there was no documented evidence that nursing monitored the resident's lung sounds throughout the day to assess for the resident's worsening condition. Further review revealed there was no documented evidence the nurses assessed an apical pulse on the resident even though the resident had a diagnosis of AFIB. Interview with Licensed Practical Nurse (LPN) #9, on [DATE] at 8:15 AM, revealed Resident #110 routinely refused his/her BiPAP treatment. She stated nurses should document refusals on the MAR (Medication Administration Record). Per interview, she could not recall if the Physician was aware of the resident's repeated refusals to wear the BiPAP. Record review revealed no documentation of notification to the Physician of the resident's refusal to wear the BiPAP. Interview with Registered Nurse (RN) #3, on [DATE] at 8:30 AM, revealed Resident #110 refused the BiPAP and wanted it off most nights because it was noisy and interfered with sleep. She stated she did not recall if the Physician had been notified of the resident's refusal to wear BiPAP. Interview with the Physician, on [DATE] at 9:23 AM, revealed the nurses did not make him aware of Resident #110's non-compliance with wearing the BIPAP at night. He further stated it would have helped the resident with his/her respiratory illness. Record review revealed Resident #110 refused to wear the BIPAP on ten (10) out of twenty (20) nights in the month of [DATE]. However, there was no documented evidence nursing staff provided encouragement and education related to the refusal of care related to wearing the BIPAP at night. Continued review of Resident #110's Nursing Progress Note, dated [DATE] at 6:05 AM, revealed Registered Nurse (RN) #3 observed Resident #110 with frothy, thick mucous in his/her mouth and throat. RN #3 noted the resident's oxygen saturation (SpO2) was ninety-two (92) percent on two (2) liters/minute of oxygen via nasal cannula. Per the Note, a nursing assessment at 6:00 AM, revealed the resident had abnormal lung sounds (rales, rhonchi, wheezing) and complained of chest pain. Further review revealed the assessment of the resident showed a resting pulse rate of one-hundred fifteen (115) beats per minute (BPM), respirations of eighteen (18) per minute, temperature of 97.6 degrees Fahrenheit, and a blood pressure (BP) of ,d+[DATE] millimeters of mercury (mmHg). The note stated Resident #110 was not wearing his/her BIPAP. In addition, the note stated RN #3 notified the Physician of Resident #110's condition and new orders were given for lab work and a chest x-ray. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continued interview with RN #3, on [DATE] at 8:30 AM, revealed Resident #110 was normal until about 5:30 AM, and at 6:30 AM, a State Registered Nurse Aide (SRNA) observed the resident with thick phlegm coming from his/her mouth. RN #3 stated she notified the Physician. Per interview, the Physician examined the resident that morning and ordered lab work and a chest x-ray. Interview with the Physician, on [DATE] at 10:12 AM, revealed he examined Resident #110 on the morning of [DATE]. Per interview, he assessed the resident with fluid overload caused by his/her recent IV antibiotic therapy, and it was his intent to diurese (remove fluid) the resident. The Physician stated he gave a verbal order to the Director of Nursing (DON) directly to place an indwelling Foley (brand of indwelling catheter) catheter, give one (1) dose of Furosemide sixty (60) mg IV, monitor lung sounds, and document strict I&O's. The Physician stated he gave the order specifically to the DON because, as an RN, she was the only nurse in the building, who could push IV Furosemide. Additionally, he stated he ordered strict I&O's and the monitoring of the resident's lung sounds to assess the resident's response to the treatment. Further, the Physician stated a staff nurse informed him that following the ordered treatment, Resident #110 was diuresed of approximately two (2) liters of fluid. Per interview, when the resident's condition did not improve, he transferred him/her to the ED for more aggressive measures. Record review revealed Resident #110 was transferred to the hospital, via EMS, on [DATE] at 5:52 PM. Interview with the DON, on [DATE] at 9:15 AM, revealed she assessed Resident #110, on [DATE], in the morning, and told the unit LPN to call the doctor to send the resident out. She stated she documented the assessment; in addition, she stated, according to the facility's policy verbal orders were given in emergency situations by the Physician to an RN. Per interview, the facility's policy dictated that verbal orders were transcribed on an order sheet and signed by the Physician. When asked if she had ever taken a verbal order from a Physician, she replied, No. When asked if Furosemide had been taken out of the emergency box (e-Box), she replied, No. The DON further stated that no one gave Resident #110 Furosemide IV on [DATE], as ordered. She stated the unit LPN was given the order to give Furosemide. In addition, the DON stated the Physician also gave the unit LPN verbal orders to place an indwelling Foley catheter, monitor lung sounds, and document strict I&O's. The DON indicated she first heard about the Physician's orders in the afternoon, however she could not recall the exact time. Additional interviews with the DON on [DATE] at 9:15 AM and review of the resident's records revealed no documented Physician's Orders for Furosemide sixty (60) mg IV, Foley catheter placement, monitoring and assessing lung sounds, strict I&Os, or to provide comfort care. Furthermore, continued review of the Nursing Progress Notes, dated [DATE], revealed no documented nursing assessment by the DON, as stated per interview. Continued review of Resident #110's Nursing Progress Note, dated [DATE] at 3:09 PM, revealed the first CIC follow-up note by LPN #9. The note stated the resident's condition had declined, and the Physician was notified. Furthermore, the note stated new orders were received to continue to hold PO (oral) medications, insert a Foley catheter for strict I&O's, and provide comfort care. However, there was not a specfic time given for receipt of the orders. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #9, on [DATE] at 8:15 AM, revealed RN #3 observed a CIC in Resident #110 during the night shift, which was documented and reported to her at shift change. LPN # 9 stated she was up and down the hall ensuring the resident was responsive and monitored his/her vital signs throughout the day. LPN #9 stated the plan was to wait for lab results to see what to do next; however, she added Resident #110 did not improve, was not verbally responsive, and his/her temperature was elevated. LPN #9 stated the Physician gave orders regarding Resident #110 to the DON, not the LPN's on the unit. In addition, she stated she was not aware whether or not the resident had received Furosemide sixty (60) mg IV or that the Physician wanted the resident diuresed. She stated she did not perform any IV diuresis, but a catheter was placed in the morning to monitor strict I&O's and for comfort care. She recalled the resident's urine output was about fourteen hundred (1400) ml's. Per interview, she stated she did not document any I&Os, was unaware of any chest pain for the resident, and did not document any abnormal lung sounds because they were clear based on the night shift nurse's finding. According to LPN #9, around 11:00 AM, Resident #110 complained he/she could not swallow, so the Physician ordered nothing by mouth and to hold oral medications. The LPN stated Resident #110 was very edematous. She stated she assessed the resident and auscultated clear lung sounds; however, she did not document her assessment. LPN #9 stated the assessment should have been documented to keep an accurate record of the resident's condition. Further interview revealed LPN #9 continued to monitor the resident's mental status, provide comfort care, and monitor his/her status of distress for a further decline in condition. Again, LPN #9 revealed she did not document the assessments and stated the facility needed a better tool for documentation because it could be overwhelming. She recalled she documented a general note later in the afternoon. LPN #9 stated the resident required a higher level of care, which the facility could not provide, and she wanted the resident sent to the hospital. She stated the UM called the Physician, and she received an order to transfer the resident to the hospital. Record review revealed there were no documented assessments for lung sounds, strict I&Os or monitoring of Resident #110's condition, on [DATE] from 6:00 AM to 3:09 PM to ensure the resident's care needs were identified. In addition, there was no documented evidence LPN #9 performed the ordered care. Interview with the Pharmacist on, [DATE] at 3:31 PM, revealed if a needed medication was not on hand, it was pulled from the e-Box. Per interview, two (2) vials of Furosemide (forty) 40 mg were kept in the e-Box, and to audit what was used from the e-Box, nursing staff must fill out a requisition form and fax it to Pharmacy. According to the Pharmacist, the Pharmacy delivered the facility an e-Box, on [DATE], and picked it up, on [DATE]. The Pharmacist stated the e-Box was missing two (2) Furosemide (forty) 40 mg/4 ml vials; however, Pharmacy did not receive a faxed inventory form requesting replacement. However, interview with the DON revealed she did not administer the Furosemide. Review of the Hospital Emergency Department (ED) Notes, dated [DATE] at 6:19 PM, revealed Resident #110 presented to the ED with Atrial Fibrillation, Generalized Edema, Altered Mental Status, a fever of 101.6 degrees Fahrenheit, diminished lung sounds bilaterally, and faint heart tones. Lab results revealed an elevated [NAME] Blood Cell (WBC) count at 15.7 (reference range is 3.7 to 10.3). Further review revealed chest x-ray results were positive for bilateral parenchymal opacities, which could represent edema or infection, and the computed tomography (CT) results of the lungs showed bilateral pleural effusions. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Hospital History and Physical (H&P) for Resident #110, dated [DATE] at 11:19 PM, revealed Resident #110's principal problems were Sepsis (widespread infection of the blood stream), Atrial Fibrillation, Healthcare-Associated Pneumonia (HCAP), Anemia, and Cor Pulmonale (an abnormal enlargement of the right side of the heart as a result of lung disease). A broad spectrum antibiotic and diuretic were ordered. Interview with Agency State Registered Nurse Aide (SRNA) #21, on [DATE] at 3:04 PM, revealed she had cared for Resident #110 and stated he/she required total assist for everything due to contractures. SRNA #21 stated Resident #110 usually had swollen extremities. She stated that when she cared for the resident recently, he/she was crying, complained of no air, and slept all day. Per interview, SRNA #21 stated that she reported the resident's condition to the nurse but did not recall if the nurse assessed the resident. Interview with Agency LPN #10, on [DATE] at 9:40 AM, revealed she was aware Resident #110 had bilateral edema in all extremities. However, there was no documented evidence that nursing staff assessed the resident's edema during the skin assessment on [DATE]. Interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), on [DATE]at 10:00 AM, revealed resident assessments should be completed and documented according to policy. She stated it was her expectation that if a resident had a change of condition related to respiratory, that an assessment should be completed and documented in the clinical record. Further, the ADON stated the provider was to be notified. Continued interview with the DON, on [DATE] at 9:15 AM, revealed she expected nursing staff to provide the correct level of care. Per interview, it was the DON's expectation that nurses did resident assessments and charted accordingly. Interview with the RCQS, on [DATE] at 3:40 PM, revealed it was her expectation that when a resident had a change of condition, it was her expectation for it to be documented in the resident's clinical record; furthermore she expected the staff to follow the resident's plan of care and notify the Physician. Furthermore, nursing staff was to assess the resident and document the results. Interview with Administrator, on [DATE] at 2:15 PM, revealed it was her expectation for staff to follow the facility's policy related to assessments and follow the Physician's Orders, as per policy. The facility provided an acceptable credible Allegation of Compliance (AoC) on [DATE] alleging removal of the Immediate Jeopardy on [DATE]. Review of the AoC revealed the facility implemented the following: 1. An audit was conducted by the Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE), and Unit Managers (UM) between [DATE] and [DATE] to determine if residents had pain, had pain medications ordered, if pain medications were effective, and if pain was not relieved. The Physician/Advanced Registered Nurse Practitioner (ARNP) were notified of unrelieved complaints of pain with new orders obtained if applicable. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. On [DATE], the DON, UM, ADON, NPE and or CQS initiated reeducation with all licensed nurses and agency nurses on the facility's policy and procedures regarding: (A) Revision of the care plan with all admissions, readmissions, and changes in respiratory status with diagnoses to include acute respiratory failure, sleep apnea, COPD, and asthma. A post-test was administered at the time of the reeducation that required a passing score of 100% that was graded by the DON, UM, ADON, NPE, and/or CQS to validate understanding. Licensed Nursing and Agency Licensed Nursing Staff not available will be provided reeducation, including a post-test, by the DON, UM, ADON, NPE, and/or Registered Nurse upon day of return to work before providing care. New licensed nursing hires and agency licensed nurses will be provided education and post-test during orientation by the DON, ADON, NPE and/or UM. 10. Care plan audits were completed for residents with diagnoses including acute respiratory failure, sleep apnea, COPD, and/or asthma and will be completed for new admissions, readmissions, and residents with a change in condition to include a change in respiratory status to determine the care plan has resident specific interventions including respiratory assessments; and, corrective actions were taken upon discovery of deficiencies. 11. Five (5) Licensed Nursing Staff interviews were completed by the CED, DON, UM, ADON, NPE, and/or CQS to determine if staff were aware of the process of a respiratory assessment when a resident's condition warranted the assessment and per the resident's plan of care will be conducted daily until the Immediate Jeopardy is abated. 12. The DON, UM, ADON, NPE, and/or CQS completed reeducation beginning on [DATE] with facility licensed staff to include agency staff on the facility's policy and procedures regarding: (A) Pain management to include implementing person-centered care plans with individualized person-centered interventions to include monitoring pain, administering pain medications as ordered, and utilizing and documenting pain scale assessments, and observe for non-verbal signs/symptoms of pain. A medication reconciliation process is in place to review discharge orders to current orders; (B) Physician/Mid-Level Provider Notification of Change in a resident's condition; and (C) Person Centered care plans regarding resident interventions for pain. A post-test was administered at the time of reeducation that required a passing score of 100% that was graded by the DON, UM, ADON, NPE, and or CQS to validate understanding. Facility licensed staff and agency staff not available will be provided reeducation including a post-test during orientation by the DON, ADON, NPE, UM, and/or LN, before allowed to work. 13. The CED and/or LN will conduct five (5) employee questionnaires daily to determine if staff were aware of the Center's process of reporting a change in condition including pain to a licensed nurse to ensure prompt intervention when a resident experienced a change in condition until Immediate Jeopardy is abated. 14. The UM's, ADON, NPE, and licensed nurses completed skin assessments on all residents on [DATE], to ensure residents, including residents with pressure ulcers, received care per Physician's orders to promote healing and prevent additional pressure ulcers with any needed corrective action taken upon discovery. 15. T [TRUNCATED]

