STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185262	A. Building B. Wing	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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** 22976 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to notify the physician for one (1) of thirty-three (33) sampled residents (Resident #428) when the resident experienced a change of condition and there was a need to alter treatment. Resident #428 had experienced a decrease in food and fluid intake since [DATE], which continued after the resident was diagnosed with COVID-19 on [DATE] and moved to the facility's COVID unit. However, there was no evidence the resident's physician was notified of the resident's decrease in food/fluid intake. In addition, although the resident's physician was notified in a telehealth visit on [DATE], that the resident's fingers and toes were discolored, there was no evidence the physician was notified the resident's extremities remained discolored until [DATE], when the resident was transferred to the hospital and admitted with diagnoses to include Acute Kidney Injury due to Severe Dehydration, Sepsis due to Pneumonia, Severe Malnutrition, Acute Respiratory Failure, and COVID-19 Viral Infection. Resident #428 expired at the hospital on [DATE]. The facility's failure to ensure the resident's physician(s) were notified when the resident experienced a change in condition and/or need to alter treatment has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE], in the areas of 42 CFR 483.10 Resident Rights (F580) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657) at the highest s/s of a J, and 42 CFR 483.25 Quality of Care (F684 and F692) at the highest s/s of a J. The facility was notified of Immediate Jeopardy on [DATE]. An acceptable Immediate Jeopardy Removal Plan was received on [DATE], which alleged removal of the Immediate Jeopardy effective [DATE]. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on [DATE]. The Immediate Jeopardy is ongoing. Refer to F657 and F692 The findings include: A review of the facility's policy, Change of Condition Standard of Practice, dated [DATE], revealed the facility would immediately (as soon as possible/no longer than 24 hours) inform/consult with the resident's physician when there was any significant change in the resident's status. (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	Review of Resident #428's closed medical record revealed the facility admitted the resident on [DATE], with diagnoses that included Dementia, Delirium, Delusional Disorder, and Encephalopathy. Review of Resident #428's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5), which indicated the resident was cognitively severely impaired. Review of Resident #428's nutritional assessment completed by the Dietitian dated [DATE], revealed the facility assessed the resident to require between 1475 milliliters (ml) to 1770 (ml) of fluid daily. Further review of Resident #428's average daily food and fluid intake report, dated [DATE], revealed the resident consumed an average of 240 ml daily, which was less than the fluid needs the resident was assessed to have, between 1475 to 1770 ml. However, there was no evidence the facility staff contacted the resident's physician when he/she decreased his/her fluid intake. Review of Resident #428's meal intake documentation from [DATE] through [DATE], revealed on [DATE]; the resident refused all meals and ate less than twenty five (25%) percent; on [DATE], the resident had no food intake documented; on [DATE], the resident ate seventy-five to one-hundred (,d+[DATE]%) percent of breakfast, but refused lunch and dinner; on [DATE], the resident had no documented intake at breakfast and refused lunch and dinner eating less than twenty-five (25%) percent; on [DATE], the resident refused breakfast, ate lunch at fifty to seventy-five (,d+[DATE]%) percent and refused dinner; on [DATE], the resident had no breakfast intake documented, refused lunch, ate less than twenty-five (25%) percent and ate twenty-five to fifty(,d+[DATE]%) percent for dinner; on [DATE], the resident ate fair with fifty to seventy-five (, d+[DATE]%) percent for breakfast; no documented intake for lunch, and ate poor for dinner, eating twenty-five to fifty (,d+[DATE]%) percent; on [DATE] and [DATE], the resident had no documented intake. However, there was no evidence found in the resident's medical record to indicate staff notified the resident's physician when he/she refused his/her meals and when the resident was documented to have eaten fair topoor for most of his/her meals, during the period of [DATE] through [DATE]. Continued review of Resident #428's closed medical record revealed on [DATE], Resident #428 tested positive for COVID-19 and was transferred to the facility's designated COVID unit. Further review of the resident's medical record revealed on [DATE], the resident had no food intake. Review of the Nursing Progress Notes, dated [DATE] at 10:25 AM, completed by, Registered Nurse (RN) #2 revealed the resident appeared lethargic and the resident's fingers and toes on the right side and three (3) fingers on the left hand were purple in color. However, there was no documented evidence the resident's physician was notified that the resident had not met his/her fluid needs or had consumed less than twenty-five (25%) percent of his/her average food intake since [DATE]. Further review of Resident #428's medical record revealed, on [DATE] at 2:33 PM, Resident #428's physician conducted a telehealth visit with the resident. Review of the Physician's Orders, dated [DATE], revealed orders for support medication (Vitamin C and Aspirin). Staff were advised to offer the resident fluids to maintain adequate hydration. However, there was no evidence that the physician was notified that the resident failed to meet his/her fluid needs and had only consumed twenty-five (25%) percent of meals since [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physician Progress Notes, completed by Physician #1 for the [DATE] telehealth visit, revealed the resident's fingers were discolored; staff were unable to obtain the resident's blood oxygenation level; and, the resident was not on oxygen. Continued review of the Physician Progress Note revealed the physician's plan was for the resident to receive Dexamethasone (steroid medication used to decrease inflammation), Tessalon (a cough medicine) and administer the resident oxygen if his/her blood oxygen saturation was lower than ninety (90%) percent on room air. A continued review of Resident #428's medical record revealed Nurses' Progress Notes dated [DATE] at 08:59 AM, completed by RN #2, revealed the Resident #428 continued to have purple fingers and toes. However, there was no documentation that the resident's physician was notified that the resident's fingers and toes remained discolored, and the resident continued to not eat or drink adequately. An interview with State Registered Nurse Aide (SRNA) #4, on [DATE] at 2:14 PM, revealed he cared for Resident #428 the night before the resident was sent to the hospital on [DATE]. SRNA #4 stated at approximately 5:00 AM on [DATE], he could not obtain an oxygen saturation on the resident and could not get the resident to take in any fluids. The SRNA stated the resident's breathing was labored and he/she was drenched in sweat. SRNA #4 stated, I thought (the resident) was going to die. Further interview revealed he notified Licensed Practical Nurse (LPN) #6 of the resident's condition multiple times during the night; however, LPN #6 did not notify the resident's physician. SRNA #4 stated LPN #6 revealed, day shift would take care of the resident when they came on shift. The SRNA #4 stated LPN #6 did not do anything to assist the resident. Interview with Licensed Practical Nurse (LPN) #6, on [DATE] at 2:58 PM, revealed she provided care to Resident #428, located on the COVID unit, during the night shift from [DATE] through [DATE], 7 PM to 7 AM. LPN #6 revealed that when she last checked on the resident, the resident was in no distress, which she could recall. Further interview revealed staff had not notified her of the resident's change in condition. She further stated that if staff had, she would have notified the resident's physician. Review of the Nurses' Progress Notes signed by Licensed Practical Nurse (LPN) #5, on [DATE] at 11:00 AM, revealed Resident #428 had vomited a large amount of dark black colored emesis, and the resident's oxygen saturation were not able to be obtained. The staff notified the resident's physician, who instructed staff to transfer the resident to the hospital for further evaluation and treatment. Review of Resident #428's hospital record dated [DATE], revealed the hospital admitted the resident with the diagnoses of Acute Kidney Injury due to Severe Dehydration, Sepsis due to Pneumonia, Severe Malnutrition, Acute Respiratory Failure, and COVID-19 Viral Infection. Further review of the medical record revealed Resident #428's condition declined, he/she was placed on comfort measures and expired at the hospital on [DATE]. (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 Physician #1, on [DATE] at 2:25 PM, revealed he was made aware of Resident #428's discolored fingers and toes during the telehealth visit on [DATE]. However, further interview revealed he was unaware of the resident's change in condition in which staff were unable to obtain the resident's oxygen saturation and of the resident's decreased food/fluids intake. Continued interview revealed he expected to be notified when a resident's condition worsened, as it would indicate further oxygenation problems. According to the physician, he was never made aware of Resident #428's refusal of meals/fluids nor was he aware the resident was not meeting his/her estimated fluid needs. Further interview revealed he had visited Resident #428 in the hospital and the resident's condition had declined since the telehealth visit on [DATE]. Physician #1 stated he had not been notified of Resident #428's decline prior to the resident's hospitalization . Further interview with the physician revealed if he had been made aware that the resident was not eating or drinking, he would have ordered labs, intravenous (IV) fluids, and would have sent the resident to the hospital sooner. Interview with the Former Director of Nursing (DON), on [DATE] at 12:29 PM, revealed she was not aware of any concern with Resident #428 not eating or meeting his/her estimated fluid needs. The DON stated she did not recall any concerns with the resident having discolored fingers, but she would have expected staff to report such concerns to the resident's physician, as a change of condition and for staff to provide increased monitoring of the resident. Further interview revealed if the Interdisciplinary Team (IDT) had been aware of the resident's decline, the physician would have been notified and orders would have been obtained from the physician for intravenous (IV) fluids, or the resident would have been sent to the hospital. Interview on [DATE] at 1:05 PM, with the Former Administrator, who was the Administrator in September of 2021, revealed she was not aware of any concerns with Resident #428. She stated she was not aware that State Registered Nurse Aide (SRNA) #4 reported Resident #428's concerns to Licensed Practical Nurse (LPN) #6, which were not addressed. The former Administrator stated daily conference calls were made during the morning meetings by the Administrator or the DON to the nursing staff working on the COVID unit. Per the interview, this call was made to discuss any concerns the floor nurse might have had while working the unit; however, there were no concerns identified related to Resident #428.

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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. 22976 Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI), Version 3.0, dated 10/2019, it was determined the facility failed to implement the Comprehensive Plan of Care related to pressure ulcers for four (4) of thirty-three (33) sampled residents (Residents #19, #39, #47, #63). Review of the Comprehensive Care Plan for Resident #47 revealed the Comprehensive Care Plan (CCP) interventions included: assess the skin and report skin breakdown; treatments as ordered; treatment to the Deep Tissue Injury (DTI) to right outer foot and monitor until resolved; treatment to the left heel as ordered; and treatment to the left outer foot as ordered. However, there was no documented evidence the facility was monitoring the resident's wounds, as there was no Wound Assessment completed from 01/13/2020 until 02/16/2022, after Surveyor intervention. Further, there was no documented evidence treatments were performed as ordered. The resident's pressure ulcers deteriorated and he/she developed Osteomyelitis (a bone Infection). Review of the Comprehensive Care Plan for Resident #19 revealed the Comprehensive Care Plan (CCP) interventions included: assess skin and report redness, rashes, bruises, abrasions or skin breakdown; provide wound care as ordered by the physician; and provide medications and treatments as per orders. However, there was no documented evidence the facility was monitoring the resident's wounds nor was there documented evidence Physician's orders were implemented related to wound care. There was no initial Wound Assessment until until 12/07/2021, twenty-eight (28) days after admission. Additionally, there was no documented evidence of a Wound Assessment from 12/07/2021, until the surveyor requested to observe a skin assessment on 02/16/2022, seventy-one (71) days later, when the resident's wounds were noted to be larger and unidentified wounds were noted. Review of the Comprehensive Care Plan for Resident #39 revealed the Comprehensive Care Plan (CCP) interventions included: Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction mattress; provide incontinent care as needed; provide wound care as ordered by the MD. However, there was no documented evidence the facility was monitoring the resident's wounds nor was there documented evidence Physician's orders were implemented related to wound care. No documented evidence of a wound assessment from 01/11/2022 until the surveyor requested to observe skin assessment on to 02/16/2022, thirty-six (36) days later, the wound has worsened with a tunneling noted at 6.5 cm. Review of the Comprehensive Care Plan for Resident #63 revealed the Comprehensive Care Plan (CCP) interventions included: Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction mattress; provide incontinent care as needed; provide wound care as ordered by the MD; treatment to stump per order. Review of Care Plan dated 02/04/2022 revealed new treatments for Resident #63's stage II coccyx and Left AKA was not updated on the care plan until 02/07/2022. No documented evidence of wound assessment for residents left AKA until the surveyor requested to observe skin assessment on to 02/16/2022. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to ensure Resident's Comprehensive care palns were implemented has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. The findings include: Interview with the Administrator on 02/21/2022 at 3:12 PM revealed the facility did not have a policy related to implementation of the Comprehensive Care Plan. According to the Administrator, the facility followed the Resident Assessment Instrument (RAI) process for developing, and implementing the plan of care. Review of the facility's copy of the RAI, Version 3.0, dated 10/2019, revealed the Minimum Data Set (MDS) views the resident in distinct functional areas to gain knowledge of the resident's functional status. Per the RAI, the facility should develop and implement an interdisciplinary care plan based on assessment information gathered throughout the RAI process. Further RAI review revealed, facility should re-evaluate the resident's status at prescribed intervals and modify the individualized care plan as appropriate. Review of the facility's Skin Care Standard of Practice Policy, dated 07/2020, revealed the facility would assess all residents on admission, readmission, and quarterly and with each change in condition that would compromise the skin. Per policy, the baseline skin assessment would be completed within twenty-four (24) hours of admission and documented in the medical record. Additionally, the Comprehensive Care Plan (CCP) initiated upon admission with the Baseline Care Plan and the development process for the CCP. Continued review revealed the CCP would reflect skin care needs, ADLs, nutrition, and activity level that would impact skin integrity risk. The Braden Risk Assessment would be completed on Admission, weekly for 4 weeks, with changes of condition, and on a quarterly basis. A skin assessment would be completed by a licensed nurse on admission/readmission, and on a minimum of weekly thereafter. 1. Review of the medical record for Resident #47, revealed the facility admitted the resident on 03/18/2019 with diagnoses which included Malignant Neoplasm of the Brain and Lung, Diabetes Mellitus Type II, and Dementia with Behavioral Disturbance. Review of Resident #47's Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicating severe cognitive impairment. Additional review revealed the facility assessed the resident as at risk for developing a pressure ulcer and as having one (1) Stage IV pressure ulcer and three (3) suspected Deep Tissue Injuries (DTIs). (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 Resident #47's Comprehensive Care Plan (CCP), dated 01/04/2022, revealed the resident had a problem with impaired skin integrity including a Deep Tissue Injury (DTI) to the left heel, an unstageable pressure ulcer to the right outer foot, and a DTI to the left outer foot. The goal with a target date of 04/04/2022, revealed the resident would have no unidentified skin issues through the next review. Interventions included: assess the skin and report skin breakdown; perform treatments as ordered; treatment to the DTI to right outer foot and monitor until resolved; treatment to the left heel as ordered; and treatment to the left outer foot as ordered. Review of Resident #47's Physician's orders, dated 01/07/2022, revealed orders for Doxycycline 100 mg (antibiotic medication) twice daily for a wound infection. Review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for treatment to clean the wound to the left outer foot with wound cleanser, pat dry, apply Santyl and cover the wound with a foam dressing daily and as needed. Continued review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for the left heel to be cleaned with Dakins solution, pat dry apply, Santyl (a medicated ointment that removes dead tissues from wounds) to the wound bed, cover with petroleum gauze cover with calcium alginate and cover with a foam dressing, change daily and as needed. Review of Resident #47's Wound Evaluation Form, dated 01/13/2022, revealed the resident had a facility acquired pressure ulcer to the left outer foot which measured 2.9 centimeters (cm) long by 2.0 cm wide; and a facility acquired Stage IV pressure ulcer to the left heel classified as a Deep Tissue Injury (DTI) which measured 6.0 cm long by 4.1 cm wide by 1.4 cm deep. Continued review revealed there were no other Wound Evaluations documented in the Electronic Medical Record, indicating the CCP was not implemented related to assessing and monitoring skin. Review of Resident #47's January 2022 Treatment Administration Record (TAR) revealed wound treatments were not documented as being completed on 01/04/2022, 01/16/2022, 01/23/2022, 01/28/2022, and 01/29/2022, indicating the CCP was not implemented related to performing treatments as ordered. Review of Resident #47's Physician's orders, dated 01/31/2022, revealed orders to clean the wound to the right foot with wound cleanser, apply Santyl and cover with a nonstick foam dressing. Review of Resident #47's Physician's orders, dated 02/05/2022, revealed orders for Santyl to be applied daily to pressure ulcer other site stage IV; however, no wound site was identified in the order. Review of Resident #47's Physician's orders, dated 02/08/2022, revealed orders for intravenous Vancomycin (antibiotic) one (1) Gram every eight (8) hours and Zosyn (antibiotic) one (1) Gram every six (6) hours for six (6) weeks for Osteomyelitis (bone infection). Review of Resident #47's Physician's Note, dated 02/11/2022, revealed there were recent skin changes to the left heel, and x-ray imaging was obtained. Imaging concerning for Osteomyelitis and C-reactive protein (a blood test used to check for inflammation) elevated at 120.4 mg/l (milligrams per liter) (normal range is considered less than 10 mg/l). Further, the resident was to continue on antibiotic coverage in the form of Vancomycin and Zosyn (antibiotic medication). (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 Resident #47's Physician's orders dated 02/14/2022, revealed orders for skin inspection to be completed on Tuesdays on the evening shift. Review of Resident #47's February 2022 TAR, revealed the ordered wound treatments were not documented as being completed on 02/04/2022, 02/06/2022, 02/11/2022, 02/12/2022, 02/13/2022, and 02/15/2022 indicating the CCP was not implemented related to assessing and monitoring skin. Record review revealed there was no documented evidence of monitoring Resident #47's wounds as per the CCP. There was no documented evidence of Wound Evaluations for Resident #47 from 01/13/2022 until 02/16/2022, when the State Survey Agency (SSA) Representative asked to observe a skin assessment. Observation of a skin assessment, performed on 02/16/2022 at 3:07 PM, by Registered Nurse (RN) #1, revealed Resident #47's Deep Tissue Injury to the left outer foot had opened and increased in size to 4.0 cm long by 3.5 cm wide by 0.2 cm deep. The Stage IV pressure ulcer to the resident's left heel had increased in size to 6.0 cm long by 2.0 cm wide by 0.2 cm deep. Additionally, the resident was noted to have an area of brown eschar to the right lateral foot measuring 2.0 cm long by 1.5 cm wide with no depth. Review of the medical record revealed the brown eschar to the right lateral foot was an unidentified area until this skin assessment. Interview with Director of Nursing (DON) #3, on 02/21/2022 at 4:44 PM, revealed he had started at the facility in January 2022, and was unaware Resident #47 had pressure ulcers. Further, he was unaware skin assessments and wound measurements for Resident #47 were not being completed as per the CCP. According to the DON, a resident's pressure ulcers/wound could get worse or become infected if not being monitored and treated. Per interview, it was his expectation Resident #47's CCP would have been implemented related to monitoring skin, completing Wound Assessments and treatments as ordered. Interview with the Medical Director, on 02/24/20 at 1:27 PM, revealed she was the primary care physician for Resident #47. Per interview, the resident was diagnosed with a left heel deep tissue injury and was started on doxycycline for a Stage IV pressure ulcer. She further stated the resident was later diagnosed with Osteomyelitis and a Peripherally Inserted Central Catheter (PICC) line was placed for intravenous antibiotics related to the pressure ulcers. Per interview, two (2) of the resident's wounds had deteriorated. Continued interview revealed it was her expectation treatments were completed as ordered and skin was monitored consistently in order to identify new skin breakdown and to note the progress of pressure ulcers. 44371 2. Review of Resident #19's medical record revealed the facility admitted the resident on 11/09/2021 with diagnoses including Osteomyelitis, Methicillin Resistant Staphylococcus Aureus (MRSA) infection, unspecified site, Pressure Ulcer, and Paraplegic. Review of Resident #19's Admission Minimum Data Set (MDS) Assessment, with a reference date of 11/15/2021, revealed the facility assessed the resident as at risk for pressure ulcers and as having two (2) Stage III pressure ulcers that were present at admission on 11/09/2021. Further, the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating intact cognition. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed there was no documented evidence of a Wound Assessment for Resident #19 on admission. Review of Resident #19's Comprehensive Care Plan, dated established 11/09/2021 and implemented 12/08/2021, revealed the resident was assessed to have two (2) Stage III pressure ulcers on the outside of the right foot; a wound to the right outer leg on the side of the knee; a wound to the mid back spine and a wound to the right outer leg. The goal with a target date of 03/08/2022 stated the resident would remain free from any unidentified skin issues through next review. The interventions included: assess skin and report redness, rashes, bruises, abrasions or skin breakdown; pressure reduction mattress; provide wound care as ordered by the physician; and provide medications and treatments as per orders. Review of Resident #19's Physician's orders, dated 11/10/2021, revealed orders to monitor the wound on the mid back for signs and symptoms of worsening or non healing every shift until resolved. Review of Resident #19's Physician's orders, dated 11/16/2021, revealed orders to monitor wounds on right outer foot for signs and symptoms (s/s) of worsening or non healing every shift until resolved, and monitor wounds on right outer leg for s/s of worsening or non healing every shift until resolved. However, there was no documented evidence of treatment orders for Resident #19's wounds. Review of Resident #19's Initial Wound Assessment, completed 12/07/2021, twenty-eight (28) days after admission revealed the resident had the following wounds: 1) Wound to the right gluteal cleft resolved, scar tissue present. 