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety 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** 44001 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure pain management was provided to residents who required such services. The facility failed to ensure pain medication was available to the resident per the Physician's Orders, the Comprehensive Care Plan, and the goals and preferences for one (1) of thirty (30) sampled residents (Resident #110). The facility admitted Resident #110, on [DATE], with diagnoses that included Chronic Pain and Thoracic, Thoracolumbar, and Lumbosacral Intervertebral Disc Disorder. Resident #110 was hospitalized , on [DATE], with Altered Mental Status, Condition Decline, and Respiratory Failure. Prior to the [DATE] acute care hospitalization , the resident was receiving Oxycodone with Acetaminophen (a narcotic opioid pain reliever given for moderate to severe pain) on a every six (6) hour schedule. When Resident #110 returned from the hospital to the facility, on [DATE], the resident's discharge medication and the Physician's Orders included the same narcotic pain medication but it was ordered every six (6) hours as needed (PRN) instead of the routine administration of every six (6) hours. Moreover, the Physician's Order was for only (3) days, to start on [DATE] and end on [DATE]. The nursing staff at the facility failed to notify the Physician or the Advanced Practice Registered Nurse (APRN) to reorder the resident's scheduled narcotic pain medication after the three (3) day order had expired on [DATE]. Interviews with staff revealed Resident #110 continued to complain of pain; interview with the resident revealed he/she was in constant pain and had made staff aware of his/her pain. Interviews with Resident #110's Physician and APRN revealed both were aware the resident had chronic pain and had been on the narcotic pain reliever. However, both stated they were unaware it had been discontinued as of [DATE]. The Physician and APRN stated, if they had known Resident #110 had stopped receiving the scheduled narcotic pain medication, they would have reordered it. In addition, the Physician stated he would have expected staff to notify him or the APRN that the order had expired. The facility's failure to have an effective system in place to ensure pain management was provided to residents who required such services has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on [DATE], in the area of 42 CFR 483.25(k) Quality of Care, Pain Management, and were determined to exist on [DATE]. The facility provided an acceptable Allegation of Compliance (AoC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. The State Survey Agency validated removal of the Immediate Jeopardy as alleged on [DATE], prior to exit on [DATE], with the remaining non-compliance at a Scope and Severity of a D while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Pain Management, revised [DATE], revealed each resident would have an individualized, interdisciplinary care plan which would be developed to address and treat his/her pain to maintain the highest possible level of comfort. Additionally, a licensed nurse should conduct a pain assessment and reassessment. The resident would be reassessed upon admission/readmission, quarterly, and with change in condition (CIC) or change in pain status. Further, the policy stated the care plan would be evaluated for effectiveness, and revised until satisfactory pain management was achieved. Per policy, at a minimum of daily, patients would be evaluated for the presence of pain by making an inquiry of the resident or by observing for signs of pain; residents who had unstable pain management would be indicated on the twenty-four (24) hour Summary Report. In addition, staff would report any observation or communication of pain to the nurse responsible for that resident. The policy stated the attending physician or APRN would be consulted as indicated. Per policy, the nurse would document on the Medication Administration Record (MAR) when an as needed (PRN) pain medication was administered. Further, the nurse would monitor the resident to evaluate the efficacy of the interventions. Review of the facility's policy titled, Change in Condition: Notification Of, revised on [DATE], revealed the facility must immediately notify and consult with the resident's physician when there was a need to change an existing form of treatment or to commence a new form of treatment. Review of the facility's policy titled, Assessment: Nursing, revised on [DATE], revealed the purpose of a nursing assessment was to determine the resident's condition and clinical needs. Further review revealed the assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff on all shifts. Per policy, the physician or APRN was to be notified of all change in condition (CIC) assessment results. Review of the facility's policy titled, Nursing Documentation, revised on [DATE], revealed the purpose of nursing documentation was to communicate the resident's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. Further review revealed the resident's record specified what nursing interventions were performed. Review of Resident #110's medical record revealed the facility admitted the resident, on [DATE], with diagnoses that included Chronic Pain; Contracture, Right Hand; Contracture, Left Hand; Contracture, Right Elbow; Thoracic, Thoracolumbar, and Lumbosacral Intervertebral Disc Disorder; Chronic Respiratory Failure with Hypoxia; and Dysphagia. Review of Resident #110's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed that on the Pain Assessment Interview, the resident self-reported to have had constant pain within the last five (5) days, making it hard for him/her to sleep. Furthermore, he/she rated the experienced pain at a two (2) out of ten (10), with ten (10) being the worst. Further review revealed Resident #110's score on the Brief Interview for Mental Status (BIMS) was nine (9), indicating the resident was cognitively intact. Review of Resident #110's MAR, dated ,d+[DATE], revealed the resident was receiving Oxycodone , d+[DATE] mg (milligrams), one (1) tablet by mouth every six (6) hours, routinely scheduled and not as needed (PRN). (continued on next page)

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	185090	A. Building B. Wing	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #110's Hospital Discharge Summary, dated [DATE], revealed the resident was discharged with Oxycodone/Acetaminophen ,d+[DATE] mg (milligrams), one (1) tablet by mouth every six (6) hours PRN for acute pain, for up to three (3) days, expiring after [DATE]. Further review revealed during the month of [DATE], the resident received as needed, every four (4) hours, Acetaminophen (a non-narcotic pain reliever for mild pain) 325 milligrams (mg), two (2) tablets, on [DATE] at 4:33 AM and at 9:11 AM, both documented as being effective. Per the record, Acetaminophen was again administered to the resident, on [DATE] at 1:00 AM, and, on [DATE] at 4:56 AM. Further, with these administrations, there was no documentation of level of pain, source, or type of pain the resident was experiencing. Review of Resident #110's Care Plan, last reviewed on [DATE], revealed the resident was at risk for alteration in comfort related to osteoarthritis (OA), muscle weakness, right upper extremity edema, contractures, hemiplegia, obesity, and polyneuropathy. The care plan goal was to achieve an acceptable level of pain control. Further review revealed pain interventions included: 1) observe for pain, and attempt non-pharmacological interventions to alleviate pain, and document effectiveness; 2) observe pain characteristics: quality, severity, location, and precipitating/relieving factors; 3) utilize the pain scale for assessment; 4) medicate as ordered for pain, observe for effectiveness and side effects, and report to physician as indicated; 5) observe for non-verbal signs/symptoms of pain; 6) complete pain assessment per protocol; 7) assist to a position of comfort, utilizing pillows as appropriate position devices as needed; 8) observe for change in mood or mental status; and 9) observe for behavioral symptoms for underlying cause, e.g. pain. Observation of Resident #110, on [DATE] at 9:05 AM, revealed the resident yelled for a nurse. Resident was moaning and groaning in pain. Per observation resident showed non-verbal ques of pain with grimacing. No one responded to the resident until the State Survey Agency (SSA) Surveyor alerted staff that the resident needed assistance. However, there was no documented evidence the Physician was notified of the resident's complaints of pain. Additional observation of Resident #110, on [DATE] at 9:20 AM, revealed the resident in bed lying on his/her left side with his/her legs crossed, one over the other, and his/her heels pressed against the mattress; shiny bilateral hands with contractures; and generalized edema was noted over the lower extremities, bilateral hands, and upper extremities. Further observation revealed the resident presented with oily, uncombed hair, and he/she smelled of urine. Interview with Resident #110 revealed he/she communicated verbally, his/her speech was clear, and he/she was able to understand and be understood when speaking. Continued observation revealed the resident's right arm was hanging at the right side of the bed and was not supported with a pillow as noted in the plan of care. In addition, the resident did not have an adaptive call bell equipment as care planned and required for use with the resident's bilateral hand contractures; the resident yelled for staff every time assistance was needed. The SSA Surveyor pressed the call bell to get staff to assist the resident; however, after five (5) minutes, the SSA Surveyor notified State Registered Nurse Aide (SRNA) #11 (the only staff available at the Nurse's Station) that the resident was in pain and needed a nurse immediately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Resident #110, on [DATE] at 9:20 AM, revealed staff did not address his/her chronic pain, and while the resident had resided at the facility, he/she had not received pain medication as needed. The resident stated his/her current level of pain was a ten (10), using a scale of one (1) to ten (10) with ten (10) being the worst pain. Additionally, the resident stated that his/her chronic and uncontrolled pain had prevented his/her mobility. Per interview, the resident stated activities of daily living (ADL's) produced increased pain, and at times, the pain was unbearable. The resident stated due to his/her pain, he/she could no longer transfer to a wheelchair and was bedridden, rendering him/her unable to participate in activities. Further interview revealed, the resident stated I am miserable and I hurt all the time. Per interview the resident stated when he/she told the nurse they wee in pain, no one would help him/her. Interview with the Activity Assistant (AA), on [DATE] at 11:10 AM, revealed Resident #110 was unable to attend group activities and was sleeping a lot more. The AA stated the resident used to get up in a wheelchair and go to Bingo, but had not recently been able to do so due to pain issues. Review of Resident #110's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed that on the Pain Assessment Interview, the resident self-reported to have had constant pain within the last five (5) days, making it hard for him/her to sleep. Furthermore, he/she rated the experienced pain at a two (2) out of ten (10), with ten (10) being the worst. Resident #110's score on the Brief Interview for Mental Status (BIMS) was nine (9), indicating the resident was cognitively intact. Review of Resident #110's MAR, dated , d+[DATE], revealed the resident was receiving Oxycodone ,d+[DATE] mg (milligrams), one (1) tablet by mouth every six (6) hours, routinely scheduled and not as needed (PRN). Review of Resident #110's Hospital Discharge Summary, dated [DATE], revealed the resident was discharged with Oxycodone/Acetaminophen ,d+[DATE] mg (milligrams), one (1) tablet by mouth every six (6) hours PRN for acute pain, for up to three (3) days, expiring after [DATE]. Review of Resident #110's Social Services Assessment, dated [DATE], revealed the resident scored an eleven (11) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) evaluation, indicating the resident was cognitively intact. Further review revealed the resident was able to express ideas and wants, and was able to understand verbal content. Review of Resident #110's Quarterly MDS Assessment, dated [DATE], revealed, on the Pain Assessment Interview, the resident self-reported to have had constant pain within the last five (5) days, making it hard for him/her to sleep. Furthermore, he/she rated the experienced pain at an eight (8) out of ten (10), with ten (10) being the worst. There was no documented evidence the nursing staff notified Resident #110's Physician of a CIC (change in condition) related to increased pain because the pain level had increased from a rating of two (2), on [DATE], or followed the resident's care plan related to pain, according to the facility's policy. Furthermore, review of the resident's MAR, revealed the resident did not have an opioid/narcotic pain reliever ordered after [DATE]. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #110's Change of Condition Transfer Form to the acute care hospital, dated [DATE], revealed the resident was sent to the ED, on [DATE], for generalized edema, atrial fibrillation, and anemia; the resident remained in the ED for approximately five (5) hours. The transfer form, completed by Licensed Practical Nurse (LPN) #13, revealed a numerical pain level of zero (0) out of ten (10) was documented on the MAR for Resident #110, on [DATE] at 10:00 PM. Review of the residents MAR revealed no documented evenidence of a numberical pain assessement since [DATE]. Therefore, Resident #110 had gone nine (9) days without a documented pain assessment on the MAR. Per the facility policy nursing staff would evaluate for the presence of pain daily. However, review of Resident #110's Vital Sign Assessment, revealed, in the month of [DATE] the only pain assessment documented was on [DATE] at 1:00 PM and [DATE] at 10:00 PM. The resident's pain was rated for the 1:00 PM and 10:00 PM assessments was zero (0) out of ten (10). Review of Resident #110's Situation, Background, Assessment, and Recommendation (SBAR) Note, dated [DATE] at 6:00 AM, revealed the resident's CIC evaluation. Resident #110 complained of chest pain. Vital signs included: pulse of one-hundred fifteen (115) beats per minute (BPM), respirations of eighteen (18) per minute, and blood pressure (BP) of ,d+[DATE] mmHg (millimeters of mercury). The SBAR showed there was no documented evidence, per the Care Plan directives, that staff evaluated the intensity, location, and duration of the chest pain; utilized the pain scale; observed or evaluated non-verbal signs/symptoms of pain; or provided medication to the resident to relieve pain. Resident #110 was sent to a local hospital Emergency Department (ED) and was admitted as an inpatient. Review of Resident #110's Hospital ED Admitting Physician Note, dated [DATE], revealed the resident arrived at the ED lethargic, did not move his/her extremities, and moaned with discomfort. Per the ED record, Morphine (an opioid narcotic pain reliever for acute pain) Injection four (4) mg was ordered and given. Review of Resident #110's Hospital ED Face Sheet, dated [DATE], revealed Morphine Injection four (4) mg was added to the resident's hospital medications. Review of Resident #110's Hospital ED Advanced Practice Provider (APP) note, dated [DATE] at 6:19 PM, revealed the resident presented with pain upon arrival to the hospital and moaned with discomfort. Review of Resident #110's Hospital History and Physical (H&P), dated [DATE] at 11:19 PM, revealed the resident experienced pain upon arrival to the hospital. The ED Hospitalist documented the resident had a large ulcer on his/her sacrum that was painful. Review of Resident #110's Hospital Palliative Care APP's note, dated [DATE] at 3:28 PM, revealed the resident presented with several wounds and a painful large wound. Further review of the Palliative Care Note revealed Resident #110 had been ordered Morphine four (4) mg intravenous (IV) every three (3) hours PRN related to wound pain. Interview with State Registered Nurse Aide (SRNA) #11, on [DATE] at 1:50 PM, revealed Resident #110 hurt all the time, especially when he/she was moved. She stated the resident could not tolerate lying on his/her right side. SRNA #11 stated the resident had a hand touch call light (required only a touch to call the nurse). However, the SSA Surveyor observed, on [DATE] at 9:20 AM, the resident did not have an adaptive hand touch call light. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Agency SRNA #21, on [DATE] at 3:04 PM, revealed Resident #110 yelled when he/she needed help and was a total assist for everything, including feeding, changing, and turning due to contractures and chronic pain in both hands. SRNA #21 stated, You can barely touch the resident, and (he/she) will scream out in pain. Per interview, she stated Resident #110 was in chronic pain and usually had bilateral edema in all extremities. SRNA #21 stated she would report Resident #110's pain to the nurses. Interview with SRNA #19, on [DATE] at 1:43 PM, revealed she had cared for Resident #110. SRNA #19 stated Resident #110 complained of chronic pain in his/her right arm and would scream out in pain when touched, moved, or when checked for incontinence or when change in clothing was performed. She stated when residents complained of pain, staff repositioned them, provided comfort measures, and if unrelieved, informed the nurse. SRNA #19 stated if something further needed to be done, the aides could go directly to the Unit Manager. In addition, SRNA #19 stated she would and did report Resident #110's pain to the nurses. Interview with Registered Nurse (RN) #3, on [DATE] at 8:30 AM, revealed Resident #110 did not complain, but if he/she needed assistance he/she would yell out for staff instead of using the call light. RN #3 stated she relied on the SRNA's to alert her about a resident's pain status, and it was important for SRNA's to tell nurses if residents were in pain so the Physician or APRN could get something ordered. Further interview revealed RN #3 utilized a numerical pain scale with alert residents, and a non-verbal scale if a resident was crying, moaning, or was unable to verbalize pain. Interview with LPN #13, on [DATE] at 3:55 PM, revealed she worked with Resident #110 and stated that he/she suffered from chronic pain, especially in the right arm. LPN #13 stated she would expect to see a pain level assessed if the resident was verbal, and if nonverbal, she would expect the nurse to assess for nonverbal cues. She stated she relied on aides to alert her to any CIC they saw in a resident, but she did not recall aides alerting her to Resident #110's pain. LPN #13 stated Resident #110 was getting scheduled pain medication prior to his/her [DATE] admission to the hospital. Per interview, upon readmission to the facility from the hospital, nurses completed a medication reconciliation and then would review the orders with the Physician or the APRN to determine new orders. In addition, she stated the resident would continue on hospital discharge orders until seen by the Physician or APRN. Furthermore, LPN #13 stated any resident that was on a scheduled narcotic pain medication and was sent back from the hospital with it ordered on an as needed (PRN) basis, should have the order clarified with the Physician or the APRN. Per interview, LPN #13 stated she would have questioned why Resident #110 was sent back to the facility on a three (3) day supply of narcotics after being on scheduled narcotics prior to admission. However, LPN #13 stated an agency nurse probably would not have questioned the order because he/she would not be as familiar with the residents. Additionally, LPN #13 stated the nurses were responsible for readmission assessments, which included observing for signs and symptoms of pain. She stated it was not good nursing practice to fail to do this, and it was important to do resident assessments and accurate documentation to ensure quality care was given. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview with Agency LPN #14, on [DATE] at 10:26 AM, revealed she worked all units and had cared for Resident #110 four (4) or five (5) times. Per interview, LPN #14 stated Resident #110 complained of pain anytime he/she was asked. LPN #14 recalled the last time she was assigned to him/her, there was an order for Oxycodone with Acetaminophen for three (3) days for chronic pain in the right arm. Further interview revealed she did not notify the Physician or APRN about continuing the medication because she assumed it would be addressed due to the resident's need for it related to chronic pain. Interview with the Unit Manager (UM), on [DATE] at 1:49 PM, revealed upon admission or readmission, it was the responsibility of the UM to reconcile hospital discharge orders and inform the on-call physician for review. She stated the UM then faxed the Physician's Orders to the Pharmacy and notified the Assistant Director of Nursing (ADON) via text of the admission. Per interview, the UM updated the Care Plan and documented in the Nursing Progress Notes of the admission or readmission. The UM stated she then notified the staff nurse on the unit of his/her assignment to the resident. Interview with Agency LPN #10, on [DATE] at 9:40 AM, revealed she was aware of Resident #110's chronic pain. LPN #10 stated, (He/she) complains of pain with every change. She stated the resident did not open the left hand due to pain. Additionally, LPN #10 stated Resident #110 had bilateral edema in all extremities. Additional interview with Agency LPN #10, on [DATE] at 1:49 PM, revealed she did not recall that she updated Resident #110's Quarterly MDS Pain Assessment Interview, on [DATE], in which she documented Resident #110's self-reported pain as constant, moderate pain and rated it at an eight (8) out of ten (10) with ten (10) being the worst. LPN #10 stated if the resident reported pain and rated it as an eight (8), an assessment and administration of pain medication would be indicated. However, LPN #10 stated she did not know Resident #110 was not being given medication for his/her chronic pain and thought he/she was receiving scheduled narcotics. Furthermore, LPN #10 stated no one had followed-up on Resident #110's discharge orders and medication reconciliation, upon the resident's readmission on [DATE]. LPN #10 stated the importance of medication reconciliation, follow-up, and assessment was to make sure the resident was comfortable and his/her needs were being met. Interview with the Nurse Educator/Wound Care Nurse, RN #2, on [DATE] at 9:00 AM, revealed she was following Resident #110 for wounds on his/her toe, forehead, and shearing on the right buttock. Per interview, RN #2 stated she would have to be very gentle with Resident #110 when moving the resident's extremities to perform wound care because of his/her issues related to chronic pain. Furthermore, RN #2 stated Resident #110, when touched, would moan and grimace. RN #2 stated she did not document Resident #110's non-verbal pain response to care and treatments or his/her pain level. Further interview revealed if there was an order for pain medication, she would generally premedicate residents prior to wound care. RN #2 did not recall providing pain medication to Resident #110 prior to wound care treatments. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the ADON (Assistant Director of Nursing), on [DATE] at 4:40 PM, revealed she was not made aware that nursing staff failed to notify the Physician or the APRN to reorder the resident's scheduled narcotic pain medication after the three (3) day order had expired on [DATE]. She stated all readmissions were reviewed in clinical meetings, but she did not recall reviewing Resident #110's hospital discharge orders. Per interview, it was the ADON's expectation that nursing staff clarified orders with the provider, so the correct orders were followed. Furthermore, she stated she expected nurses to assess and document resident's assessments, using the numerical pain scale of one (1) to ten (10) with ten (10) being the worst pain, and for nonverbal residents, using the Morse Pain Scale (uses faces to mimic pain levels). The ADON stated it was important to use the pain scale to understand better a person's pain and to measure the effectiveness of treatment. In addition, the ADON stated she expected nursing staff to assess pain according to what the resident self-reported and to never assume the degree to which a resident was in pain because it could harm residents, stating Pain is what the resident says it is. Per interview, it was the ADON's expectation that nursing staff would notify the Physician or APRN for a resident's unresolved pain or clarification of orders should there be any question regarding a resident's care to ensure the resident was comfortable and correct care was being given. However, record review revealed there was no documented evidence the nursing staff notified the Physician that the resident was no longer on schedule Oxycodone with Acetaminophen after returning from the hospital. Furthermore, there was no documented evidence that the nursing staff notified the Physician of a CIC related to pain, according to facility policy. Interview with the Regional Clinical Quality Specialist (RCQS), on [DATE] at 3:40 PM, revealed it was her expectation that nursing staff utilized skilled charting to document the resident's pain level using a scale of one (1) to ten (10) with ten (10) being the worst pain, as well as assess for nonverbal pain cues. Per interview, it was important to assess, using a pain scale, to indicate the resident's response to questions about pain to determine treatment and alleviate suffering. The RCQS stated staff should not assume a resident's tolerance of pain, and pain was what the resident considered as pain. Per interview, she was not aware Resident #110 was not receiving scheduled pain medication. Furthermore, she stated nursing staff was to reassess the resident's pain level after administration of pain medications for effectiveness and document its effectiveness on the Medical Administration Record (MAR). The RCQS stated, with Resident #110's pain management, there was a communication breakdown because there was no documented evidence the nursing staff notified the Physician or the APRN of a CIC related to pain, according to facility policy. Further interview with the RCQS, revealed the DON reviewed each resident's pain level scores; if the resident was rated at a 0, she did not follow-up with the resident. Additional interview with the RCQS, on [DATE] at 5:06 PM, revealed it was the nurse's responsibility to ensure medications were verified with the Admitting/Readmitting Physician and necessary prescriptions were obtained and sent to the Pharmacy. Per interview, after an admission/readmission, it was also the Unit Manager's responsibility to contact the on-call provider for necessary prescriptions. The RCQS stated it was important that residents received ordered pain medication to ensure optimum care, effective treatment, and control of pain, according to facility policy. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the APRN, on [DATE] at 2:30 PM, revealed she was aware the resident had chronic pain and mobility issues, used opioid medications and took Oxycodone ,d+[DATE] mg (milligrams), one (1) tablet by mouth every six (6) hours, scheduled, prior to his/her admission to the hospital on [DATE]. However, nursing staff did not make her aware the Oxycodone ,d+[DATE] mg, one (1) tablet by mouth every six (6) hours as needed for pain was only prescribed for three (3) days and was PRN. She stated Resident #110 had chronic pain and that most recently in the last months, she changed the resident's pain medication from PRN to scheduled, four (4) times a day for better pain control. Per interview, if she had known, she would have ordered to continue the scheduled Oxycodone ,d+[DATE] mg four (4) times a day. However, record review revealed no documented evidence the nursing staff notified the APRN that the resident was no longer on scheduled Oxycodone after returning from the hospital. Furthermore, there was no documented evidence the nursing staff notified the APRN of a CIC related to pain, or followed the resident's care plan related to pain, according to facility policy. She further stated it was her expectation for staff to inform her if there was a discrepancy with orders. The APRN stated she would have ensured Resident #110 had his/her pain medication. Interview with the Physician, on [DATE] at 10:15 AM, revealed he was aware the resident was receiving Tylenol for pain; however, he was not aware the Oxycodone ,d+[DATE] mg four (4) times a day, scheduled, had not been renewed after a three (3) day prescription from the acute care facility. He stated he would have expected staff to notify him or the APRN that the order had expired. Per interview, expiring medications were put into a book that was on each unit, which he or the APRN reviewed on each visit to the facility. However, the Physician stated there were no view alerts to let the providers know if a medication was expiring, the nursing staff was responsible for the alert. Further interview revealed, before reducing a narcotic that the resident had taken for a period of time, he looked at the duration the resident had been on the narcotic and could gradually decrease the frequency or the dosage given. He stated, in reducing narcotic pain medication, or at any time, he depended on nurses to inform him if a resident was having or continued to have pain or had increasing pain. There was no documented evidence the nursing staff notified the Physician the resident was no longer on scheduled Oxycodone after he/she returned from the hospital. Interview with the Director of Nursing (DON), on [DATE] at 9:18 AM, revealed residents with pain should have a pain assessment completed; the pain assessment was triggered in the Electronic Medical Record (EMR) and alerted the nurse to assess and document interventions. The DON stated it was important to assess, using a pain scale, to indicate the resident's response to questions about pain to address and treat the resident appropriately. Regarding resident admission orders, the DON stated the reconciliation was a work in progress for the unit nurse and the UM, who were responsible for new admissions and readmission reconciliations and following-up if any questions or for clarifications. She stated she expected nurses to assess for pain when a resident returned from the hospital, and if a resident had a complaint of pain, the nurse would discuss his/her assessment with the Physician, who would follow-up, possibly with new orders. The DON stated that follow-up on admission/readmission orders was important to address and treat the resident appropriately. Per interview, the DON stated there was no documented evidence the nursing staff notified the Physician that the resident was no longer on scheduled Oxycodone, after returning from the hospital. Interview with the Administrator, on [DATE] at 5:28 PM, revealed she expected residents with pain to have pain management per standards of practice; pain should be assessed and documented when noted. Continued

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 41721 Based on interview, record review, and review of the facility's Policy, it was determined the facility failed to ensure the consultant pharmacist's recommendation from the monthly medication regimen reviews (MRR) were received, reviewed, and acted upon by the Attending Physician or Advanced Registered Nurse Practitioner (ARNP) for five (5) of thirty (30) sampled residents (Residents #49 #64, #101, #114 and #125). The Pharmacist made monthly MRR reports on each resident and sent the medication irregularities to the facility via email. However, there was no documented evidence the facility regularly provided the reports to the care providers in a timely manner or reviewed the reports in the Quality Assurance and Performance Improvement (QAPI) meetings, as per policy. The findings include: Review of the facility's Policy, Medication Regimen Review, effective [DATE] and revised [DATE], revealed that when the MRR Consultant Report was received from the Consultant Pharmacist, the Center Nurse Executive (CNE) would provide copies to the attending physician and the Medical Director. The MRR Consultant Report, that required a response from the attending Physician, including all reports of irregularities, would be filed in the physician's communication folder. The attending Physician/Advanced Registered Nurse Practitioner (ARNP) must review each MRR Consultation Report, document a response, sign, and return the report to the facility within 30 days of the date of the MRR Consultant Report. Continued review revealed the facility would review the MRR Consultation Reports and Quarterly Quality Assurance Reports in the QAPI meeting. The review would be documented in the QAPI minutes. The CNE or designee would ensure follow-up of the pharmacist's recommendations. If the attending physician/ARNP did not choose to follow the Pharmacist's recommendation, it was his/her responsibility to document the clinical reason in the medical record. Copies of MRRs were maintained in the facility either as part of the patient's (resident's) medical record or in a special file according to applicable law. Review of the Pharmacy's policy titled, Medication Regimen Review, for Long Term Care Facilities Receiving Pharmacy Products and Services from Pharmacy, effective [DATE] and [DATE], revealed the Consultant Pharmacist would conduct MRRs if required, under a Pharmacy Consultant Agreement and make recommendations based on the information available in the resident's health record. The Pharmacist would address copies of residents' MRRs to the Director of Nursing and/or the attending Physician and the Medical Director. Facility staff should ensure that the attending Physician, Medical Director, and Director of Nursing were provided with copies of the MRRs. The facility should encourage the Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. The attending Physician should document in the resident's health record that the identified irregularity had been reviewed and what action had been taken to address it. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Quality Assurance Performance Improvement (QAPI) meeting agenda, for 2021 revealed that MRR Consultation Reports were not on the agenda for review as per the facility's policy. Review of the Pharmacy Consultant Pharmacist Medication Regimen Reviews Summary report, dated February 1, 2021, through February 26, 2021, revealed the consultant pharmacist presented one hundred fifty-three (153) reviews performed, with (80) recommendations presented. However, there was no documented evidence the reports had been reviewed or documentation of actions taken. Review of the Pharmacy Consultant Pharmacist Medication Regimen Reviews Summary report dated [DATE] through [DATE] revealed there were one hundred fifty-six (156) reviews performed, with seventy-two (72) recommendations presented. However, there was no documented evidence the reports had been reviewed or documentation of actions taken. 1. Medical record review revealed the facility admitted Resident #49 on [DATE], with diagnoses that included Acute Embolism and Thrombosis of Unspecified Deep Veins of Right Lower Extremity, Coagulation Defect and Dementia. Review of the Annual Minimum Data Set (MDS)for Resident #49, dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was cognitively intact. Review of the Physician's Orders for Resident #49's, dated [DATE], revealed Apixaban (anticoagulant) five (5) mg to be administered orally two (2) times daily, Aspirin eighty-one (81) mg to be administered one (1) time daily and Clopidogrel Bisulfate Tablet (antiplatelet) seventy-five (75) mg to be administered once daily. Review of the Pharmacy Medication Regiment Review report for Resident #49, dated [DATE], revealed the consultant pharmacist made recommendations to consider discontinuing Apixaban, Aspirin Low strength and Clopidogrel since the resident had been receiving since ,d+[DATE]. Continued review of the Pharmacy Medication Regiment Review revealed the recommendation(s) had been made previously on [DATE], [DATE], and [DATE]. Per the report, there was increased risk for serious, potentially fatal bleeding, concurrent use of Apixaban or Edoxaban and medications, which may increase the risk for bleeding, should be used with caution. Per the report, the manufacturer recommended against the concomitant use of anticoagulants and stated that long-term safety of concomitant aspirin or NSAID (nonsteroidal antiinflammatory drugs) use had not been studied . If both therapies were to continue, it was recommended that the prescriber document an assessment of risk versus benefit, indicating that it continued to be a valid therapeutic intervention for this individual; and (b) the facility's interdisciplinary team (IDT) should ensure ongoing monitoring for effectiveness and potential adverse consequences. Continued review of the Pharmacy Medication Regimen Review report revealed the Health Care Provider failed to acknowledge the pharmacy's recommendations until [DATE]. On [DATE], the provider discontinued the Clopidogrel and Aspirin. 2. Medical record review revealed the facility admitted Resident #64 on [DATE], with diagnoses that include Paraplegia, Chronic Kidney Disease, Above Knee Amputation of Right and Left Leg, Major Depressive Disorder, Unspecified Mood Affective Disorder and Anxiety Disorder. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quarterly Minimum Data Set (MDS) Resident #64, dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact. Review of the Physician's Orders for Resident #64, revealed an order dated [DATE] for Amitriptyline (antidepressant) fifty (50) mg to be administered orally each night at bedtime. Continued review revealed an order dated [DATE] for Olanzapine (antipsychotic) five (5) mg to be administered orally each day. Further review of the Physician's Orders revealed an order, dated [DATE], for Duloxetine (antidepressant) sixty (60) mg to be administered orally each day. Review of the Pharmacy Medication Regimen Review report for Resident #64, dated [DATE], revealed the consultant pharmacist made recommendations for a gradual dose reduction (GDR) of Amitriptyline fifty (50) milligrams (mg) administered every night at bedtime (QHS) with the initial order dated ,d+[DATE]; Olanzapine five (5) mg administered daily with the initial order dated [DATE] and Duloxetine sixty (60) mg administered daily initially ordered [DATE]. Per the report, recommended the GDR should be attempted in two (2) separate quarters, with at least one (1) month between attempts within the first year in which an individual was admitted on psychotropic medication or after the facility initiated such medicines, and then annually unless clinically contraindicated. If the therapy was to continue, it was recommended that the prescriber document in the resident's medical record an assessment of risk versus benefit; documentation of specific target behavior, desired outcome, and the effectiveness of individualized, non-pharmacological interventions e.g., cognitive behavioral therapy, and the facility's interdisciplinary team ensured ongoing monitoring for effectiveness and potential adverse consequences. Continued review of the Pharmacy Medication Regimen Review report, revealed the Health Care Provider failed to acknowledge the pharmacy's recommendations for the medications until [DATE], with a stamped signature and a stamped message indicating no change. There was no documented evidence an explanation or rationale for the decision was provided, per the facility's policy. 3. Medical record review revealed the facility admitted Resident #101 on [DATE] with diagnoses that included Chronic Kidney Disease, Muscle Weakness, Cerebellar Stroke Syndrome, Vascular Dementia without Behavior Disturbance, Major Depressive Disorder, Cerebral Infarction, Acute Failure to Thrive and Generalized Anxiety Disorder. Review of Resident #101's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Review of the Physician's Orders for Resident #101 revealed an order, dated [DATE] for Citalopram (antidepressant) twenty (20) mg to be administered orally daily and an order for Olanzapine (antipsychotic) five (5) mg to be administered orally daily for expressions or indications of distress related to dementia. Continued review revealed a Physician's Order, dated [DATE], for Gabapentin (anticonvulsant) one hundred (100) mg to be administered orally two (2) times each day. Further review of the Physician's Oders revealed an order, dated [DATE], for Oxycodone HCL (opioid analgesic) five (5) mg to administer two (2) tablets orally every six (6) hours. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of of the Pharmacy Medication Regimen Review report for Resident #101, dated [DATE], revealed the consultant pharmacist requested a prompt response to repeated medication review recommendations from [DATE] and [DATE]. Continued review revealed the medications for review were Olanzapine five (5) mg daily for expressions or indications of distress related to dementia, Citalopram twenty (20) mg daily, Gabapentin one hundred (100) mg administered two times each day and Oxycodone HCL five (5) mg tablets to administer two (2) tablets orally every six (6) hours. The rationale for this recommendation was that CMS (Centers for Medicare and Medicaid) required that antipsychotics used to treat expressions or indications of distress related to dementia be evaluated quarterly with documentation in the resident's medical record regarding continued clinical appropriateness. Olanzapine five (5) mg daily and Citalopram twenty (20) mg daily was last ordered by the physician on [DATE]. Gabapentin one hundred (100) mg twice daily was last ordered on [DATE], and Oxycodone five (5) mg was ordered [DATE]. However, there was no documented evidence the MD (medical doctor) responded to the recommendations until [DATE]. 4. Medical record review revealed the facility admitted Resident #114, on [DATE], with diagnoses that included Hemiplegia Affecting the Left Dominant Side, Dysphagia, History of TIA (transient ischemic attack/stroke), Cognitive Communication Deficit, Epilepsy, Vascular Dementia with Behavioral Disturbance, Unspecified Mood Disorder, Major Depressive Disorder and Generalized Anxiety Disorder. Review of the Annual Minimum Data Set (MDS) for Resident #114, dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15), indicating the resident was moderately cognitively impaired. Review of the Physician's Orders for Resident #114 revealed an order, dated [DATE], for Quetiapine (antipsychotic) twelve and one-half (12.5) mg to be administered orally each night at bedtime for anxiety. Review of the Pharmacy Medication Regimen Review report for Resident #114, dated [DATE], revealed this was a repeat Pharmacy recommendation with the original recommendation made on [DATE] for the facility to respond promptly to consider a trial discontinuation of Quetiapine twelve and one half (12.5) mg at bedtime (QHS), while concurrently monitoring for a reemergence of target behaviors and/or withdrawal symptoms. The resident was receiving Quetiapine QHS for expressions or indications of distress related to dementia. Per the recommendation, the rationale was that CMS required that antipsychotics, used to treat expressions or indications of distress related to dementia be evaluated quarterly with documentation in the resident's medical record regarding continued clinical appropriateness. Quetiapine was ordered for this resident on [DATE]. However, there was no documented evidence the MD responded to the recommendations until [DATE]. 5. Medical record review revealed the facility admitted Resident #125 on [DATE] with diagnoses that included Pneumonia, Multiple Sclerosis, Alzheimer's Disease Unspecified, Dementia, Abnormal Posture, Cognitive Communication Deficit, Hemiplegia, Anxiety Disorder and Major Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) for Resident #125, dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15), indicating the resident was moderately impaired cognitively. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Physician's Orders for Resident #125 revealed an order, dated [DATE], for Citalopram (antidepressant) thirty (30) mg to be administered once each day and Lorazepam (benzodiazepine - anti-anxiety) one-half (0.5) mg to be administered orally every twelve (12) hours. Review of the Pharmacy Medication Regimen Review report for Resident #125, dated [DATE], revealed the consultant pharmacist repeated the first recommendation made on [DATE] regarding Resident #125's medications. The medications for review were Citalopram thirty (30) mg daily and Lorazepam one-half (0.5) mg every twelve (12) hours, both medications were initially ordered on [DATE]. Per the report, the rationale for this recommendation was a GDR should be attempted in two (2) separate quarters, with at least one (1) month between quarters. If the therapy was to continue, it was recommended that the prescriber document in the resident's medical record an assessment of risk versus benefit, contain specific target behavior, desired outcome, and the effectiveness of individualized, non-pharmacological interventions, e.g., cognitive behavioral therapy, and the facility's interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences (e.g., drowsiness, nausea, headache). However, there was no documented evidence the MD responded to the recommendations until [DATE]. Phone interview with the Clinical Pharmacist Consultant, on [DATE] at 11:39 AM, revealed the Pharmacy provided pharmacy services on a contractual basis. The Pharmacy had remote access to the facility's Electronic Medication Administration Record (eMAR). She revealed the process for conducting Medication Regimen Review (MRR) involved looking at certain classifications of medications such as psychotropic medications, such as Prozac, Abilify, Depakote (not used for seizures), used for behaviors. Continued interview revealed during their review, they reviewed the resident's medical record. They look at medications, dosages, indications, and based on regulations, inform the facility of their recommendations. Per interview, the Pharmacist usually recommended only reducing one medication at a time so that if there was a reaction to the dose reduction, it was easier to know which drug the resident had a response. Continued interview revealed a twelve (12) week waiting period between each decrease to determine which drug affected the resident. In addition to looking at regulation requirements, the Pharmacist also looked at the resident's progress notes, nurses' notes, and psych notes. She stated the Medication Regimen Reviews were conducted monthly. Continued interview revealed the Pharmacist sent a summary report of irregularities and recommendations via email monthly to the Director of Nurses (DON) and the Administrator. Interview with the Nurse Practitioner (ARNP), on [DATE] at approximately 12:00 PM, revealed she had been employed approximately one year as the Nurse Practitioner Consultant to the facility. She stated it was a part of her responsibility to review the Pharmacy Medication Regimen Review and take appropriate actions as needed. Further interview revealed the pharmacy sent MRR findings and recommendations to the facility. She stated the nursing staff would give these recommendations to the ARNP and the MD. Continued interview revealed that receiving those reports was often sporadic and not provided on a routine basis. She stated for a while, she did not see many; however, she started seeing more of them recently. The ARNP stated when she received pharmacy recommendations, she responded to them. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Director of Nurses (ADON), on [DATE] at 5:00 PM, revealed she had been the ADON since [DATE]. Per interview, oversight of MRR was not one of her roles and responsibilities; however, the expectation was that the reports were received, reviewed, and acted upon timely. She stated that MRRs were performed, so that all medications were reviewed and tracked for proper usage and efficacy. In addition, the expectation was that each resident's psychotropic drug regimen and other medications requiring GDR were managed and monitored to promote their highest level of functioning and that recommendations were responded to promptly by the MD or ARNP. She added that the pharmacy kept track to see if the resident had been on the medication too long and without adverse effects. In addition, if recommendations were made, and there was no response to the recommendations, staff would need to find out where the breakdown occurred. She stated there should be documented rationale(s) for not taking the recommendation. Interview with the Regional Clinical Quality Director, on [DATE] at 2:37 PM, revealed she was the acting DON. She stated the MRR process was that the Pharmacist would perform a chart review, put together a monthly report, and fax the information to the facility. The DON would receive the report and disseminate the reports to staff and others who needed it. The reports were reviewed, and agreed upon recommendations were entered into the electronic health record (PCC). For those recommendations not approved by the provider, a rationale was placed in the resident's medical record. Continued interview revealed it was her expectation that staff and providers review the reports, make appropriate recommendations, and act accordingly. In addition, she said the facility switched from paper to iPad entries into the medical record, and there was a breakdown in the process when the changeover occurred. The facility was looking at this entire process, and making changes to ensure that medication reviews were received and delivered to the appropriate personnel more efficiently. She stated the facility could not provide evidence of emails/faxes of MRR irregularity reports sent to the DON and/or Administrator by the Pharmacist or documentation that the appropriate provider received the report. Interview with the Administrator, on [DATE] at 5:34 PM, revealed she absolutely expected MRR reports to be appropriately received, reviewed, and actions taken. Adding she wanted to start a new process based on the recent revelation that there was a breakdown in the current process. Per interview, as soon as an irregularity was received or a recommendation was made, the team would sit down and address the concern promptly. The additional step would become a part of the new process to assure that everything was done as required and per their policy. She stated Pharmacy recommendations had gotten lost in faxes and emails. She stated the rationale for monitoring medications or failure to monitor medications properly would keep residents from functioning at their highest practical level.