2) Right outer knee wound measured Length-2.0 centimeters (cm) x Width-1.5 cm x Depth-unable to be determined (UTD), no odor, slough covering wound bed, small amount of bloody drainage noted when wound cleaned. However, the description did not indicate the type of wound or stage of wound. 3) Mid back wound measured Length-2.0 cm x Width-1.0 cm with no Depth recorded, no odor but large amount of bloody drainage when cleaned. However, the description did not indicate the type of wound or stage of wound. 4) Right outer calf wound measured Length-15 cm x Width-4.0 cm x Depth-0.2 cm, area of wound close to 12 o ' clock position was noted to have a small area of slough noted, bright red epithelization and granulation present. The wound was described as a Stage III pressure ulcer. 5) Right outer foot wound at base of fifth toe measured Length-2.5 cm x Width-2.0 cm x Depth-0.1 cm, small amount of bloody drainage noted when cleaned, granulation and epithelization present, no odor. The description did not indicate the type of wound or stage of wound. 6) Right outer foot measured Length-1.5 cm x Width-1.5 cm x Depth-0.2 cm, small amount of bloody drainage noted when cleaned. The description did not indicate the type of wound or stage of wound. Review of Resident #19's Physician's orders, dated 12/08/2021, revealed orders to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown (daily). (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 Resident #19's January 2022 Treatment Administration Record (TAR), revealed the intervention to clean the two (2) Stage III Pressure ulcers on the outside of the right foot with wound cleanser, pat dry, and apply Santyl and cover with border gauze daily at 7:00 AM. However, the treatment was not signed to indicate the treatment was completed on 01/01/2022 and 01/02/2022, indicating the CCP was not implemented related to treatments as ordered. Review of Resident #19's Physician orders, dated 01/14/2022, revealed orders for Iodosorb External Gel 0.9% (Cadexomer Iodine), one (1) application to the back daily between 7:00 AM and 6:59 PM. Cleanse wound to back with wound cleanser, pat dry, and apply Iodosorb to wound, and cover with dry dressing. Change dressing daily and PRN (as needed). Review of Resident #19's Physician's orders, dated 02/05/2022, revealed orders for Vaseline gauze to the right leg and foot and wrap with Gauze every three (3) days. Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown, was not signed to indicate the treatments were completed for thirteen (13) days including 02/01/2022,02/02/2022, 02/03/2022, 02/04/2022, 02/05/2022, 02/08/2022, 02/09/2022, 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, 02/15/2022, and 02/18/2022, indicating the CCP was not implemented related to treatments as ordered. Review of Resident #19's February 2022 TAR, revealed the intervention to monitor the wound on the resident's mid back was not signed to indicate monitoring at 7:00 AM for seven (7) days including 02/02/2022, 02/04/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, 02/13/2022, and 02/15/2022, indicating the CCP was not implemented related to treatments as ordered. Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment air mattress was not signed at 7:00 AM for six (6) days including 02/02/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, and 02/13/2022, indicating the CCP was not implemented related to treatments as ordered. Observation of Resident #19, on 02/14/2022 at 9:41 AM, revealed the resident was sitting up in bed. Resident #19 reported there was no bandage on his/her back. The resident's right leg was wrapped in gauze, dated 02/10/2022. Per the TAR, Resident #19's bandage to the right leg was to be changed on 02/12/2022, two (2) days prior, indicating the CCP was not implemented related to treatments as ordered. Observation on 02/16/2022 at 9:41 AM, of a skin assessment for Resident #19 performed by the Education Director, revealed the resident's mid back wound measured Length-7.0 cm x Width-7.0 cm with an open area in the center which measured 1.0 cm x 1.0 cm x 0.5 cm with purulent drainage; the resident's right calf wound measured Length-22 cm x Width-7.0 cm x Depth-0.25 cm ; right great toe wound measured Length-2.0 cm x Width-3.5 cm x (no depth) and was scabbed; right inner ankle wound measured 2.5 cm x 4.5 cm x (no depth) and was scabbed. This Wound Assessment was completed seventy-one (71) days after the last wound assessment, after Surveyor intervention, indicating the CCP was not implemented related to assessing the resident's skin. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and record review revealed from 12/07/2021 until 02/16/2022, the wound to Resident #19's mid back became larger; the area to the right outer calf became larger and increased in depth; and new unidentified areas were found on the resident's right great toe and right inner ankle. The unidentified areas revealed the CCP was not implemented related to assessing skin. Interview, on 02/16/2022 at 1:40 PM, with the Education Director, revealed the nurses were responsible for the skin assessments and wound treatments at this time. She was unaware skin assessments and wound treatments were not being completed as ordered and revealed the CCP was to be implemented related to skin breakdown. Interview with Registered Nurse (RN) #1, on 02/19/2022 at 2:42 PM, revealed she had not been completing Wound Assessments. She further stated the nurses had not been trained to do Wound Assessments and she was not sure which staff member was responsible for completing them. Interview with Resident #19's Physician, on 02/24/2022 at 1:27 PM, revealed she was aware the resident sometimes refused care, especially wound treatments. However, she stated it was her expectation for staff to try to perform wound treatments, and to ensure wound measurements, staging and description of wounds were documented weekly. Further, it was her expectation that all wounds have a treatment in place, and Resident #19 should have had a treatment in place from admission related to pressure ulcers. 3. Record review revealed the facility admitted Resident #39 on 12/20/2021 with Essential (primary) Hypertension, other chronic pain, Polyneuropathy, unspecified, Pressure Ulcer of Right Buttock, Stage 3, Adult Failure to Thrive, Hypokalemia, Hyperglycemia, unspecified, Hyperlipidemia, unspecified, Pressure Ulcer of Right Buttock/unstageable and Acute Kidney Failure, unspecified. Review of Resident #39's Admission MDS Assessment, dated 12/24/2021, revealed the facility had assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating cognitive impairment. Continued review revealed Resident #39 was assessed to be at risk for pressure ulcers and had one unstageable deep tissue injury present on admission on 12/21/2021 and a care plan was developed. Review of Braden Scale for Predicting Pressure Sore Risk, dated 01/31/2022, revealed Resident #39 was at high risk with a total score of twelve (12). Review of Resident #39's Comprehensive Care Plan, dated 12/20/2021, revealed the resident had a Stage III Pressure to right buttock. Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction cushion; provide incontinence care as needed; provide wound care as ordered by the MD; air mattress as ordered; treatment to buttocks per order. Review of Resident #39's initial Wound Assessment, dated 12/21/2022 revealed the resident had a wound measuring 12.2 cm in length x 7 cm in width x 0 cm depth. The wound was dry; black in color; with macerated tissue; no drainage, odor or pain. There was no documented evidence of the wound Stage or where the wound was located. (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 Resident # 39's Physician orders, dated 01/07/2022, revealed Santyl External Ointment 250 unit/gm (collagenase) apply to buttock daily between 7:00 AM and 6:59 PM. Cleanse wound to right buttock with wound cleanser, pat dry and apply silvadene to the outer perimeter of wound. Apply Santyl to eschar on wound, to cover with border gauze and to change daily and PRN. Review of Resident # 39's EMR revealed the next documented Wound Assessment was eighteen (18) days later, on an MD Note, dated 01/07/2022. Per Note the visit was a telehealth wellness visit. The resident had an Unstageable (US) Wound on his/her sacral, which was worse, deeper getting bigger; the wound had no tunneling, no eschar. The wound measurements were 4 cm in length x 2 cm in width. There was no documented evidence of the wound depth or color. Additional review of Resident #39's EMR revealed a Wound Assessment four (4) days later, dated 01/11/2022 at 5:03 PM. Continued review of the Wound Assessment revealed the resident's wound measurements were 11 cm in length x 6.8 cm in width x o cm in depth, the wound was black in color, necrotic, with discolored tissue, small/minimal drainage, no odor, no pain. The wound was documented as not worse. There was no documented evidence of the wound location or Stage. However, continued review of Resident #39's EMR, on 01/11/2022 at 5:10 PM, revealed a Wound Assessment where the wound was measured at 12.4 cm in length x 7.4 cm in width x 0 cm in depth. Per this Assessment the tissue was broken, with moderate serosanguineous drainage, an odor was present, there was no pain and the wound was not worse. However, the measurements were greater, and the wound now had drainage and odor. Further, the Assessment did not include the location of the wound or the Stage of the wound. Review of Resident #39's February 2022 MAR revealed inconsistency in documentation for wound treatment Silvadene order. Continued review revealed blanks areas for seven days on 02/02/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, 02/13/2021 and 02/15/2022, indicating the CCP was not implemented. Review of Resident #39's February 2022 TAR revealed no documented evidence that wound care treatments had been completed for a twice per day coccyx treatment to cleans the wound and appy Silvadene and oil emulsion with a wet to dry gauze dressing for the 9:00 AM treatment dates of 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022 and 02/15/2022 and the 9:00 PM treatment dates of 02/09/2022, 02/11/2022, 02/12/2022 and 02/13/2022, indicating the CCP was not implemented. Interview with Resident #39, on 02/16/2022 at 11:25 AM, revealed the resident felt bad. The resident additionally stated he/she had sores on his/her bottom, and they hurt. The resident was unable to state when the wounds were acquired. The resident further stated the nurses looked at the sore but not daily. Observation of Resident #39 during care provided by Agency SRNA #1, on 02/16/2022 at 11: 30 AM, revealed the resident had two (2) dressings on his/her buttock. One dressing (the top one) was dated 02/14/2022; however, orders revealed the dressing would be changed daily, indicating the CCP was not implemented. (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 SRNA #1, on 02/16/2022 at 11:30 AM, revealed she had worked at the facility for nine (9) months on day shift. She was assigned to the resident Resident #39 on 02/16/2022. Per interview, the resident was total care for all Activities of Daily Living . Additionally, the resident had a really big bed sore on his/her buttock since the resident was admitted to the facility. Continued interview revealed the resident was incontinent of bowel and bladder and wore briefs. The resident needed to be changed every two (2) hours; however, it was common practice for the aides to not complete the first round (check and change for peri-care) until after breakfast due to their assignments of vitals and passing trays. Per interview the first round could be after 10:00 AM. Further, the resident had a wound infection earlier in the year and the wound looked a better now. Further review of the EMR revealed Resident #39's wound was assessed on 01/11/2022 and not assessed again until 02/16/2022 at 12:12 PM, thirty-six (36) days between assessments. Per the Wound Assessment, dated 02/16/2022, the wound measurement was 12 cm in length x 7 cm in width x 2.5 cm in depth, to the left wound. The wound was moist, with intact tissue, small/minimal sanguineous drainage, no odor, mild pain and undermining to the left of the wound at the 9:00 o'clock position. Per the Assessment the wound was not worse; however, the wound measurements were greater since the 01/11/2022 assessment, the wound now had pain and undermining. Further, the Assessment did not include the wound location or Stage. Interview, on 02/16/2022 at 1:35 PM, with LPN #7 who was agency staff, revealed she had been to the facility eight (8) times and had not received any training from her agency or the facility on wound care, wound assessment, or documentation of wounds. Additionally, she did not know what the order for treatment was for Resident #39. Further, she told the Director of Nursing (DON) who was present with the Education Director Nurse, she did not feel comfortable performing wound care on the resident. Interview, on 02/16/2022 at 1:40 PM, with the Education Director Nurse, revealed she had worked at the facility since May of 2021 however had been in her current role since February 2022. Per interview, Resident #39 was admitted to the facility with the coccyx wound, at that time it was completely covered with eschar and the treatment was to cover with Santyl. She stated when the border came off, there was a huge wound with tunneling under it. Additionally, she had rounded with the Medical Director on 02/09/2022 for the major wounds in the facility because the wound nurse was no longer at the facility at that point. When she rounded with the physician, the physician told her the resident's wound was Unstageable. Continued interview revealed the wound nurse, prior to leaving the facility, was responsible for all skin and wound assessment and documentation as well as rounding with the physician for wounds. Additional interview revealed after completion of treatment or assessment, the primary nurse was now responsible to documented on the TAR/MAR in the EMR. (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 wound care performed for Resident #39, on 02/16/2022 at 1:45 PM with the Education Director Nurse, the DON and the Agency LPN #7, revealed there were two (2) adhesive border dressings intact to the mid buttock. The top dressing was dated 02/16/2022 with initials, there were two dime size bright red blood spots on the top right corner of the dressing. The bottom dressing had two (2) nickel size bright red blood spots on the distal end of the dressing, it was dated 02/16/2022 and initialed. Continued observation revealed the Education Director Nurse removed the dressing revealing a large, irregular shaped wound that was moist with a beefy red wound bed with scattered yellow slough throughout the wound bed. No drainage noted. No odor noted. No eschar. Peri wound skin was pink but blanchable. The edges of the wound were thick and rolled. At the top of the wound a large hole was noted which tunneled upward and slightly towards the right. The wound was cleaned with wound cleanser on a 4x4 gauze and patted dry. The wound measurements were 11 cm length x 5.5 cm width x no depth measured. Tunneling of the wound was measured at 6.5 cm with Q-tip and the nurse stated the tunneling was from 12:00 -1:00 o'clock positions. Two 4x4 gauze pads were saturated with normal saline and laid over the tunneling hole. An oil emulsion was laid over remaining wound bed and Silvadene was thinly applied around the wound edges. No eschar was noted and no Santyl was used. One (1) adhesive border gauze was placed over the treatment, initialed and dated. Interview with the Regional Quality RN, on 02/16/2022 at 3:00 PM, revealed she had completed a wound assessment for the resident on 02/16/2022 because she heard the SSA wanted to watch wound care. She stated she used the National Pressure Injury Advisory Panel (NPIAP) as a resource for wound assessment. She staged the wound as a Stage III because there was no tendon or muscle showing only deep tissue. Continued interview revealed she measured the wound to be 12 cm length x 7 cm width (at widest across) x 2.5 cm with tunneling. She stated she did not measure tunneling because she did not have a Q-TIP and knew someone else was going to be measuring it with the SSA observing. Additionally, she stated the tunnelling appeared to go upward towards the left and that is why she documented it as at the 9:00 o'clock position to show it went towards the left. Further, she stated p [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. 22976 Based on interview, record review, the facility's policy and the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, revised October 2019, it was determined the facility failed to revise the Comprehensive Care Plan with interventions to prevent malnutrition and dehydration for one (1) of thirty-three (33) sampled residents (Resident #428). In September 2021, Resident #248 was not meeting his/her estimated fluid needs and not eating. Resident #428 was later diagnosed with COVID-19. Resident #248 was transferred to the hospital and diagnosed with Severe Dehydration, Malnutrition, and Acute Renal Failure. In addition, the facility failed to revise the Comprehensive Care Plan with interventions to treat pressure ulcers and prevent worsening of the pressure ulcers for three (3) of thirty-three (33) sampled residents (Residents #19, #39 and #63). The facility's failure to ensure resident Comprehensive Care Plans were revised as indicated has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/18/2022 and was determined to exist on 09/12/2021, in the areas of 42 CFR 483.10 Resident Rights (F580) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657) at the highest s/s of a J, and 42 CFR 483.25 Quality of Care (F684 and F692) at the highest s/s of a J. The facility was notified of Immediate Jeopardy on 02/18/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. An Acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to remove the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. The findings include: 1. Interview on 02/21/2022 at 3:12 PM, with the Administrator, revealed the facility did not have a policy for revision of residents' care plans. According to the Administrator, the facility followed the Resident Assessment Instrument (RAI) process for developing, revising, and following the plan of care. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, revised October 2019, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, 4.7 revealed the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Further review revealed facilities were to use the past fifteen (15) months of assessments results to develop, review, and revise the resident's comprehensive plan of care. Further review revealed the resident's care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving. (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 #428's closed medical record revealed the facility admitted him/her on 05/18/2021, with diagnoses which included Delirium, Dementia, Encephalopathy, and Delusional Disorder. A review of Resident #428's Quarterly Minimum Data Set (MDS) Assessment, dated 08/03/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5), which indicated the resident was cognitively impaired. The facility assessed the resident to require the extensive assistance of staff for eating and weighed one hundred and thirty (130) pounds. Further review of the assessment revealed the resident had no weight loss or gain in the past month or six (6) months, and had no assessed concerns for nutrition and hydration. Review of Resident #428's Comprehensive Care Plan revealed a nutritional services care plan for the resident dated 06/11/2021. Review of the nutritional services care plan revealed Resident #428 had problems noted of difficulty swallowing/chewing, and weight gain of 6.9% in one (1) month. Continued review revealed goals had been developed for Resident #428 which included the resident to maintain a consistent body weight plus or minus five (5) percent for ninety (90) days, and remain free of signs and symptoms of dehydration for ninety (90) days. Further review revealed the interventions developed included: staff to allow for the resident's likes/dislikes; provide his/her diet, snacks and supplements as ordered; provide follow up diet education/encouragement if preferences were not in compliance with prescribed diet; monitor his/her weight; and provide nutritional counseling as needed. In addition, review of the care plan further revealed no documented evidence of any revisions made to Resident #428's Comprehensive Care Plan after the date of 06/11/2021. Review of a nutrition assessment completed for Resident #428 by the dietitian, dated 07/29/2021, revealed the facility assessed the resident's estimated fluid need was 1475 to 1770 milliliters (ml) per day. In addition, Resident #428's documented food intake from 09/12/2021 until 09/20/21, revealed Resident #428 had only consumed meals five (5) times in the eight (8) day period. Further review revealed no documented evidence of any food intake for Resident #428 for the dates of 09/13/2021, 09/15/2021, and 09/19/2021. Review of Resident #428's closed medical record revealed the resident was diagnosed with the COVID-19 virus on 09/15/2021. Further review revealed five (5) days later, on 09/20/2021, the resident was transferred to the hospital following a change of condition. The resident was noted to vomit a dark black substance. Review of the hospital record for Resident #428 revealed the resident was admitted to the hospital on 09/20/2021, with diagnoses that included severe malnutrition, and dehydration. The resident's BUN (blood urea nitrogen, a test that measures waste product in your blood) was 110 (normal range is 5-20) and his/her creatinine was 3.91 (normal range is 0.74 to 1.35). The Emergency Department Physician documented Resident #428 was thin and cachetic (extreme weight loss and loss of muscle mass). According to the hospital Dietitian's assessment of Resident #428, on 09/21/2021, the resident was severely malnourished with a Body Mass Index (BMI) of 17.52. The Hospital dietetic also documented the resident had severe loss of muscle mass, prominent protrusion of bones, and pronounced hollowness/depression of the eyes. Resident #428 passed away at the hospital on 09/26/2021. (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 MDS Nurse, on 02/24/2022 at 8:56 AM, revealed she did not develop or revise Resident #428's plan of care for nutrition/hydration when the resident had a decline in food/fluid intake. Further interview revealed the Dietitian was responsible for developing and revising the resident's plan of care for nutrition and hydration. Interview with Dietitian #1, on 02/18/2022 at 2:47 PM, revealed she was responsible for revising the nutritional services care plan for Resident #428. According to the Dietitian, she had not been made aware that Resident #428 had not been eating and drinking, and not meeting his/her estimated fluid needs. The Dietitian stated she came to the facility and met with the Interdisciplinary Team (IDT) weekly. She stated during her weekly visit she reviewed any resident identified as having a nutritional concern. The Dietician stated she mainly focused on weight loss or, on residents whom the facility had identified as nutritionally at risk. However, the Dietician stated she was never notified of a concern regarding Resident #428, and she had not assessed the resident. Further the Dietician stated in the previous month (August 2021) Resident #428 had improved as far as his/her weight and nutrition. She stated since the improvement, the IDT had determined Resident #428's weekly weights could be changed to monthly weights. Dietician #1 further stated she could not recall any concerns being discussed in the IDT meetings related to Resident #428's nutrition and hydration. Interview with the former Director of Nursing (DON) #1 on 02/19/2022 at 12:29 PM, revealed the DON had conducted the daily clinical review (DCR) meetings with members of the IDT. She stated in the DCR meetings, she and the IDT members reviewed any concerns that had developed regarding residents. According to former DON #1, if a resident was not eating and drinking and that information had not been noted, she and the other IDT members might not become aware. Former DON #1 stated average daily intake reports for residents were printed by the Unit Manager, or the DON if the Unit Manager was working the floor. She stated the report was reviewed weekly in the facility's IDT meetings. Further interview revealed the former DON had not been made aware of any concern regarding Resident #428 not eating or meeting his/her estimated fluid needs. She further stated if the IDT had been made aware of any concerns regarding Resident #428's nutritional or fluid deficits, the Dietitian would have revised the resident's care plan with interventions to address those issues. 