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 41721 Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident's drug regimen was free from unnecessary drugs and psychotropic drug regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. The facility failed to ensure that medication gradual dose reduction (GDR) recommendations from the consultant pharmacist were received and responded promptly by the care providers, to ensure residents did not receive unnecessary drugs or failed to indicate that the continued use of the drug to be a valid therapeutic intervention for five (5) of thirty (30) sampled residents (Resident #49, #64, #101, #114 and #125). The findings include: Review of the facility's policy, Medication Regimen Review, (MRR) effective date [DATE], and revised [DATE], revealed that when the MRR Consultant Report was received from the Consultant Pharmacist, the Center Nurse Executive (CNE) would provide copies to the attending physician and Medical Director. The MRR Consultant Reports that required a response from the attending Physician, including all reports of irregularities, would be filed in the physician's communication folder. The attending Physician/Advanced Registered Nurse Practitioner (ARNP) must review each MRR Consultation Report, document a response, sign, and return the report to the Center. The facility must receive a response from the practitioner within thirty (30) days of the date of the MRR Consultant Report. The facility would review the MRR Consultation Reports and Quarterly Quality Assurance Reports in the QAPI meeting and document them in the QAPI minutes. The CNE or designee would ensure follow-up of the pharmacist's recommendations. If the attending physician/ARNP chose not to follow the Pharmacist's recommendation, it was his/her responsibility to document the clinical reason in the medical record. Copies of the MRRs were maintained in the facility either as part of the patient's (resident's) medical record or in a special file according to applicable law. Review of the Pharmacy's policy titled Psychotropic Medication Use, effective [DATE], and revised [DATE], revealed a psychotropic drug was any medication that affects brain activities associated with mental processes and behavior. The facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services (CMS), the State Operations Manual (SOM), and all other applicable laws relating to the use of psychopharmacologic medications, including gradual dose reductions. The facility should ensure that the ordering Physician/Prescriber reviews the medication plan and considers a gradual dose reduction (GDR) of psychotropic medications for finding the lowest effective dose unless a GDR was clinically contraindicated. The Physician/Prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Pharmacy's policy titled Medication Regimen Review, for Long Term Care Facilities Receiving Pharmacy Products and Services from Pharmacy, effective [DATE] and [DATE], revealed the consultant pharmacist would conduct MRRs if required, under a Pharmacy Consultant Agreement and make recommendations based on the information available in the resident's health record. The Pharmacist would address copies of residents' MRRs to the Director of Nursing and/or the attending Physician and the Medical Director. Facility staff should ensure that the attending Physician, Medical Director, and Director of Nursing were provided copies of the MRRs. The facility should encourage the Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. The attending Physician should document in the resident's health record that he/she reviewed the identified irregularity and what action was taken to address it. Review of the facility's Quality Assurance Performance Improvement (QAPI) meeting agendas, for 2021 revealed that MRR Consultation Reports were not on the agenda for review. 1. Record review revealed the facility admitted Resident #49 on [DATE], with diagnoses to include Dementia, Acute Embolism and Thrombosis of Unspecified Deep Veins of Right Lower Extremity, and Coagulation Defect. Review of Resident #49 Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident to be cognitively intact. Review of Resident #49's Physician's Orders, dated [DATE], revealed Apixaban (anticoagulant) five (5) mg was ordered to be administered orally two (2) times daily, Aspirin Tablet eighty-one (81) mg to be administered orally one (1) time daily and Clopidogrel Bisulfate Tablet (antiplatelet) seventy-five (75) mg to be administered orally once daily. Review of Resident #49 Pharmacy Medication Regiment Review report, dated [DATE], revealed the consultant pharmacist made recommendations to consider discontinuing Apixaban, Aspirin Low strength and Clopidogrel since the resident had been receiving these medications since ,d+[DATE]. Continued review of the Pharmacy Medication Regiment Review report revealed the repeated recommendation(s) dated [DATE], [DATE], and [DATE]. Per the report, there was an increased risk for serious, potentially fatal bleeding, with the concurrent use of Apixaban or Edoxaban and medications, which may increase the risk for bleeding, and should be used with caution. Per the report, the manufacturer recommended against the concomitant use of anticoagulants and stated that long-term safety of concomitant aspirin or NSAID use had not been studied . Combination therapy with an antiplatelet agent may be an appropriate choice in select higher risk individuals. Continued review revealed if concomitant therapy was to continue, it was recommended that the prescriber document an assessment of risk versus benefit, indicating that it continued to be a valid therapeutic intervention for this individual; and (b) the facility's interdisciplinary team ensured ongoing monitoring for effectiveness and potential adverse consequences (unusual bruising, bloody or black tarry stools, red or dark brown urine, abdominal pain or swelling, bleeding gums or nose). Any of these symptoms should be reported to the prescriber immediately. Further review of the Pharmacy Medication Regimen Review report revealed the Health Care Provider failed to acknowledge the pharmacy's recommendations until [DATE]. On [DATE], the provider discontinued the Clopidogrel and Aspirin. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review revealed the facility admitted Resident #64 on [DATE], with diagnoses to include Paraplegia, Chronic Kidney Disease, Above Knee Amputation of Right and Left Leg, Major Depressive Disorder, Unspecified Mood Affective Disorder and Anxiety Disorder. Review of the Quarterly Minimum Data Set (MDS) for Resident #64, dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact. Review of Resident #64's Physician Orders revealed an order dated [DATE] for Amitriptyline (antidepressant) fifty (50) mg to be administered orally every night at bedtime. Continued review revealed an order dated [DATE] for Olanzapine (antipsychotic) five (5) mg to be administered orally daily. Further review revealed an order, dated [DATE], for Duloxetine (antidepressant) sixty (60) mg to be administered orally daily. Review of the Pharmacy Medication Regimen Review report, dated [DATE], revealed the consultant pharmacist made recommendations for a gradual dose reduction (GDR) on Resident #64's Amitriptyline fifty (50) milligram (mg) to be administered every night at bedtime (QHS), ordered on [DATE]; Olanzapine five (5) mg, ordered on [DATE]; and Duloxetine sixty (60) mg daily, ordered on [DATE]. Per the report, the GDR should be attempted in two (2) separate quarters, with at least one month between attempts within the first year in which an individual was admitted on psychotropic medication or after the facility had initiated such medicines, and then annually unless clinically contraindicated. If the therapy was to continue, it was recommended that the prescriber document an assessment of risk versus benefit; the documentation should contain documentation of the specific target behavior, desired outcome, and the effectiveness of individualized, non-pharmacological interventions, e.g., cognitive behavioral therapy, and the facility's interdisciplinary team ensured ongoing monitoring for effectiveness and potential adverse consequences, e.g. , nausea, appetite changes, falls, etc.). Continued review revealed, the health care provider acknowledged the pharmacy's recommendations on [DATE], with a stamped signature and a stamped message of no change. However, there was no documented evidence an explanation or rationale for the decision was documented in the resident's medical record, as per policy. 3. Record review revealed the facility admitted Resident #101 on [DATE] with diagnoses to include Chronic Kidney Disease, Muscle Weakness, Cerebellar Stroke Syndrome, Vascular Dementia without Behavior Disturbance, Major Depressive Disorder, Cerebral Infarction, Acute Failure to Thrive and Generalized Anxiety Disorder. Review of Resident #101's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident to have Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident to be cognitively intact. Review of the Physician's Orders for Resident #101 revealed an order, for Citalopram (antidepressant) twenty (20) mg to be administered orally each day and an order for Olanzapine (antipsychotic) five (5) mg to be administered orally daily for expressions or indications of distress related to dementia. Continued review revealed an order, dated [DATE], for Gabapentin (anticonvulsant) one hundred (100) mg to be administered orally two (2) times a day. Further review revealed an order, dated [DATE], for Oxycodone five (5) mg to be administer two (2) tablets orally every six (6) hours. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Pharmacy Medication Regimen Review report, dated [DATE], revealed the consultant pharmacist requested a prompt response to repeated medication review recommendations made on [DATE] and [DATE] of Resident #101's medications. The medications requested for review were Olanzapine five (5) mg daily for expressions or indications of distress related to Dementia, Citalopram twenty (20) mg daily, Gabapentin one hundred (100) mg administered two (2) times a day, and Oxycodone HCL five (5) mg to be administered two (2) tablets every six (6) hours. The rationale for this recommendation was that CMS required that antipsychotics to treat expressions or indications of distress related to Dementia be evaluated quarterly with documentation regarding continued clinical appropriateness. Olanzapine and Citalopram were last ordered on [DATE]. Gabapentin was last ordered on [DATE], and Oxycodone was ordered on [DATE]. On [DATE], the MD declined the recommendations stating the GDR was clinically contraindicated for this individual, adding a GDR attempt at this time was likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented and the resident was stable on the regimen. 4. Record review revealed the facility admitted Resident #114 on [DATE] with diagnoses to include Hemiplegia Affecting the Left Dominant Side, Dysphagia, History of TIA, Cognitive-Communication Deficit, Epilepsy, Vascular Dementia with Behavioral Disturbance, Major Depressive Disorder, Generalized Anxiety Disorder and Unspecified Mood Disorder. Review of Resident #114's Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15) indicating the resident to be moderately cognitively impaired. Review of Resident #114's Physician's Orders revealed an order, dated [DATE], for Quetiapine (antipsychotic) twelve and one-half (12.5) mg to be administered orally at bedtime for anxiety. Review of the Pharmacy Medication Regimen Review report, dated [DATE], revealed the consultant Pharmacist repeated the recommendation made on [DATE] for the facility to respond promptly to consider trial discontinuation of Resident #114's Quetiapine twelve and one-half (12.5) mg at bedtime (QHS), while concurrently monitoring for a reemergence of target behaviors and/or withdrawal symptoms. Continued review revealed the resident was receiving Quetiapine for expressions or indications of distress related to Dementia. The rationale for this recommendation was that CMS required that antipsychotics used to treat expressions or indications of distress related to Dementia, was evaluated quarterly with documentation regarding continued clinical appropriateness. The care provider ordered the Quetiapine on [DATE]. On [DATE], the Physician documented to decline the recommendation stating the GDR was clinically contraindicated for this individual. Further review of the Physician's decline revealed a GDR attempt at this time was likely to impair this individual's function or increase distress behavior as documented; however, there was no documented evidence of behaviors listed or documented on the response. 5. Record review revealed the facility admitted Resident #125 on [DATE] with diagnoses to include Pneumonia, Multiple Sclerosis, Alzheimer's Disease Unspecified, Dementia, Abnormal Posture, Cognitive-Communication Deficit, Major Depressive Disorder, Anxiety Disorder and Hemiplegia. Review of Resident #125's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15), indicating the resident to be moderately impaired cognitively. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #125's Physician's Orders revealed an order, dated [DATE], for Citalopram (antidepressant) thirty (30) mg to be administered orally daily and Lorazepam (benzodiazepine - anti-anxiety) one-half (0.5) mg to be administered orally every twelve (12) hours. Review of the Pharmacy Medication Regimen Review report, dated [DATE], revealed the Consultant Pharmacist repeated the first recommendation made on [DATE] regarding Resident #125's medications. The medications for review were Citalopram thirty (30) mg daily and Lorazepam one-half (0.5) mg every twelve hours, both ordered on [DATE]. The rationale for this recommendation was a GDR should be attempted in two (2) separate quarters, with at least one month between quarters. If the therapy was to continue, it was recommended that the prescriber document an assessment of risk versus benefit, it contained specific target behavior, desired outcome, and the effectiveness of the individualized, non-pharmacological interventions, e. g., cognitive behavioral therapy and the facility's interdisciplinary team ensured ongoing monitoring for the effectiveness and potential adverse consequences (e.g., drowsiness, nausea, headache). Continued review revealed the Physician responded to the recommendations on [DATE]. On [DATE], the MD declined the recommendation stating a GDR was clinically contraindicated for this individual. A GDR attempt at this time was likely to impair this individual's function or increase distress behavior as documented; however, there was no documented evidence of behaviors listed or documented in the response. Phone interview with Clinical Pharmacist Consultant, on [DATE] at 11:39 AM, revealed the pharmacy provided pharmacy services to the facility on a contractual basis. The pharmacy had remote access to the facility's electronic eMar. She reported the process for conducting Medication Regimen Review (MRR) and Gradual Dose Reduction (GDR) involved looking at certain classifications of medications such as psychotropic meds, such as Prozac, Abilify, Depakote (not used for seizures), used for behaviors. They look at dosages, indications, and based on regulations, inform the facility when it was time to consider a GDR. Per interview, the Pharmacist usually recommended only reducing one medication at a time. If there was a reaction to the dose reduction, it was easier to know which drug. Continued interview revealed there should be a twelve (12) week waiting period between each decrease to determine which drug affected the resident. In addition to looking at regulation requirements, the Pharmacist would also look at the resident's progress notes, nurses' notes, and psych notes twice a year based on the regulations. She stated for Dementia purposes, the review was conducted quarterly and the Medication Regimen Reviews were conducted monthly. Further interview revealed the Pharmacist sends a summary report of irregularities and recommendations via email monthly to the Director of Nurses (DON) and the Administrator. Interview with Advanced Registered Nurse Practitioner (ARNP), on [DATE] at approximately 12:00 PM, revealed she had been employed for about one year as a Nurse Practitioner Consultant to the facility. Continued interview revealed it was part of her responsibility to review the Pharmacy recommendations and to take action on the recommendations. She stated that the Pharmacy sends the MRR and GDR findings and recommendations to the facility. The ARNP stated she was unsure of the method, but she knew that the staff received the recommendations from the DON. The nursing staff gave the recommendations to the ARNP and the MD. Continued interview revealed that receiving the reports were often sporadic and not provided on a routine basis. She stated for a while, she did not see many; however, she started seeing more of them recently. In addition, she stated the facility would sometimes talk to the MD about GDR, and they followed the doctor's orders. She stated that when she received pharmacy recommendations, she responded to them. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Director of Nurses (ADON), on [DATE] at 5:00 PM, revealed that oversight of the MMR and GDR was not one of her roles and responsibilities; however, the expectation was that the reports were received, reviewed, and acted upon timely. She stated that MRRs and GDRs were to be reviewed and tracked for proper usage and efficacy. In addition, the expectation was that each resident's psychotropic drug regimen and other medications requiring GDR were managed and monitored to promote their highest level of functioning and that recommendations were responded to promptly by the MD or ARNP. The ADON stated there needed to be a documented rationale for not taking the recommendations. She added that the Pharmacy kept track to see if the resident had been on the medication too long and without adverse effects. In addition, if the Pharmacist made recommendations, and there were no responses to the recommendations, staff would need to determine the breakdown. Interview with the Regional Clinical Quality Director, on [DATE] at 2:37 PM, revealed she was acting for the DON, as the DON was out of the facility. She stated the Center's Nurse Executive was the DON. Per the interview, the GDR process was a part of the MRR process. She reported the Pharmacist would perform a chart review, put together a monthly report, and fax the information to the facility. The DON received the report and disseminates the report to staff and others who needed it. Per interview, the reports were reviewed, and agreed upon recommendations were entered into the electronic health record (PCC). For those recommendations not approved by the provider, a rationale would be placed in the medical record by the provider. Continued interview revealed it was expected that staff and providers review the reports, make appropriate recommendations, and act accordingly. In addition, she said the facility switched from paper to iPad entries into the medical record, and there was a breakdown in the process when this occurred. Continued interview revealed the facility was looking at this entire process and making changes to ensure that medication reviews were received and delivered to the appropriate personnel more efficiently. She stated she could not provide evidence of emails/faxes of Pharmacy recommendation reports sent to the DON and/or Administrator by the Pharmacist that they were placed in the MD/Practitioner's box. Interview with the Administrator, on [DATE] at 5:34 PM, revealed she absolutely expected the GDRs reports to be appropriately received, reviewed and acted upon timely per the facility's policy. Per interview, she wanted to start a new process based on the recent revelation that there was a breakdown in the current process. She stated as soon as an irregularity was received or a recommendation was made, the team would sit down and address the concern promptly. The additional step would become a part of the new process to assure that everything was done as required. Continued interview revealed the MRR and GDR process was important so residents would not be on unnecessary medications. This new process would also apply to psychotropic medications. Both MRRs and GDRs would be addressed in the same email and handled the same way. Further interview revealed in the past, that there was a breakdown in this process. She stated that recommendations got lost in faxes and emails. She stated the failure to monitor medications properly kept residents from functioning at their highest practical level.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on observation, interview, record review and review of the facility's Policy, it was determined the facility failed to review medication orders that were written on an as needed basis (PRN) for psychotropic drugs limited to 14 days and for the attending physician or prescribing practitioner to evaluate the resident for the appropriateness of the medication for one (1) of thirty (30) sampled residents (Resident #84). Resident #84 had a Physician's order, dated 03/16/2021, for Ativan (psychotropic medication) one-half (0.5) milligram (mg) to be administered through the G-tube (gastric/feeding tube) every eight (8) hours as needed for anxiety. The order failed to contain a fourteen (14) day stop date or documentation of rationale in the resident's medical record indicating the appropriateness for the PRN order to be extended beyond the fourteen (14) days and the duration for the PRN order. The findings include: Review of the facility's Policy titled Psychotropic Medication Use, dated 11/28/2016, revealed PRN orders for psychotropic drugs were limited to fourteen (14) days. If the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Per the policy, PRN orders for Anti-psychotic drugs should be limited to fourteen (14) days and should not be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for efficacy, risks, benefits and harm adverse consequences. Review of the medical record revealed the facility admitted Resident #84 on 09/28/2020 with diagnoses to include Epilepsy, Unspecified Disorder of Adult Personality and Behaviors. Review of Resident #84's Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident to be cognitively severely impaired. Continued review revealed the resident was receiving antipsychotic, antianxiety, and antidepressant medications. Review of Resident #84 Physician's Orders, dated 03/16/2021, revealed an order for Ativan one-half (0.5) mg to be administered through the resident's G-tube every eight (8) hours as need (PRN) for anxiety. Continued review of the Physician's Order revealed the order failed to have a stop date. Review of Resident #84's medical record revealed no documented evidence the Physician or prescriber assessed the resident for the appropriateness to extend the Ativan beyond fourteen (14) days. Further review revealed there was no documented evidence of his/her rationale to continue the medication with a duration or stop date for the PRN order. Continued review revealed no documented evidence a pharmacy review was completed for the Physician ordered Ativan, dated 03/16/2021. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #84's Medication Administration Record (MAR), dated 03/2021, revealed an active order for Ativan one-half (0.5) mg was ordered on 03/16/2021 to be administered via G-tube every eight (8) hours PRN for Anxiety. Continued review revealed Ativan one-half (0.5) mg was administered on 03/19/2021 at 1:20 AM, 03/20/2021 at 12:57 PM and 03/28/2021 at 12:00 AM. Review of Resident #84's Medication Administration Record (MAR), dated 04/2021, revealed an active order for Ativan one-half (0.5) mg was ordered on 03/16/2021 to be administered via G-tube every eight (8) hours PRN for Anxiety. Continued review revealed Ativan one-half (0.5) mg was administered on 04/01/2021 at 11:48 PM. Interview with the Pharmacist, on 04/23/2021 at 11:39 AM, revealed she reviewed resident medications on a monthly basis and had a process to send the facility a report of the medication reviews with recommendations. Per interview, the report would be sent by E-mail to the Administrator and the Director of Nursing, (DON). Continued interview revealed another pharmacist completed the review during the 03/17/201 period and failed to make recommendations for Resident #84's Ativan. She stated the order for Ativan, dated 03/16/2021, did not have a stop date or rational and was missed by the pharmacy review. Further interview revealed the pharmacy failed to send recommendations for Ativan on their medication review report. Interview revealed that as part of her process, she reviewed the previous medication recommendations and if they were not signed by the physician she would re-issue the recommendations. She further stated that after the review of the PRN medications, she would issue the recommendations pertaining to Resident #84's antipsychotic medications to include if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, to document their rationale in the resident's medical record and indicate the duration for the PRN order. Interview with the Advanced Registered Nurse Practitioner (ARNP), on 04/23/2021 at 12:05 PM, revealed it was a part of her responsibility to review the pharmacy recommendations and to enter a stop date or rationale for medications to be continued. Continued interview revealed she looked over the medications and possible gradual dose reductions (GDR), reviewed the medications for stop date, and rationale by the Psychiatric Physician and monitored for medication side effects. Continued interview revealed, the pharmacy recommendations reports were sent to the DON; however, she had not seen many recommendations recently. Further interview revealed she had not seen a pharmacy recommendation for Resident #84's Ativan. Per interview, when ordering a PRN Psychotropic medication, it should be limited to fourteen (14) days. Interview with the DON, on 04/14/2021 at 9:18 AM, revealed the facility's process was for pharmacy to complete their review and send a report to the facility. The report would be given to the Physician or provider to determine if he/she wanted to change from a PRN status to a standard scheduled order or to discontinue the medication. Continued interview revealed it was her expectation for all Psychotropic medication PRN orders to be temporary and limited to fourteen (14) days and after that timeframe for the Physician or provider to make a determination to continue the medication with a stop date, schedule the medication or discontinue the medication with the rationale for the action to be documented in the resident's medical record, per the facility's policy. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviewed with Administrator, on 04/28/2021 at 5:15 PM, revealed the facility's procedure was for pharmacy to perform their reviews and send a report to the facility. Continued review revealed the report would be given to the Physician or provider for review of the recommendations and any actions. Per interview, the facility recently identified a breakdown in the current process in receiving the pharmacy recommendations and addressing the recommendations in a timely manner. Further interview revealed it was her expectation that pharmacy consultation reports were received, reviewed and action taken on the recommendations in a timely manner, per the facility's policy. She stated the failure to properly monitor these medications would keep residents from functioning at their highest practical level.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44000 Based on observations, interview, record review and review of the facility's policy, it was determined the facility failed to ensure drugs and biologicals were stored in an orderly manner and labeled in accordance with currently accepted professional principles and include the expiration date for six (6) of thirty (30) sampled residents (Residents #7, #80, #81, #130, #335 and #336). On 05/05/2021 the facility discharged Resident #81 home with medications; however, on 05/07/2021 resident #81 noticed he/she had medication belonging to Resident #80. Observation on 05/13/2021 at 9:30 AM revealed Resident #7's fluticasone 50 microgram nasal spray was in the medication cart drawer with Resident #2's medications. Three (3) other residents' medications, Resident #335, Resident #130, and Resident #336, were also observed in the medication cart drawers that were labeled for other residents' rooms. The findings include: Review of Medication Storage policy Storage and Expiration Dating of Medications, Biological's, Syringes and Needles, dated October 2016, revealed the facility should ensure that medications and biological's are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding. 1. Review of Resident #81's medical record revealed the resident was admitted to the facility, on 03/12/2021, for short-term rehabilitation upon discharge from an acute care hospital episode for Alcoholic Hepatitis with Ascites, Generalized Weakness, Difficulty with Walking, and Chronic Pancreatitis. Review of his/her initial Minimum Data Set (MDS) Assessment, dated 03/18/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review of the record revealed initial medication orders, dated 03/12/2021, as well as changes to the orders, as indicated, throughout the course of Resident #81's stay at the facility. However, the record revealed no order for Risperadol at any time during the course of care for Resident #81. In addition, the record revealed the Physician ordered Resident #81 to be discharged home with medications, on 05/05/2021. Continued review revealed the resident was discharged home with medications per the order, by Licensed Practical Nurse (LPN) #3. (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 Resident #81's Family Member, on 05/11/2021 at 2:12 PM, revealed, on 05/07/2021, Resident #81 called to inform her that he/she had discovered a medication box that was given to him/her from the facility. The Family Member stated Resident #81 told her the box contained a medication that was not ordered for him/her. She stated the box had thirty (30) pills of Risperadol 0.25 mg, take one (1) tablet daily. In addition, the resident told the Family Member the box was labeled with Resident #80's name, and he/she had taken two (2) doses. Per interview, Resident #81 took photos of the medication box labeled with Resident #80's name and forwarded it to her. The Family Member stated she verified the picture of the medication box in Resident #81's possession that had Resident #80's name and was labeled Risperadol 0. 25 mg, take one (1) tablet daily. Review of Resident #80's medical record revealed an order for Risperadol, 0.25 mg, with instructions to be administered by mouth one (1) time a day. Interview with LPN #3, on 05/12/2021 at 10:20 AM, revealed when a nurse discharged a resident, they sent what was in the resident's medication drawer with the resident. LPN #3 stated the actual medication boxes were sent home with the resident. LPN #3 stated she had been over the whole process in her memory and did not know how Resident #81 received Resident #80's medication, other than human error. She also stated that prior to COVID, the Pharmacy came through at regular intervals and reviewed all medications, medication storage in the cart, and stocked the medication carts. However, with current COVID restrictions, LPN #3 stated Pharmacy depended on nursing to store medications. Telephone interview with the Pharmacist in charge, on 05/13/2021 at 9:09 AM, revealed the Pharmacy was not involved with discharge medications. Interview with the Director of Nursing (DON), on 05/14/2021 at 9:18 AM, revealed with medication reconciliation, she expected the discharging nurse to compare the written list, prescription by prescription, with the actual medications to be sent home. She stated the facility followed these recommendations from Pharmacy about how the nursing staff should manage the discharge process for medications. The DON stated, in the incident with Resident #81 where an incorrect medication was sent home with the resident, the only answer she had was it involved human error and Resident #80's medication must have been stored in Resident #81's drawer. Interview with the Administrator, on 05/12/2021 at 2:20 PM, revealed she expected medications to be stored in an orderly manner per their policy. She said medications should be in order in the medication cart by resident room, and she expected each resident's medications to be in the correct slot. 2. Observation on 05/13/2021 at 9:30 AM revealed Resident #7's fluticasone (corticosteroids) 50 microgram nasal spray was in Resident #2's drawer. Resident#2's drawer was labeled 101-2. Resident #7's medication drawer was labeled 102-2. Observation on 05/13/2021 at 10:00 AM revealed Resident #335's medications were in drawer labeled 117-1. Resident #335's room was #115-1. Observation on 05/13/2021 at 10:30 AM revealed Resident #130's medications were in the drawer labeled 118-1. Resident #130's room was 117-2. Observation on 05/13/2021 at 10:35 AM revealed Resident #336's medications were in the drawer labeled 118-1. Resident #336 resided in room [ROOM NUMBER]-1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/13/2021 at 10:05 AM with LPN #17 revealed Resident #335 used to be in room [ROOM NUMBER] and moved to room [ROOM NUMBER]-1. LPN #17 also reported Resident #130 moved from room [ROOM NUMBER]-1 to room [ROOM NUMBER]-2. Interview on 05/13/2021 at 9:35 AM with LPN #6 revealed medications should be stored in the medication carts in separate compartments for each resident labeled by the resident's room number. She stated the front compartment of the drawer was for the resident in bed #1 and the second compartment was for the resident in bed #2. She said when she found a medication stored in the wrong compartment she moved it. She further stated she was an agency nurse and she did not know if the facility performed routine cart audits on medication storage. Interview on 05/14/2021 with the Director of Nursing (DON) at 9:18 AM, revealed she audited the medication carts, as well as the Assistant Director of Nursing (ADON), the nurse educator, and the unit managers. She revealed staff had been doing the audits for about one year, with pharmacy doing cart audits prior to the pandemic. She revealed she was uncertain if there was documentation regarding cart audits conducted by staff, and she was also unaware of any cart audit policy, or of frequency of cart audits. Interview with the administrator on 05/12/2021 at 2:20 PM, revealed it was her expectation that medications be in order in the cart by resident room, and that they should be stored orderly and not be stored in compartments labeled for other residents.