2. Review of Resident #19's medical record revealed the facility admitted the resident on 11/09/2021, with diagnoses which included Pressure Ulcer, Osteomyelitis, Methicillin-Resistant Staphylococcus Aureus (MRSA), and Paraplegia. Review of Resident #19's Admission MDS Assessment, dated 11/15/2021, revealed the facility assessed the resident to be at risk for pressure ulcers with two (2) Stage III pressure ulcers present on admission on 11/09/2021. A care plan was developed. Continued review revealed the facility assessed Resident #19 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated the resident was cognitively intact. Review of Resident #19's Physician's Orders revealed an order dated 11/09/2021 for an air mattress to be used on his/her bed to promote wound healing. Continued review of the Physician's Orders revealed an order dated 11/11/2021 for a pressure reducing boot to Resident #19's left leg. (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 #19's Admission Care Plan dated 12/08/2021, revealed the facility had noted and care planned the resident for the following skin issues: two (2) Stage III pressure ulcers on the outside of the right foot; wound to right outer leg on side of knee; wound to mid-back spine; and wound to the right outer leg. Continued review revealed interventions which included: staff to assess Resident #19's skin and report redness, rashes, bruises, abrasion or skin breakdown. Record review revealed additional interventions included: a pressure reduction mattress; provide wound care, treatments and medications as ordered by the Physician. Further review revealed Resident #19's care plan was not revised/updated with the Physician's Order dated 11/09/2021, for the air mattress to bed to promote wound healing for the resident, until 12/08/2021 (twenty-eight [28] days after receiving the order). In addition, further review revealed Resident #19's care plan had not been updated/revised to include the Physician's Order dated 11/11/2021, for the pressure reducing boot to the resident's left leg every shift as tolerated until 12/08/2021 (twenty-six [26] days after the order was received). Continued review of Resident #19's medical record and care plan revealed the resident was noted as a left above the knee amputee (AKA). Further review revealed Resident #19 was a left AKA and the pressure reduction boot was ordered for the wrong leg. Review of the facility's, Initial Wound Assessment note for Resident #19 dated 12/07/2021, which was completed twenty-eight (28) days after admission, documented the following wounds and measurements: wound to right gluteal cleft resolved; wound to right outer knee measured 2 cm (centimeters) x 1.5 cm x UTD (unstageable depth of a wound); wound to mid back measured 2 cm x 1 cm x UTD; wound to the right outer calf measured 15.0 cm x 4 cm x 0.2 cm; wound to right outer foot at base of pinky toe measured 2.5 cm x 2 cm x 0.1 cm; and the wound to his/her right outer foot measured 1.5 cm x 1.5 cm x 0.2 cm. Further review revealed no evidence of other Wound Assessment Notes or wound measurements present in Resident #19's medical record until 02/16/2022. Review of the care plan revealed the facility failed to update the care plan with interventions to treat pressure ulcers and prevent worsening of the pressure ulcers Observation on 02/16/2022 at 9:41 AM with the Education Director revealed measurements were completed of Resident #19's wounds. Observation revealed the right calf wound measured: Length-22 cm x Width-7 cm x Depth-0.25 cm; right great toe wound measured Length-2 cm x Width-3.5 cm x scab (no depth); right inner ankle wound measured Length-2.5 cm x Width-4.5 cm x scab (no depth); and mid back wound measured 7 x 7 cm with open area in the center that was 1 cm x 1 cm, with purulent drainage. Review of Resident #19's skin assessments and Progress Notes revealed it had been seventy-one (71) days since the last assessment was documented. The facility failed to complete skin assessments and revise Resident #19's care plan to ensure appropriate care was provided. 3. Review of Resident #39's medical record revealed the facility admitted the resident on 12/20/2021. The resident's diagnoses included Chronic Pain; Polyneuropathy; unspecified, Stage 3 Pressure Ulcer of right buttock; Adult Failure to Thrive; unspecified, unstageable Pressure Ulcer of right buttock; and Acute Kidney Failure, unspecified. (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 #39's Admission MDS Assessment, dated 12/24/2021, revealed the facility assessed the resident as at risk for pressure ulcers. Continued review of the MDS revealed the facility had assessed the resident with one (1) unstageable pressure injury which presented as a deep tissue injury which was present on the resident's admission. Further review revealed the facility assessed Resident #39 with a BIMS' score of six (6), which indicated the resident was moderately cognitively impaired. Review of the facility's IDT Notes dated 12/20/2021, revealed on admission, the facility assessed Resident #39 to have a large unstageable deep tissue injury (DTI) that was covered in black tissue with varying degrees of redness surrounding it. Review of Resident #39's admission Care Plan, dated 12/20/2021, revealed the facility documented and care planned the resident for a Stage 3 pressure ulcer to the right buttock. Continued review of the care plan revealed no interventions were implemented until 01/07/2022, seventeen (17) days later. Interventions noted on 01/07/2022 included for staff to assess the resident's skin and report any redness, rashes, bruises, abrasion or skin breakdown. Further review revealed the 01/07/2022 interventions additionally included a pressure reduction mattress, and staff to provide wound care as ordered by the Physician, and provide incontinent care as needed. Continued review of Resident #39's medical record revealed the resident was sent to a Wound Care Physician on 02/09/2022 for evaluation of his/her right buttock pressure ulcer. The evaluation revealed a note from the Wound Physician dated 02/09/2022, which documented Resident #39's wound as worse with Santyl ointment (debriding agent) currently being used. Continued review of the Progress Note revealed Resident #39 had been documented as bed bound and wound was deep and getting bigger. Further review revealed the Plan for Resident #39's right buttock pressure ulcer was to discontinue the Santyl ointment; start Silvadene to the center of the ulcer with a dressing twice a day. Review of the Plan further revealed avoid direct pressure to the pressure ulcer with an air mattress and side to side position changes for the resident. Further review of Resident #39's care plan revealed no documented evidence of updates/revisions to the care plan regarding the new Physician's Orders received on 02/09/2022. Review of the facility's Initial Wound Assessment note for Resident #39 dated 12/21/2021, revealed the resident had been noted to have an unstageable pressure ulcer on his/her right buttock. Continued review of the Wound Assessment note revealed the wound measurements were documented as 12.0 cm length x 7 cm width x depth 0. Further review revealed the unstageable pressure ulcer on Resident #39's right buttock was noted as dark purple/black in color and feels boggy. In addition, further review revealed Resident #39's skin around the unstageable pressure ulcer on the right buttock was macerated (condition occurring when skin remains in contact with moisture for too long) and had moisture-associated skin damage (MASD) noted. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of wound care and measurements performed on 02/16/2022 at 1:45 PM, by Licensed Practical Nurse (LPN) #4, with the facility's Regional Quality Manager (RQM) and DON also present, during LPN# 4 conducted wound care and measurements. Observation revealed the measurements of Resident #39's right buttock unstageable pressure ulcer revealed LPN #4's measurements were 11 cm length x 5.5 cm width; however, the depth of the wound was not documented. Further observation revealed LPN #4 observed tunneling (occurs when a pressure ulcer progresses causing passageways underneath the surface of the skin) was measured as 6.5 cm with a cotton swab and the RQM stated the tunneling was from 12:00-1:00 o'clock (a clock format used to describe location). 4. Review of Resident #63's medical record revealed the facility admitted him/her on 01/14/2022, with Peripheral Vascular Disease, unspecified, Acquired absence of left leg above knee (AKA), Asthma, Chronic Pulmonary Embolism, and Acute Respiratory Failure with Hypoxia. Review of the Admission MDS Assessment, dated 01/19/2022, revealed the facility assessed Resident #63 as at risk for pressure ulcers, with one (1) Stage II Pressure Ulcer and a surgical wound present on admission. Record review revealed a care plan was developed to address Resident #63's skin issues. Further review revealed the facility had assessed Resident #63 with a BIMS' score of fifteen (15), which indicated the resident was cognitively intact. Review of the facility's IDT's notes dated 01/14/2022, revealed the admission orders for Resident #63's Stage II pressure ulcer on the coccyx and left AKA had been received. However, further review revealed no documentation that the IDT addressed the admission orders in Resident #63's care plan. Review of Resident #63's Admission Care Plan, dated 01/14/2022, revealed the resident was noted to have a Stage II Pressure to his/her coccyx and a left AKA which had been care planned. Continued review revealed Resident #63 had new wound orders related to the left AKA dehiscence; however, the facility failed to revise the care plan until 02/07/2022. Continued review revealed interventions included staff to assess skin and report redness, rashes, bruises, or skin breakdown; pressure reduction mattress to bed; provide incontinent care as necessary; and provide wound care and treatment to stump (left AKA wound) as ordered. However, review of Resident #63's Comprehensive Care Plan dated 02/04/2022, revealed new treatments for Resident #63's Stage II coccyx and left AKA were not updated on the care plan until 02/07/2022. Review of the facility's Initial Wound Assessment note for Resident #63, dated 02/16/2022, revealed the resident had a deep wound from dehiscence (partial or total separation of previously approximated surgical wound edges). Continued review revealed the wound measurements were documented as 6 cm in length x 5 cm in width x 1 cm depth. Further review revealed the wound was noted as red flesh, with a small amount of yellow drainage. Review further revealed Resident #63 had complained of pain with the packing of the wound. In addition, record review revealed no documented evidence of the wound tissue or location of the wound. Observation on 02/21/2022 at 1:30 PM, with State Registered Nurse Aide (SRNA) # 17 and Kentucky Medication Aide (KMA) #2 revealed Resident #63 had an open hole on his/her coccyx between the gluteal fold. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of wound care and interview on 02/21/2022 at 1:50 PM, with LPN #13 revealed the open hole observed on Resident #63's coccyx wound was circular but irregular in shape; the peri skin was blanchable; and there was no drainage or odor. Continued observation revealed LPN #13 measured the coccyx wound and the wound measurements obtained were 1 cm length x 0.9 cm width x 0.4 cm depth, which was the first documented evidence of the coccyx wound assessment since the resident was admitted , thirty-eight days prior. LPN #13 stated she was uncertain of the stage of the coccyx wound, and this had been the first time she had seen the wound or provided care for the resident. Interview with LPN #4 on 02/20/2022 at 4:00 PM, revealed residents' wound changes and treatments were to be updated/revised on their care plans. LPN #4 stated nursing staff used residents' care plans to provide the appropriate care and treatments. Interview with LPN #12 on 02/20/2022 at 4:15 PM, revealed she used residents' care plans to know how to care for the residents. LPN #12 stated she knew residents' care plans needed to be updated or revised when changes occurred with a resident. Interview with the MDS Nurse on 02/24/2022 at 8:55 AM, revealed the facility had no audits in place to ensure residents' care plans were an accurate reflection of the residents. She stated all residents had a baseline care plan when admitted . Interview revealed she relied on the staffs' documentation to know when changes occurred, and she updated/revised the residents' care plans with more specific interventions, after the changes. Continued interview revealed residents' care plans were to be revised and updated to ensure they were accurate. She stated the care should be revised timely to reflect each resident's needs to ensure staff knew how to care for them. The MDS Nurse stated, everyone (all staff) used the residents' care plans as it told them how to take care of each resident. According to the MDS Nurse, the potential problems of residents having an incomplete or inaccurate care plan was that a resident might not receive the care they needed, or the resident might develop a wound which might not be cared for as needed. She stated the floor nurse could tell her or the DON, if the care was not accurate for a resident, and she or the DON would make the necessary changes. Further interview revealed on a resident's admission, the nurses did the face-to-face assessment of the new resident. The MDS Nurse stated she did not normally do a head to toe assessment even on a resident's admission. She further stated she relied on the documentation that was discussed and reviewed in the facility's daily clinical meeting to know when to revise residents' care plans. In addition, she stated all new treatment orders and wound changes should have been placed on the residents' care plans to ensure the care plan was revised timely. The MDS Nurse stated if a resident's care plan was not updated or revised timely it could be harmful for the resident. Interview with the Administrator on 02/24/2022 at 12:58 PM, revealed her expectations were for facility staff to update and revise residents' care plans. Continued interview revealed with any new Physician's Orders the resident's care plan needed to be reviewed and updated, because the care plan showed staff how to care for residents. She stated the residents' care plans were the way staff knew what care the residents needed; therefore, the care plans needed to be updated timely. The Administrator stated she was not aware the residents' care plans were not being updated or revised as required. Interview with the facility's Medical Director on 02/24/2022 at 1:27 PM, revealed residents' care plans were to be revised timely to show changes with residents in order to ensure and maintain the continuity of care for the residents. The Medical Director stated ensuring residents' care plans were revised was for best practices. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	44371

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, review of Novartis Pharmaceuticals Corporation medication administration recommendations and review of the [NAME] Manual of Nursing Practice, it was determined the facility failed to ensure medication administration met professional standards of quality for two (2) of thirty-three (33) sampled residents (Residents #33 and #39). Observation during the medication pass revealed, staff did not use the gravity method to administer medication into a gastrostomy tube. In addition, further observation revealed staff did not assess the resident's pulse or blood pressure before administering a blood pressure medicine. The findings include: Review of the facility's policy titled, Administration of Medications, dated 12/2012, revealed Gastrostomy tube (G-tube/feeding tube) medication was not addressed in the policy. Review of the [NAME] Manual of Nursing Practice, 9th Edition, page 751, for standards of nursing practice, revealed that the nurse should pinch off the tube, attach the barrel of the catheter-tipped syringe, then fill the syringe with the water and medication mix and allow the fluid to flow by gravity. Per standards of practice, following the gravity method prevents air from entering the stomach, prevents clogging the tube, prevents distention from air in the stomach or too much liquid too quickly. Review of the package insert for Metoprolol Tartrate, https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/017963s062,018704s021lbl.pdf , provided by Novartis Pharmaceuticals Corporation, revised 02/2008, revealed the drug is a is a beta-blocking agent used for the treatment of Hypertension. Metoprolol Tartrate produces a decrease in sinus heart rate, known as Bradycardia (a pulse of less than sixty (60) beats/minute) in most clients. Per manufacturer's instructions the clients should be assessed for Bradycardia prior to administration of the medication. 1) Review of the medical record revealed the facility admitted Resident #33 on 11/18/2020 with diagnoses to include Encephalopathy, Chronic Pain, Heart Failure, Hypertension, Cerebral Vascular Accident, Aphasia, and a Seizure Disorder. Review of Resident #33's Quarterly Minimum Data Set, dated dated [DATE], revealed the facility assessed the resident to have a BIMS of ninety-nine (99), indicating the resident could not complete the interview. Per MDS review, the resident was admitted with a feeding tube due to Cerebral Vascular Accident and Impaired Function Status. Review of Resident #33's Comprehensive Care Plan revealed a focus area related to the resident being at risk for injury/complications related to Aphagia following a Stroke with an intervention to give medications as ordered per G-tube. The facility care planned Resident #33 for nutritional problems related to Aphagia, and Chronic Pain related to Stroke, and G-tube placement. Each focus area had an intervention to administer medications as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33's Physician's Order Summary Report, dated 02/24/2022, revealed a Physician's Order to have pills administered through Gastrostomy tube (G-tube) secondary to Aphagia. Observation of Licensed Practical Nurse (LPN) #8, on 02/18/2022 at 3:01 PM, revealed LPN #8 obtained one (1) Baclofen oral tablet 10 milligrams (mg) medication, halved the tablet at the scored line, and then crushed the pill. LPN #8 then mixed the medication with thirty (30) millimeter (mL) of water. Further observation revealed LPN #8 performed a G-tube placement check for signs of malposition and checked for residual. Finally, LPN #8 administered the medication to Resident #33 by placing the tip of the syringe into the G-tube and then pushing the plunger. Interview with LPN #8, on 02/18/2022 at 3:10 PM, revealed he had forgotten that it was facility policy to use the gravity method for medication administration. LPN #8 stated it was a standard of care to administer G-tube medications via the gravity method. He explained that he had worked for another facility, where the process was to push the medication with a syringe. He stated the risk to the resident was abdominal distention and air in the stomach. The LPN stated using the gravity method to administer medications through a G-tube was safer for the resident. Interview with the Regional Quality Manager/Director of Nursing (RQM/DON) #4, on 02/18/2022 at 3:13 PM, revealed administration of a G-tube medication was not different than any other medication. Continued interview revealed a Physician's Order was required to give the medications in combination with a water flush. However, she stated the facility's policy and best practice was to use the gravity method for administering medications per G-tube. She further stated that nursing staff should administer medications using the gravity method and not force with a syringe. Per interview, the facility followed the [NAME] Manual of Nursing Practice, 9th Edition, for standards of nursing practice. Interview with Registered Nurse (RN) #1, on 03/04/2022 at 4:48 PM revealed medications administered via g-tubes should be crushed individually. Each medication should be administered with thirty (30) milliliters (ml) of water. She stated she verified placement before medication administration. RN #1 stated that she used a syringe to administer medication. Further interview review revealed she does not use the gravity method. 2) Review of Resident #39's medical record revealed the facility admitted the resident on 12/20/2021 with diagnoses to include Hypertension. Review of Resident #39's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident to have a Brief Interview of Mental Status Score (BIMS) of six (06) out of fifteen (15) indicating very severe impairment. Observation of Licensed Practical Nurse (LPN) #7, on 02/22/2022 at 8:45 AM, revealed the nurse administered Metoprolol Tartrate (medication to lower blood pressure) 25 milligrams (mg) one (1) tablet by mouth to Resident #39. LPN #7 failed to obtain the resident's blood pressure (BP) or pulse prior to administration of the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #7, on 02/22/22 at 8:45 AM, revealed she stated that the State Registered Nurse Aide's (SRNA) take the residents' vital signs in the morning and document them in the chart. She could not say what time the aide took the resident's vital signs. LPN #7 stated she looked at Resident #39's vital signs in the chart before administering his/her medication. She stated Resident #39's pulse was 76 beats per minute (bpm). She stated these parameters were well within the limits for administering the drug; however, she could not ensure that Resident #39's pulse had not changed since the time the SRNA obtained them. LPN #7 stated the only way to ensure the pulse had not change was to assess the resident's pulse again. She stated that the risk to the resident by administering Metoprolol Tartrate without knowing the pulse was that it could cause the heart to beat slower. Interview with DON #5, on 03/04/2022 at 5:36 PM, revealed that it was her expectation that nursing staff assess a resident prior to administering a medication with parameters for administration. She stated nurses should not rely on another nurse or SRNA's assessment. Interview with Administrator, on 02/18/2022 at 3:25 PM, revealed the facility does not have a policy on administering medications via g-tubes. Per the interview, the Administrator revealed she was not clinical and would have to defer to her DON to answer a clinical question regarding medication administration.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22976 Based on observation, interview, record review and review of the facility's policy, the [NAME] Manual of Nursing Practice, Ninth Edition, it was determined the facility failed to ensure one (1) of thirty-three (33) sampled residents (Resident #428) received the necessary quality of care and treatment services in accordance with professional standard of practices. State Registered Nurse Aides (SRNAs #3 and #4) observed a change of condition for Resident #428. Staff were not able to obtain the resident's oxygen saturation level due to the resident being drenched in sweat. The resident's fingers were purple almost black in color. The facility had no documented evidence staff conducted a thorough assessment of Resident #428's physical condition including his/her respiratory status, nor documented evidence of staff's inability to obtain the resident's oxygen saturation level. Resident #428 was transported to the hospital and according to the hospital record he/she required eight (8) liters of supplemental oxygen per minute to maintain his/her oxygen saturation levels. In addition, Resident #428 was diagnosed with Sepsis (medical emergency caused by the body's response to an infection which could be life-threatening) due to Pneumonia and Acute Respiratory Failure due to Hypoxia (lack of adequate oxygenation). The facility's failure to ensure residents received quality of care and treatment has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/18/2022 and was determined to exist on 09/12/2021, in the areas of 42 CFR 483.10 Resident Rights (F580) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657) at the highest s/s of a J, and 42 CFR 483.25 Quality of Care (F684 and F692) at the highest s/s of a J. The facility was notified of Immediate Jeopardy on 02/18/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. The findings include: Interview with Director of Nursing (DON) #5, on 03/04/2021 at 5:36 PM, revealed the facility did not have a policy regarding professional standard of practice. However, the facility utilized, the [NAME] Manual of Nursing Practice, Ninth Edition, to guide its nursing staff's practice to meet professional standards. (continued on next page)

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Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the [NAME] Manual of Nursing Practice, Ninth Edition, page 284, revealed for acute respiratory disorders the standards of care guidelines for respiratory compromise was for the nurse to perform a thorough systematic assessment. Continued review revealed the thorough systematic assessment was to include assessment of: mental status; vital signs; cardiovascular status and respiratory status. Further review revealed the nurse should evaluate for signs of hypoxia (low level of oxygen in the blood) when anxiety, restlessness, confusion, or aggression of new onset were noted. Further review revealed the nurse was to document the patient's condition to provide a record for continuity of care and notify the appropriate health care provider of significant findings of hypoxia; cyanosis, rapid and shallow respirations, abnormal breath sounds, change in behavior or level of consciousness (LOC). Review of Resident #428's closed medical record revealed the facility admitted the resident on 05/18/2021 with diagnoses which included Dementia, Delirium, Delusional Disorder, and Encephalopathy. Review of the most recent Quarterly Minimum Data Set (MDS) assessment completed for Resident #428 with a date of 08/03/2021 revealed the facility assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of five (5). Further review revealed the facility assessed the resident to require the extensive assistance of two (2) staff for transfers, bed mobility, and toileting. Continued review revealed the facility assessed the resident as always incontinent of bowel and bladder. Review of Resident #428's Comprehensive Care Plan revealed the facility had revised the plan of care for Resident #428 with a positive COVID status on 09/14/2021. Interventions included to place the resident in transmission based precautions, per the facility's COVID 19 protocol and administer medications as ordered. Review of the Nursing Progress Notes for Resident #428, dated 09/20/2021 at 11:34 AM, revealed thirty minutes earlier on 09/20/2021 at 11:00 AM, the resident was documented to have had a large emesis (vomit) which was dark black in color. Continued review of the 09/20/2021 Nursing Progress Note, revealed Resident #428's vital signs were noted as: blood pressure 173/83; pulse of 85; respirations of 18; and the resident's oxygen saturation was not able to be obtained. According to the Note, the physician was contacted and orders were received to send the resident to the hospital for evaluation and treatment. Further review of the Nursing Progress Notes for Resident #428 revealed no documented evidence of assessment of the resident's respiratory status from 6:00 AM until 11:00 AM on 09/20/2021 when the resident was sent out to the hospital. Review of the hospital's medical record for Resident #428 revealed when the resident arrived at the emergency room (ER) on 09/20/2021, the resident required oxygen at eight (8) liters per minute (LPM) to maintain his/her oxygen saturation Continued review revealed Resident #428 was noted to have crepitus (palpable or audible popping, crackling, grating, or a crunching sensation) lung sounds and had been diagnosed with Sepsis due to Pneumonia and Acute Respiratory Failure due to Hypoxia. Further review revealed Resident #428's fingers and toes were assessed as cyanotic (bluish or purplish discoloration of the skin due to lack of adequate oxygen) and the resident's lower extremities were mottled (blotches or spots indicating abnormal flood flow). Review of the hospital records revealed Resident #428 was placed on comfort measure at the hospital. Resident #428 passed away at the hospital six (6) days later on 09/26/2021. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/08/2022 at 4:06 PM, with State Registered Nurse Aide (SRNA) #3 revealed on the morning of 09/20/2021 at approximately 5:00 AM, Resident #428 would not take a drink for her. The SRNA stated they had checked on the resident every two hours. Continued interview revealed Resident #428's fingers had been purple almost black and she and SRNA #4 reported the changes to Licensed Practical Nurse (LPN) #6. SRNA #3 stated LPN #6 had not done anything for Resident #428. Further interview revealed due to LPN #6's not doing anything, she had decided to report her concerns regarding Resident #428 to the oncoming day shift nurse. The SRNAs stated there was no night shift supervisor on duty. However, she had not been able to report to the day shift nurse because LPN #6 had been with the day shift nurse at shift change for shift report. Further interview with SRNA #3 revealed since she couldn't talk to LPN #6, she attempted to notify the Director of Nursing (DON) and the Administrator, but they did not answer their phone. Interview on 02/08/2022 at 2:14 PM, with SRNA #4 revealed the SRNA had been working the night before the resident was sent to the hospital on 09/20/2021. SRNA #4 stated around 5:00 AM, Resident #428 had a change of condition and wasn't eating and drinking. Continued interview revealed the SRNA had been unable to obtain an oxygen saturation on Resident #428, and the resident's breathing was labored. He stated Resident #428 had been drenched in sweat and he thought the resident was going to die. Further interview revealed he and SRNA #3 reported everything regarding Resident #428's condition to LPN #6 multiple times. SRNA #4 stated LPN #6 told him that the resident was not going to die in the next two hours and day shift would take care of Resident #428 when they came in to work. Interview on 02/18/2022 at 2:58 PM, with LPN #6 revealed she had provided care for Resident #428 on the night shift on 09/19/2021 from 7:00 PM to 7:00 AM on the morning of 09/20/2021. LPN #6 stated she checked on the resident every hour. According to the LPN, she could not remember any concerns regarding Resident #428 not eating or drinking and had not been made aware of any changes in the resident's condition. Continued interview revealed LPN #6 denied any knowledge of SRNA #3 and SRNA #4 reporting concerns of Resident #428's fingers being purple/black and not being able to get an oxygen saturation level on the resident. LPN #6 stated if she had known of that information, she would have assessed Resident #428, and reported any changes of condition to the Physician and resident's family. Further interview revealed LPN #6 could not recall why she had not documented any Progress Notes on her shift for Resident #428 on 09/19/2021 through 09/20/2021. Interview on 02/18/2022 at 11:55 AM, with LPN #5 revealed the LPN could not recall very much about Resident #428, other than sending the resident to the hospital. LPN #5 stated sometimes the SRNAs got residents' vital signs and sometime she would get the vital signs. She stated she was not aware why vital signs for Resident #428 were not documented from 6:00 AM to 11:00 AM, or why there was no assessment documented either. Continued interview revealed residents were checked on every hour. However, she might have been busy and forgot to put Resident #428's vital signs in the computer. LPN #5 stated that might also have been why she had not made any notes for Resident #428 in the computer. Further interview revealed she could not recall Resident #428's fingers being blue, nor not being able to obtain an oxygen saturation level for the resident. LPN #5 further stated Resident #428 had experienced a change of condition, vomiting a large black emesis, and she called the Physician and sent the resident out to the hospital as she documented in his/her record. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with SRNA #8 on 02/19/2022 at 10:13 AM revealed he often provided care for Resident #428 on the COVID Unit from 09/15-20/2021. SRNA #8 stated the resident did not eat and drink well. However, he stated he could not document the resident's food and fluid intake because he was an agency staff and did not have computer access to chart care in the electronic medical record. Further interview revealed Resident #428 did not eat and drink very much and he thought it was normal for the resident and didn't report anything to the nurse. Interview on 02/19/2022 at 12:29 PM, with former Director of Nursing (DON) #1 revealed if a resident had a change of condition the nurse was supposed to assess the resident. Continued interview revealed the nurse assessing a resident's change in condition was also to document the findings of the assessment in the resident's electronic medical record, notify the Physician and document the notification and Physician's orders. According to the DON, residents on the COVID Unit, were required to have their respiratory status assessed every two (2) hours. The assessment should include: checking oxygen saturation levels, and if warranted, assessment of the resident's lung sounds because they were on the COVID Unit. The DON stated they reviewed residents' electronic medical records in the morning meeting, but she did not recall any concerns with Resident #428. Continued interview revealed former DON #1 was not aware assessments of the oxygen saturation level for Resident #428 had not been documented from 6:00 AM to 11:00 AM as required. The DON stated she did not recall any concerns with Resident #428 having had discolored fingers. However, she stated she expected this information to have been reported to the Physician as a change of condition for the resident. She stated she also expected Resident #428 to have been monitored by nursing staff. Further interview revealed she was not aware of any concerns regarding LPN #6 not assessing Resident #428 after SRNAs #3 and SRNA #4 reported to her they had not been able to obtain the resident's oxygen saturation level, and the resident was drenched in sweat with his/her fingers purple almost black. The DON stated she was not aware of any concerns with LPN #6 not assessing residents. She stated staff should have came to her and reported concerns of a nurse not checking on residents. Interview on 02/19/2022 at 1:05 PM, with the former Administrator #1 (who was the Administrator of record in September 2021) revealed she was not aware SRNA #3 and SRNA #4 had reported concerns regarding Resident #428 to LPN #6. She was not aware the LPN took no action to assess the resident and document her findings in accordance with professional standards of practice. The Administrator stated she was also not aware that LPN #6 had not assessed Resident #428 from 6:00 AM to 11:00 AM, prior to the resident being sent to the hospital. According to the Administrator, she monitored care provided for residents on the COVID Unit by having a daily conference call with the nurse assigned to work on the COVID Unit. Further interview revealed the Administrator also stated she monitored residents' care on the COVID Unit by reviewing the status of each resident. However, she could not recall any concerns regarding Resident #428. In addition, the Administrator stated the nurses should provide care in accordance with professional standards to ensure residents received the quality care necessary. She stated she was not aware that SRNAs #3 and #4 had any concerns with LPN #6. She stated they if the nurse was not checking on a resident for a change of condition, the staff should have reported the incident to her.

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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 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** 22976 Based on observation, interview, record review and a review of the facility policy, it was determined the facility failed to have an effective system in place to ensure residents wounds were assessed and received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for four (4) of thirty-three (33) sampled residents (Residents #47, 19, #39, and #63). Record review and interview revealed the facility's Wound Nurse resigned from the facility in January 2022, and although the Administrator became aware that same month the Wound Assessments were not being completed consistently, there was no documented evidence of a skin sweep of all residents in order to identify any new pressure ulcers or identify if pressure ulcers were deteriorating. Wound Assessments were left for the staff nurses to complete. However, interview with the staff nurses revealed they were unaware they were to complete the Wound Assessments, had not had training related to measuring and staging of wounds, and were not comfortable completing this type of wound assessment. Review of the facility's Skin Care Standard of Practice revealed a skin assessment would be completed weekly by a licensed nurse and staging and measuring would be completed by the assigned nurse to maintain continuity in documentation of progression of wound healing. However, record review revealed these assessments were not consistently completed and there was no documented evidence of consistent monitoring of the progress of the residents' wounds. As a result, observation of skin assessments performed revealed there was deterioration of residents wounds and unidentified wounds. The facility's failure to ensure resident wounds were assessed and received necessary treatment and services has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. Refer to F656 and F657 The findings include: Review of the facility policy, titled Skin Care Standard of Practice dated July 2020, revealed the facility would ensure residents with pressure ulcers receive necessary treatment and services consistent with professional standards of practice to promote healing and prevent infection. Further review of the policy revealed a skin assessment would be completed weekly by a licensed nurse and staging and measuring would be completed by the assigned nurse to maintain continuity in documentation of progression of wound healing. Further review of the policy, revealed weekly documentation of wound status and response to healing including need to alter treatment would be included in the medical record. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of Resident #47's closed medical record revealed the facility admitted the resident on 03/18/2019 with diagnoses including Malignant Neoplasm of the Brain and Lung, Diabetes Mellitus Type II, and Dementia with Behavioral Disturbance. Review of Resident #47's Physician's orders, dated 10/12/2020, revealed orders for weekly skin inspections. Review of Resident #47's Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for bed mobility, and extensive assistance of two (2) staff for transfers. Continued review revealed the resident was assessed as always incontinent of bowel and bladder. Additional review revealed the facility assessed the resident as at risk for developing a pressure ulcer and as having one Stage IV pressure ulcer and three (3) suspected Deep Tissue Injuries (DTIs). Review of Resident #47's Comprehensive Care Plan (CCP), dated 01/04/2022, revealed the resident had a problem with impaired skin integrity including a Deep Tissue Injury (DTI) to the left heel, an unstageable pressure ulcer to the right outer foot, and a DTI to the left outer foot. The goal, with a target date of 04/04/2022, revealed the resident would have no unidentified skin issues through next review. The interventions included: assess the skin and report skin breakdown; treatments as ordered; treatment to the DTI to right outer foot and monitor until resolved; treatment to the left heel as ordered; and treatment to the left outer foot as ordered. However, the facility failed to revise the CCP with interventions to treat pressure ulcers. Further, the facility failed to ensure the CCP was followed. (Refer to F656 and F657). Review of Resident #47's Physician's orders, dated 01/07/2022, revealed orders for Doxycycline 100 mg (antibiotic medication) twice daily for a wound infection. Review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for treatment to clean the wound to the left outer foot with wound cleanser, pat dry, apply Santyl (a medicated ointment that removes dead tissues from wounds) and cover the wound with a foam dressing daily and as needed. Review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for left heel to be cleaned with Dakins solution, pat dry apply, Santyl (a medicated ointment that removes dead tissues from wounds) to the wound bed, cover with petroleum gauze cover with calcium alginate and cover with a foam dressing, change daily and as needed. Review of Resident #47's Wound Evaluation Form, dated 01/13/2022, revealed the resident had a facility acquired pressure ulcer to the left outer foot measuring 2.9 centimeters (cm) long by 2.0 cm wide; and a facility acquired Stage IV pressure ulcer to the left heel classified as a Deep Tissue Injury (DTI) measuring 6. 