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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. 32635 Based on observation, interview and review of facility's policy, it was determined the facility failed to keep food in a safe and sanitary environment as determined by observations during initial and continued tour of the kitchen. Observations on 04/20/2021 and 04/21/2021 revealed a fan in the dish room was covered with a dust-like substance and the floors underneath and behind equipment with food debris. Observation of the resident nourishment refrigerators on three (3) of three (3) resident care units, revealed food products not labeled or dated for expiration. The findings include: Review of the facility policy titled Food: Safe handling for Foods from Visitors, dated 07/2019, revealed the responsible facility staff member, would ensure the food brought to the facility was easily distinguishable from the facility food. Continued review revealed the responsible staff member would ensure the food was in a sealed container to prevent cross contamination and would label the food with the resident's name and the current date. Review of the facility policy titled Snacks, dated 09/2017, revealed snacks would be assembled, labeled, dated, and delivered to resident care areas. Review of the facility form titled Master Cleaning Schedule, from 03/01/2021 through 04/22/2021, revealed the schedule had assigned areas of the kitchen to be cleaned daily, weekly, monthly and quarterly. Continued review revealed the cleaning duties of sweeping the floors, wet mop and light scrub, the three (3) compartment sink, oven, steam table, coffee machine and dish machine was assigned to be completed daily, once by the AM cook and once by the PM cook. However, review of the Master Cleaning Schedule form, dated 03/01/2021 through 04/22/2021, revealed the form had been signed as completed by one shift and not the second shift, per the facility's process. Review of the facility form titled Sanitation Audit Report, dated 03/19/2021 revealed it was utilized by the dietary staff for kitchen sanitation inspections. Continued review of the the report revealed no documented evidence floor surfaces, around and underneath equipment was audited for sanitation. Further review of the Food Storage Section of the report, revealed the food bulk bins were not dated. The Sanitation Audit Report revealed under Corrective Action Plans the staff were educated to label and date the bulk bins and the house shakes with individual thaw dates. The Corrective Action Plan included the bulk bins and the individual house shakes were then labeled and dated. Observation during the initial Kitchen tour, on 04/20/2021 at 10:27 AM, revealed an electric fan in the dish room. Continued observation revealed the fan was located on the clean side of the dishwasher and was covered in a dust like substance. Observation of the kitchen, on 04/21/2021 at 11:30 AM, revealed food crumbs on the floor around the wall, underneath the equipment, preparation tables and the dishwasher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the 200 Unit nourishment room refrigerator, on 04/21/2021 at 8:55 AM, revealed health supplemental shakes were in two (2) drawers of the refrigerator. Continued observation revealed the health shakes had no dates of expiration. Further observation of the refrigerator revealed two (2) take out brown bags located on the shelf with no resident identification or dates on the bags. Observation of the 300 Unit nourishment refrigerator, on 04/21/2021 at 9:15 AM, revealed five (5) health shake supplements with no expiration date. Continued observation revealed personal staff lunches and food products with no label or date. Observation of the 100 Unit nourishment refrigerator, on 04/21/2021 at 9:20 AM, revealed two (2) personal staff lunches in the refrigerator. Continued observation revealed five (5) health shakes with no date of expiration. Interview with Cook #1, on 04/23/2021 at 8:03 AM, revealed she swept and mopped the kitchen production area each shift. Per interview, she tried to sweep and mop behind the equipment to prevent buildup of grease, food and to prevent bugs from entering the facility. Interview with Dietary Aide #2, on 04/23/2021 on 8:40 AM, revealed the kitchen should be swept and mopped throughout the day and as needed using sanitizer bleach and water in bucket. She stated she tried to sweep underneath the tables and behind equipment each shift. Per interview if debris was left under the equipment it could cause cross contamination and attract bugs. Continued interview revealed snacks and health shakes were placed onto to a tray, and staff dated the tray, not the individual shakes. The items were then delivered to each unit where nursing staff would take the items off the tray and place the individual health shakes into the refrigerator. Interview with Dietary Aide #1, on 04/23/2021 at 8:08 AM, revealed she swept the area around her, behind, and underneath the dish machine daily. Dietary Aide #1 stated she tried to look underneath the dish machine daily. Per interview, she stated it was important to sweep and mop underneath the dish machine daily because the debris could attract bugs into the kitchen and into the food. Continued interview revealed the resident unit's nourishment refrigerator snacks should be dated and labeled with the expiration date. She stated the health shakes should be dated with the date of expiration when they were sent to the units. Interview with State Registered Nurse Assistant (SRNA) #11, on 04/23/2021 at 1: 47 PM, revealed food brought to the facility by a resident's family must be labeled, dated and resident room number on the food item. Per interview, if a food item was not labeled and dated correctly, it should be thrown away because there would be no way to determine if the product was good to eat or drink. SRNA #11 stated staff were to store their personal food items in the staff break room and not in the resident nourishment refrigerator. Interview with Licensed Practical Nurse (LPN) #9, on 04/23/2021 at 2:21 PM, revealed she had observed sandwiches not labeled and dated appropriately and health shakes that have no expiration dates. Per interview, the food brought to the facility by a resident's family should be labeled and dated. LPN #9 stated staff were to store their personal food items in the staff break room and not in the resident nourishment refrigerators. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with LPN #3, on 04/23/2021 at 2:43 PM, revealed dietary staff were responsible to bring the resident snacks. She stated she did not know if the snacks brought by dietary were labeled and dated. Per interview, the food brought to the facility by a resident's family needed to be identified and labeled with the resident's name and date received. LPN #3 stated staff had refrigerators in the break room and should not store their personal food in the resident's refrigerator. Interview with the Dietary Manager (DM), on 04/23/2021 on 8:30 AM, revealed staff should sweep and mop the kitchen at the end of each shift and as needed for spills with a bucket of bleach solution, per the facility's process. He stated staff should try to reach under the kitchen equipment and to the wall if possible. The DM stated at times, the staff needed to go down on their hands and knees to reach the very tight spots and move tables to reach behind the equipment. He stated this would help to remove debris, prevents ants and other bugs, or rodents, from contacting with the food and other equipment surfaces to prevent cross contamination. The DM stated the fan in the kitchen should be cleaned regularly to prevent dust from accumulating and contaminating the clean dishes. Further interview revealed snacks taken to the resident units should be labeled and date, per the facility's process. He stated the health shakes should be dated with an expiration date. Interview with Director of Nursing (DON), on 04/14/2021 at 9:18 AM, revealed food items in the resident nourishment refrigerators should be labeled and dated per the facility's policy. She stated if a food item was not labeled and dated, it could potentially be harmful to residents and should be discarded. Per the DON, facility food and food brought in by a resident's family should be separated. She stated food items brought by a family member should be labeled with the resident's name and dated. Per interview, staff food items should be stored in the break room and not the resident nourishment refrigerator. She stated she expected the kitchen and storage areas to be cleaned, per the facility's policy, for infection control. Interview with Administrator, on 04/24/2021 at 11:54 AM, revealed her expectations for the food service sanitation in the kitchen to be cleaned on regular basis and often as needed per the facility's policy. She stated the food debris left under the equipment would encourage pests to enter the facility. Per interview, all resident snacks and food brought into the facility by family should be identified labeled and dated per the facility's policy.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 44000 Based on observation, interview, review of the Director of Nursing's Job Description, review of the Administrator's Job Description, and review of the facility's policies, it was determined the facility's administration failed to ensure it was administered in manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental foe its residents. Observations of the 100, 200, and 300 Units and specific residents' rooms revealed urine and fecal odors on each unit and in residents' rooms throughout the facility. Interviews with residents and staff revealed there were unpleasant, foul odors in the facility and in their rooms which were concerning to them. Interviews with the Administrative staff revealed they were aware of the unpleasant, foul odors, and it was their responsibility to manage them, but they had failed to eliminate the odors. The findings include: Review of the facility's policy titled, Resident Rights, dated 03/01/2018, revealed residents had the fundamental right to considerate care that safeguarded their personal dignity along with respecting cultural, social, and spiritual values. Further review revealed the facility would comply with resident rights which stated a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life. Review of the facility's policy titled, 483.70 Administration, undated, revealed the facility would be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Further review revealed the facility would conduct and document a facility wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. Review of the facility's Job Description for Administrator, dated 01/01/2016, revealed the Administrator's job was to create an environment where staff members were highly engaged and were focused on providing the highest level of clinical care and compassion to residents and families. Continued review revealed the Administrator was to create a culture of Service Excellence which focused on the resident's experience, and was responsive to patient (resident)/families concerns and grievances. Additional review revealed duties and responsibilities of the Administrator included promoting adherence to applicable legal requirements, standards, policies and procedures. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Job Description for Director of Nursing (DON), dated 01/01/2016, revealed the DON led the facility's clinical team to fulfill its mission and values. In addition, the position had overall accountability for providing leadership, direction, and administration of day-to-day operations associated with direct patient care. Per the job description, the DON created a culture of Service Excellence which focused on the resident's experience and was responsive to the resident's or the family's concerns and grievances. In addition, further review revealed the DON implemented and assured adherence to the organization's policies and procedures. Per the job description, the DON was responsible for the overall resident experience. Further review revealed the DON completed daily rounds on the units to observe residents and to determine if their needs were being met. Observations on 04/12/2021 at 11:45 AM, 12:30 PM, 4:05 PM, and 5:10 PM revealed strong odors on the 200 and 300 Units, with less pronounced odors present in the lobby and on the 100 Unit. Observations on 04/13/2021 at 9:00 AM, 1:42 PM, and 4:45 PM revealed strong fecal odors on the 200 Unit. Observations on 04/14/2021 at 8:02 AM, 9:37 AM, 11:10 AM, 12:26 AM, and 2:23 PM revealed strong fecal odors on the 200 and 300 Units. Observations on 04/15/2021 at 7:50 AM and 8:50 AM revealed extremely overpowering urine and fecal odors on the 200 Unit. Observations on 04/22/2021 at 9:10 AM, 11:30 AM, and 1:50 PM revealed strong odors on the 200 Unit. Observation on 04/27/2021 at 9:50 AM revealed strong foul odors on the 200 and 300 Units. In addition, observation, on 04/27/2021 at 4:45 PM, revealed strong odors on the 100 Unit. Observations on 04/28/2021 at 8:00 AM during the tour revealed foul odors on the 200 and 300 Units. In addition, on 04/28/2021 at 9:25 AM, when in the conference room on the 200 Unit, State Survey Agency Surveyors smelled foul odors when the door was opened to the hallway. Interview with Resident #59, on 04/14/2021 at 8:35 AM, revealed there were foul odors all the time. Resident #59 further stated, I don't like this. It smells and makes me feel dirty. I'm leaving here soon. I just cover it up so I don't look at it until they change it. When I ask them to change the linen they will if they have linen, but they are out of linen frequently. Observation of Resident #114's room, on 04/14/2021 at 9:00 AM, revealed a strong odor coming from his/her side of the room. Interview with Resident #114, on 04/14/2021 at 9:00 AM, revealed he/she did not like the odors, and they made him/her feel dirty. Observation of Resident #84's room, on 04/13/2021 at 4:50 PM, revealed there was a strong odor in the room. Interview with Resident #84, on 04/13/2021 at 4:50 PM, who resided on the 100 Unit, revealed he/she had concerns about the continuous daily unpleasant odors. Observation of Resident #88' room, on 04/12/2021 at 11:14 AM, revealed a strong odor was present in his/her room. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Resident #88, on 04/12/2021 at 11:14 AM, revealed the resident wore a face mask when going to therapy to prevent him/her from smelling the odors in the hallway. Observation of Resident #108's room, on 04/12/2021 at 12:45 PM, revealed an unpleasant odor was present in his/her room. Interview with Resident #108, on 04/12/2021 at 12:45 PM, revealed the resident had to keep his/her door shut due to the unpleasant odors in the hallway. Observation of Resident #41's room, on 04/14/2021 at 8:40 AM, revealed unpleasant odors were present in his/her room. Interview with Resident #41, on 04/14/2021 at 8:40 AM, revealed foul odors were present and he/she was bothered by the smell. Observation of Resident #96's room, on 04/14/2021 at 8:45 AM, revealed there was a foul odor in the resident's room. Interview with Resident #96, on 04/14/2021 at 8:45 AM, revealed foul odors were present all the time, and he/she was bothered by the smell. The resident stated he/she attempted to alleviate the odors by keeping the door shut, but the bad odors were still present. Interview with an Emergency Medical Services (EMS) worker, on 04/26/2021 at 5:33 PM, revealed he had come to the facility on several occasions and each time there was a foul odor and the residents looked unkempt. Interview with the Assistant Director of Nursing, (ADON) on 04/13/2021 at 10:49 AM, revealed foul odors were present in the facility. She stated she was not sure where the odors originated or why they were present and did not know how or if the facility's administration was addressing them. Interview with the Director of Nursing (DON), on 05/14/2021 at 10:43 AM, revealed the facility had experienced several issues with plumbing, some of which maintenance had been working on. She stated she was aware of the odors throughout the facility. Interview with the Administrator, on 05/12/2021 at 2:25 PM, revealed she was aware of the foul odors in the facility. Furthermore, the Administrator stated she took responsibility for it because her position mandated that she had oversight of the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, and review of the facility's policies, the Centers for Medicare and Medicaid Services (CMS), the Center for Disease Control and Prevention and the Kentucky Department for Public Health (Health Department) state guidelines for COVID - 19 it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases. Observation, on 04/13/2021, revealed staff failed to properly doff and dispose of personal protective equipment (PPE) and perform hand hygiene after providing resident care. Observation revealed staff failed to empty contaminated linen and trash causing storage barrels to overflow and prevent secure closure. Contaminated trash and linen barrels were stored in a shower room actively used for residents. Continued observation revealed multiple staff failed to redirect a resident in transmission based precautions(TBP) to wear a mask. Further observations revealed staff failed to store dirty linen separately from resident's medical equipment and clean linen. Observation, on 04/21/2021, revealed staff members failed to perform hand hygiene after obtaining vital signs and providing care to residents; failed to disinfect shared medical equipment between resident uses. Observation, on 05/14/2021, revealed a staff nurse failed to remove gloves and hand sanitize after performing blood glucose monitoring. Further observation revealed staff nurse failed to sanitize a shared glucometer, after use. The findings include: Review of the Facility's policy, COVID-19, dated 03/27/2020 and revised 11/15/2020, revealed the purpose of the policy was to prevent the development and transmission of COVID-19. Further review revealed the facility would follow the local public health and state regulations, when applicable, and implement universal use of facemasks/N-95 respirators and eye protection while in the facility. Removal of PPE (personal protective equipment) was to be performed prior to exiting the resident's room, followed by hand hygiene. Furthermore, staff would perform hand hygiene per the Centers for Disease Control and Prevention (CDC) guidelines and the corporation's Health Care policy. Furthermore, staff would assist/remind residents to complete hand hygiene as needed. Per policy, residents on transmission based precautions must wear a facemask, perform hand hygiene, limit movement in the facility, and perform social distancing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Standard Precautions, dated 09/01/2004 and revised 11/15/2020, revealed the purpose of the policy was to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Facility staff would: 1) perform hand hygiene before and after all resident contact; 2) wear gloves when exposure to blood, body fluids or potentially contaminated intact skin was likely, and when exposed to non-intact skin, wound drainage, or drainage tubes; 3) change gloves after contact with the resident or resident's environment, between tasks and procedures on the same individual, and after contact with material that may contain a high concentration of microorganisms; 5) remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination; 6) wear gloves and PPE as needed when handling equipment soiled with blood/and or body fluids; 7) not use reusable equipment for the care of another individual until it had been cleaned and disinfected appropriately; 8) remove and bag PPE and perform hand hygiene before exiting a room; and 9) remove bagged PPE from room and discard. Review of the facility's policy, Hand Hygiene, dated 02/15/2001 and revised 11/15/2020, revealed the purpose of the policy was to improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. Facility staff would perform hand hygiene 1) before and after all resident contact; 2) before an antiseptic procedure; 3) after contact with blood or other body fluids, even if gloves were worn; and 4) after contact with the resident's environment. Review of the facility's policy, Contact Precautions, (dated 02/15/2001 and revised 06/15/2019), revealed that in addition to Standard Precautions, Contact Precautions would be used for diseases transmitted by direct or indirect contact with the resident or the resident's environment. The purpose of the policy was to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Facility staff must wear gown and gloves when entering resident's room. Prior to exiting resident's room, staff must remove and bag gown and gloves, and wash hands. Soiled and bagged PPE must be discarded in a soiled utility room. Further review revealed dedicated personal care equipment or disposable equipment was to be used. If use of common equipment was unavoidable, clean and disinfect equipment before use with another resident. Review of the facility's policy, Droplet Precautions, dated 09/04/2004 and revised 11/15/2020, revealed the purpose of the policy was to prevent transmission of infectious agent by droplets. Facility staff must wear gown, gloves and surgical mask when entering the room. Prior to exiting room, staff must remove and bag PPE, and perform hand hygiene. Soiled and bagged PPE must be discarded in a soiled utility room. Further review revealed dedicated personal care equipment or disposable equipment was to be used. If use of common equipment was unavoidable, clean and disinfect equipment before use with another resident. Observation on, 04/12/2021 at 2:10 PM, on the 100 Unit's transmission based precaution (TBP) hall, revealed biohazard linen and trash being stored in a shower room actively used for residents' showers. Linen and trash barrels stored in the shower room were overflowing with contaminated bags, and not covered. Observations, on 04/14/2021 at 11:15 AM, revealed stored medical equipment (i.e., Hoyer lift (brand of mechanical lift) and wheelchairs) in the shower room on the 200 Unit. Further observation of the shower room revealed two (2) covered barrels, one with dirty linen and one with dirty trash, stored approximately three (3) feet away from the clean linen stored on a large uncovered linen cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations, on 04/14/2021 at 2:12 PM, on the 200 Unit revealed pungent urine and fecal odors in the front end of the hall. Observation of the shower room revealed bagged trash and soiled linen heaped in barrels without secured lids. Observation of room [ROOM NUMBER] on 04/14/2021 at 2:20 PM, revealed there was no trash bag for contaminated PPE. Interview with State Registered Nurse Aide (SRNA) #2, on 04/12/2021 at 2:15 PM, revealed PPE was to be doffed inside the room, bagged in clear plastic bags, and placed in biohazard hampers in hallway. Per interview, when the hampers were full, bags were tied up and disposed of in barrels located in the shower room. Barrels were to be taken to the dumpster at 11:00 AM, and 3:00 PM, or when full. SRNA #2 stated it was important to dispose of contaminated trash to prevent the spread of infection. Further interview revealed staff should use alcohol-based hand rub (ABHR) or soap and water before and after patient care to reduce the spread of infection. Interview with SRNA #6, on 04/14/2021 at 11:30 AM, revealed that dirty linens and trash were bagged and disposed of in the shower room with the medical equipment and clean linen. Staff was responsible for emptying the large barrel containers when they were full. SRNA #6 Stated it was important to dispose of contaminated trash to prevent the spread of infection. Interview with LPN #2, on 04/14/2021 at 2:25 PM, revealed PPE was doffed inside the room, then bagged in clear plastic bags. Dirty bags were placed in the biohazard hampers in hallway. She stated contaminated gloves disposed of in biohazard hamper for trash. Observation, on 04/13/2021 at 9:25 AM, revealed a resident in TBPs come off the unit with no mask. The resident walked down the hall, past non-isolated residents, to the courtyard for his/her smoke break. Multiple residents in TBPs gathered with non-isolated residents at the 100 Unit Nurses' Station to get cigarettes. Isolated TBP residents shared the smoke break area with non-isolated residents. Social distancing was not observed. Observation, on 04/14/2021 at 10:15 AM, revealed residents on the 100 Unit walking and sitting in the hall without masks, or with masks below the nose. Social distancing was not observed. Observation, on 04/21/2021 at 3:15 PM, in the Front Lobby, revealed a resident walking out of the 100 Unit without a mask and talking to staff. Staff failed to redirect the resident to put on a mask. Observation, on 04/21/2021 at 3:17 PM, revealed several residents congregated around the nursing station on the 100 Unit. Residents were not social distanced and several residents were wearing their mask below their nose. Further observation revealed staff did not redirect or educate the residents on the importance of wearing a mask. Interview with Licensed Practical Nurse (LPN) #3, on 04/21/2021 at 3:20 PM, revealed many of the residents on the 100 Unit were noncompliant. LPN #3 stated staff tried to redirect and educate residents. The LPN stated the importance of educating residents to wear mask was to prevent the spread of infection. (continued on next page)

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	185090	A. Building B. Wing	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace Nursing and Rehabilitation Center	7300 Woodspoint Drive Florence, KY 41042

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation, on 04/22/2021 at 9:45 AM, revealed an empty intravenous (IV) bag and tubing in room [ROOM NUMBER]. The IV bag and tubing were not dated, timed, or initialed. Observation, on 04/20/2021 at 11:15 AM, revealed Resident #16's oxygen (O2) tubing was not dated or initialed. Observation, on 04/20/2021 at 4:05 PM, of room [ROOM NUMBER], revealed the oxygen tubing was not dated or initialed. Further observation revealed the trash can in the room was overflowing with tubing, and an O2 concentrator humidifier, was dated 04/14/20. Observation, on 04/21/2021 at 9:05 AM, of Resident #110, revealed O2 tubing was not dated or initialed. Continued observation revealed the resident's Bi-level Positive Airway Pressure (BiPAP) mask and tubing were not inside a protective bag and were on the floor. Observation, on 04/21/2021 at 3:30 PM, on the 300 Unit, revealed SRNAs #14 and #15 obtained vitals on both residents in room [ROOM NUMBER]. Staff failed to clean and sanitize the shared equipment between residents. Staff did not clean the rolling vital sign machine. Furthermore, SRNA #15, and SRNA #15 did not perform hand hygiene between residents, or prior to leaving the room. Interview with SRNAs #14 and #15, on 04/21/2021 at 3:35 PM, revealed that they did not know to wipe down the shared equipment between residents. Both stated they were agency staff, and employed at the facility for two (2) weeks. SRNA #14 and #15 stated they did not receive infection control training upon assignment at this facility. Per interview, both stated they did not receive orientation at this facility. The SRNAs were unable to explain why sanitizing equipment and using hand hygiene was important. Observation with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), on 04/21/2021 at 9:35 AM, revealed a rolling vital sign machine plugged into the wall. The machine's base was covered with dust and dirt; and, the screen display was not clean and covered with fingerprints. Interview with the ADON/IP, on 04/21/2021 at 935 AM, revealed the rolling vital sign machine cart was dirty. She stated, per policy, shared equipment was to be cleaned and disinfected between residents. The ADON/IP stated the importance of cleaning shared equipment between residents was to reduce the spread of infection. Observation on 04/21/2021 at 3:40 PM, on the 200 Unit, revealed the dirty rolling vital sign machine, which the SSA Surveyor had shown to the ADON/IP at 9:35 AM, in a different location on the unit. It had not been cleaned. Observation, on 04/20/2021 at 12:05 PM, revealed several staff members failed to sanitize their hands between serving meal trays to Rooms 315A, 315B, 316A, and 316B. Furthermore, staff failed to provide hand hygiene to residents in Rooms 315A, 315B, 316A, and 316B prior to meal pass. Observation, on 04/20/2021 at 10:05 AM, of the Front Lobby, revealed a staff member pulled his/her mask down to talk to another staff member as they clocked out and left the building. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation, on 05/11/2021 at 3:51 PM, revealed LPN #16 failed to remove gloves and hand sanitize after performing blood glucose monitoring Resident #102, and handling a test strip. Further observation revealed LPN #16 failed to sanitize the shared glucometer after use. Furthermore, LPN #16 placed the contaminated glucometer into the medication cart drawer, which held other medical supplies, without first sanitizing. Interview with LPN #16, on 05/11/2021 at 3:51 PM, revealed she was not aware she failed to remove her gloves and perform hand hygiene after performing the fingerstick on Resident #102. Per interview, LPN #16 stated she did not disinfect the glucometer because she did not have bleach wipes on the medication cart. She stated the importance of cleaning shared medical equipment, proper doffing of PPE, and performing hand hygiene, was to prevent cross contamination and the spread of infection. LPN #16 did not use the glucometer on another resident and stated she would clean it before using it again, further stating she always cleans it with the Micro-Kill wipes and lets it sit for a five (5) minute dry time. She had completed her medication pass, and took the cart to the nurses' station to clean. She stated the carts have two (2) glucometers, so that one can dry if the other needs to be used. Further interview revealed it is policy to disinfect the glucometer and any medical equipment that is shared between residents. In addition, it is policy to remove soiled gloves and hand sanitizes after resident care/procedures. Interview with SRNA #4, on 04/14/2021 at 10:59 AM, revealed staff should use ABHR before and after resident care. If soiled, hands should be washed with soap and water. SRNA #4 further stated soiled item were bagged inside the room and then placed in hampers in the hallway. She stated when the hampers were full, the bags were emptied into trash and the linen barrels were stored in a shower room. Per interview, SRNA #4 stated wheelchairs and lifts, along with clean linen carts, were stored together with the dirty linen and trash. She stated staff was responsible for emptying the large barrel containers when they were full, usually two (2) times a shift. Further interview revealed staff had been educated to wipe off shared medical equipment with bleach wipes. She stated the rolling vital sign machine was cleaned at the end of each shift, and not in between resident rooms. SRNA #4 Stated the importance of cleaning the equipment and using hand hygiene between residents was to reduce the risk of infection. Interview with LPN #3, on 04/14/2021 at 2:30 PM, revealed PPE was doffed inside the room. Staff should use ABHR before and after patient care. If soiled, hands should be washed with soap and water. N-95 masks were to be worn in the TBP unit. LPN #3 stated soiled linen and trash were bagged in clear plastic bags inside the room, the bag was placed in hampers located in all the hallways. Continued interview revealed staff emptied the hampers into the barrels in the clean shower room throughout the day. She stated, Well that's how we do it today. Tomorrow might be different. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #2, Nurse Educator, 04/25/2021 at 4:35 PM, revealed Agency staff was trained prior to coming to the facility. She stated, There's a process to ensure competencies, which is not yet in place for new hires. Per interview, all new hires were paired with a trainer for one (1) to two (2) days to orientate. RN #2 stated, Personally, I don't believe that was enough time. Trainers report if there were any issues with competencies related to resident care, or infection control and prevention practices. She stated she relied on other staff to check that staff was competent. RN #2 stated she did not currently follow up with an employee who lacked competencies. Per interview, she stated, The goal was to spend one-on-one time with all staff, but for right now, the process was broken. It was important to have competent staff so residents would receive safe, quality care, and infection control measures were followed. Interview with the ADON/IP, on 04/25/2021 at 10:00 AM, revealed it was her expectation that nasal cannulas and O2 tubing should be dated and initialed when changed. Per policy, BiPAP tubing and masks were stored in a plastic bag. The ADON/IP stated it was her expectation that tubing and masks were kept off the floor. Per interview, ADON/IP stated if not stored properly then a resident could experience a respiratory infection. Further interview revealed it was her expectation that IV bags and tubing should be dated and initialed when hung according to the facility's policy. She stated dating and initialing IV bags and tubing was important in order to know when it was hung and which nurse administered the IV medication. She stated she expected staff to perform hand hygiene with ABHR, or soap and water, before and after each resident's care. Per interview, she educated staff to use gel when going in and out of rooms. Furthermore, staff must hand sanitize before and after donning and doffing of all PPE. She stated PPE was to be doffed inside the resident's room. She stated it was never appropriate to doff PPE in the hallway. Staff were to bag contaminated PPE and place in hampers. She stated it was the responsibility of staff to empty hampers and barrels when full. Continued interview with the ADON/IP revealed she expected staff to wear masks properly, over the mouth and nose, and to redirect residents to wear masks appropriately to decrease the risk of spreading COVID-19. Further interview revealed it was her expectation that all equipment was thoroughly sanitized between each resident use, and dry times were followed. Shared medical equipment, such as Hoyer lifts and the rolling vital sign machine, were sanitized between each resident use. Furthermore, it was the ADON/IP's expectation that dirty linen and trash were stored separately from clean supplies/linen, and soiled trash, linen, and equipment were kept out of clean areas used for resident care. She stated it was important to prevent contamination of clean supplies, and stop the spread of infection. Continued interview with the ADON/IP revealed all staff received infection control and prevention (ICP) education upon hire. Updates were shared at monthly staff in-services and staff meetings. She stated updates to policy and process changes were provided by word-of-mouth, handouts, and in-services. The ADON/IP further stated staff received post- education tests to ascertain knowledge. Per interview, nursing leadership (DON, ADON/IP, Nurse Educator, and Unit Managers) monitored for compliance, however she could not produce documentation of staff monitoring audits. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON), on 05/14/2021 at 9:30 AM, revealed staff was given training on infection control upon hire. She stated the facility's IP audited staff for ICP compliance. Further interview revealed the purpose of proper hand hygiene and doffing of PPE was to decrease the risk of transmission of infection. Continued interview revealed that the DON monitored staff to ensure they followed proper ICP practices. Per interview, O2 tubing should be changed weekly, and it was to be dated and initialed by the nurse when changed. She stated that all tubing and masks were stored off the floor to prevent infection. The DON stated it was her expectation that all staff followed the facility's policy and procedures related to ICP. Interview with the Administrator, on 04/24/2021 at 12:00 PM, revealed all staff had received ICP education. Staff was aware that contaminated items should be stored separately from clean items. Per interview, she stated staff was given opportunity to be involved in quality improvement efforts. Per interview, monthly town hall meetings were attended by all staff. The Administrator stated there was no formal process for staff to offer feedback related to quality improvement, but stated, I have an open door policy for all staff. She stated it was the responsibility of leadership (Administrator, DON, ADON/IP, Nurse Educator, and Unit Managers) to audit for compliance. She stated leadership audited staff for compliance, however, she stated there was no documentation of staff ICP audits. Per interview, it was the Administrator's expectation that all staff maintain ICP guidelines at all times. The importance was to decrease the potential spread of infection.