0 cm long by 4.1 cm wide by 1.4 cm deep. Resident #47 did not have any other Wound Evaluations documented in the Electronic Medical Record. Review of Resident #47's January 2022 Treatment Administration Record (TAR) revealed the resident's ordered wound treatments were not documented as being completed on 01/04/2022, 01/16/2022, 01/23/2022, 01/28/2022, and 01/29/2022. (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 Resident #47's Physician's orders, dated 01/31/2022, revealed orders to clean the wound to the right foot with wound cleanser, apply Santyl and cover with a nonstick foam dressing. However, there was no documented evidence of a wound to the right foot during this timeframe. Review of Resident #47's Physician's orders, dated 02/05/2022, revealed orders for Santyl to be applied daily to pressure ulcer other site stage IV; however, there was no wound site was identified in the order. Review of Resident #47's Physician's orders, dated 02/08/2022, revealed orders for intravenous Vancomycin (antibiotic) one (1) Gram every eight (8) hours and Zosyn one (1) Gram every six (6) hours for six (6) weeks for Osteomyelitis (bone infection). Review of Resident #47's Physician's Note, dated 02/11/2022, revealed there were recent skin changes to the left heel, and x-ray imaging was obtained. Imaging concerning for Osteomyelitis and C-reactive protein (a blood test used to check for inflammation) elevated at 120.4 mg/l (milligrams per liter) (normal range is considered less than 10 mg/l). Per the Note, the resident was to continue on antibiotic coverage in the form of Vancomycin and Zosyn (antibiotic medication). Review of Resident #47's Physician's orders dated 02/14/2022, revealed orders for skin inspection to be completed on Tuesdays on the evening shift. Review of Resident #47's February 2022 TAR, revealed the ordered wound treatments were not documented as being completed on 02/04/2022, 02/06/2022, 02/11/2022, 02/12/2022, 02/13/2022, and 02/15/2022. There was no documented evidence of weekly skin assessments or Wound Evaluations for measurements/staging documented from 01/13/2022 until 02/16/2022, over a month later, when the State Survey Agency (SSA) Representative asked to observe a skin assessment for Resident #47. Observation of a skin assessment for Resident #47, conducted on 02/16/2022 at 3:07 PM, by Registered Nurse (RN) #1, revealed the resident's Deep Tissue Injury to the left outer foot had opened and increased in size to 4.0 cm long by 3.5 cm wide by 0.2 cm deep. The Stage IV pressure ulcer to the left heel had increased in size to 6.0 cm long by 2.0 cm wide by 0.2 cm deep. Additionally, the resident was noted to have an area of brown eschar to the right lateral foot measuring 2.0 cm long by 1.5 cm wide with no depth. Per record review, the brown eschar to the right lateral foot was an unidentified area until this skin assessment. The area to the right lateral foot was observed without a dressing in place prior to this skin assessment. Interview with Registered Nurse (RN) #1, on 02/16/2022 at 3:10 PM, revealed the wound on Resident #47's right foot should have been covered with a dressing and she was not aware the wound was not covered. According to the nurse the area to the resident's right lateral foot was not new, but she was not aware of when the area developed. Per interview, the area was supposed to have a treatment to be cleaned with 1/2 strength Dakins (a wound cleanser) and Santyl (an ointment to remove dead tissue from a wound) and covered with a foam dressing. However, there was no documented evidence of a Physician's order for 1/2 strength Dakins and Santyl. (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 Licensed Practical Nurse (LPN) #LPN #7, on 02/22/2022 at 8:35 AM revealed she was an Agency nurse and was often assigned to Resident #47. Per interview, she did not receive any training on wounds during her orientation. When the LPN was questioned if she completed skin assessments and wound treatments, she stated she was unable to perform wound treatments/ or wound assessments as she was not comfortable with this and would pass the treatments/assessments off to the next shift to complete. However, she did not know if the next shift was completing the treatments/assessments that she did not complete. Interview with Licensed Practical Nurse (LPN) #5, on 02/22/2022 at 5:18 PM, revealed she was the former wound nurse and assessed and measured wounds weekly and made wound rounds with the physician. Per interview, it was her responsibility to complete weekly skin assessments as well as complete wound assessments weekly. Further, she left the facility in January of 2022 and the floor nurses were supposed to take over measuring the wounds weekly and document wound assessments in the Electronic Medical Record (EMR) system. According to the wound nurse she documented the wound assessments on paper because of problems with the computer system deleting information, and then handed the assessments and measurements to the Administrator. Per interview she started back at the facility as the wound nurse on 03/02/2022. Interview with Director of Nursing (DON) #3, on 02/21/2022 at 4:44 PM, revealed he had started at the facility in January 2022. Further interview revealed he was not aware Resident #47 had pressure ulcers, nor was he aware skin assessments and wound measurements for Resident #47 were not being completed. According to the DON, he was new to long term care and was in training and was monitoring residents by making rounds in the facility, but was still trying to learn and did not monitor for anything specific. Further interview revealed a resident's pressure ulcers/wound could get worse or become infected if not being monitored and treated, or if the correct treatment was not ordered. Interview with the Medical Director, on 02/24/2022 at 1:27 PM, revealed she was also the primary care physician for Resident #47 and stated the resident had declined and was more debilitated in recent months due to Cancer. Per interview, the resident was diagnosed with a left heel deep tissue injury. Further, the resident was started on Doxycycline for a Stage IV pressure ulcer, but the resident was frail and the wound wouldn't heal. She stated the resident was later diagnosed with Osteomyelitis and a Peripherally Inserted Central Catheter (PICC) line was placed for intravenous antibiotics. According to the Physician, she did look at notes and tried to track down a time line for Resident #47's wounds and noted two (2) of the resident's wounds had deteriorated. Further interview revealed some of the treatment orders were incorrect as there was confusion related to the wounds on the right and left lower extremities. Per interview, the order dated 01/31/2022, to clean the wound to the right foot with wound cleanser, apply Santyl and cover with nonstick foam dressing should not have been ordered. 44371 2. Review of Resident #19's medical record revealed the facility admitted the resident on 11/09/2021 with diagnoses including Osteomyelitis, Methicillin Resistant Staphylococcus Aureus (MRSA) infection, unspecified site, Pressure Ulcer, and Paraplegic. Further review of Resident #19's medical record revealed no skin assessments were completed on admission. Review of Resident #19's Braden Scale for Predicting Pressure Sore Risk, dated 11/09/2021, revealed Resident #19 was at mild risk for pressure ulcers with a total score of fifteen (15). (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 Resident #19's Physician's orders, dated 11/10/2021, revealed orders to monitor wound on mid back for signs and symptoms of worsening or non healing every shift until resolved. Resident #19's Physician's orders dated 11/16/2021, revealed orders to monitor wounds on right outer foot for signs and symptoms (s/s) of worsening or non healing every shift until resolved, and monitor wounds on right outer leg for s/s of worsening or non healing every shift until resolved. However, there was no documented evidence of treatment orders for Resident #19's wounds. Review of Resident #19's Admission Minimum Data Set (MDS) Assessment, with a reference date of 11/15/2021, revealed the facility assessed the resident as at risk for pressure ulcers and also as having two (2) Stage III pressure ulcers that were present at admission on 11/09/2021. Further review revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating intact cognition. Continued review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for transfers. There was no documented evidence of a Wound Assessment until 12/07/2021, which was twenty-eight (28) days after admission. Review of Resident #19's Initial Wound Assessment Note, dated 12/07/2021, revealed the following: 1) Wound to the right gluteal cleft resolved, scar tissue present. 2) Wound to the right outer knee measured Length-2.0 centimeters (cm) x Width-1.5 cm x Depth-unable to be determined (UTD), no odor, slough covering wound bed, small amount of bloody drainage noted when wound cleaned. This description did not indicate the type of wound or stage of wound. 3) Wound to mid back measured Length-2.0 cm x Width-1.0 cm with no Depth recorded, no odor but large amount of bloody drainage when cleaned. This description did not indicate the type of wound or stage of wound. 4) Wound to right outer calf measured Length-15 cm x Width-4.0 cm x Depth-0.2 cm, area of wound close to 12 O'clock noted to have small area of slough noted, bright red epithelization and granulation present. This wound was described as a Stage III pressure ulcer. 5) Wound to right outer foot at base of fifth toe measured Length-2.5 cm x Width-2.0 cm x Depth-0.1 cm, small amount of bloody drainage noted when cleaned, granulation and epithelization present, no odor. This description did not indicate the type of wound or stage of wound. 6) Wound to right outer foot measured Length-1.5 cm x Width-1.5 cm x Depth-0.2 cm, small amount of bloody drainage noted when cleaned. This description did not indicate the type of wound or stage of wound. Review of the Resident #19's Comprehensive Care Plan, dated 12/08/2021, revealed the resident had two (2) Stage III pressure ulcers on the outside of the right foot; a wound to the right outer leg on the side of the knee; a wound to the mid back spine and a wound to the right outer leg. The goal with a target date of 03/08/2022 revealed the resident would remain free from any unidentified skin issues through next review. Interventions included: assess skin and report redness, rashes, bruises, abrasions or skin breakdown; pressure reduction mattress; provide wound care as ordered by the physician; and provide medications and treatments as per orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	However, there was no documented evidence the CCP was implemented, nor was the CCP revised with interventions to treat the resident's wounds. (Refer to F656 and F657) Review of Resident #19's Physician's orders, dated 12/08/2021, revealed orders to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown. Review of Resident #19's January 2022 Treatment Administration Record (TAR), revealed the intervention for wound treatment to the two (2) Stage III Pressure ulcer on the outside of the right foot with wound cleanser and pat dry. Apply Santyl and cover with border gauze daily at 7:00 AM. However, the treatment was not signed to indicate the treatment was completed at 7:00 AM on 01/01/2022 and 01/02/2022. There was no Physician's order found in the medical record for intervention. Resident #19's Physician orders, dated 01/14/2022, revealed orders for Iodosorb External Gel 0.9% (Cadexomer Iodine), one (1) application to back daily between 7:00 AM and 6:59 PM. Cleanse wound to back with wound cleanser, pat dry, and apply Iodosorb to wound, cover with dry dressing. Change daily and PRN (as needed). Review of Resident #19's Physician's orders, dated 02/05/2022, revealed orders for Vaseline gauze to right leg and foot an wrap with Gauze every three (3) days. Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown at 7:00 AM, was not signed to indicate the treatments were completed for thirteen (13) days including 02/01/2022, 02/02/2022, 02/03/2022, 02/04/2022, 02/05/2022, 02/08/2022, 02/09/2022, 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, 02/15/2022, and 02/18/2022. Interview with Registered Nurse (RN) #1, on 02/19/2022 at 11:20 AM, revealed she did wound care for Resident #19 on 02/18/2022, but had no explanation as to why this treatment was not charted. Review of Resident #19's February 2022 TAR, revealed the intervention to monitor the wound on the resident's mid back was not signed to indicate monitoring at 7:00 AM for seven (7) days including 02/02/2022, 02/04/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/1/20222, 02/13/2022, and 02/15/2022. Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment air mattress was not signed at 7:00 AM for six (6) days including 02/02/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, and 02/13/2022. Interview with Resident #19, on 02/10/2022 at 9:41 AM, revealed he/she did not receive the wound care treatment like the doctor ordered. The resident stated he/she did not currently have a bandage on his/her back. (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 Licensed Practical Nurse (LPN) #4, on 02/10/2022 at 10:15 AM, revealed she was assigned to Resident #19, but had not checked on Resident #19's bandages today. She further stated she had no knowledge if the resident had his/her bandages on or when they were changed last . Further interview with LPN #4, on 02/10/2022 at 10:45 AM, revealed the resident's dressing to the mid back was not in place and the dressing to the resident's right leg should have been changed a few days ago and she would change the dressings. Observation on 02/14/2022 at 9:41 AM, revealed there was no bandage on Resident #19's resident's back. The resident's right leg was wrapped in gauze, dated 02/10/2022. Per the TAR, Resident #19's bandage to the right leg was to be changed on 02/12/2022, two (2) days prior. Interview with LPN #4, on 02/20/2022 at 4:00 PM, revealed she did change Resident #19's right leg bandage on 02/12/2022 and she had no explanation as to how the bandage was dated 02/10/2022. Continued interview revealed she could see how it could be a concern if wound bandages were not changed timely. Further, she did not perform Wound Assessments and she did not know who was responsible for performing Wound Assessments and she had never been instructed to do this. Observation on 02/16/2022 at 9:41 AM, of a skin assessment for Resident #19 performed by the Education Director, revealed the mid back wound measured Length-7.0 cm x Width-7.0 cm with an open area in the center which measured 1.0 cm x 1.0 cm x 0.5 cm with purulent drainage; the resident's right calf wound measured Length-22 cm x Width-7.0 cm x Depth-0.25 cm ; right great toe wound measured Length-2.0 cm x Width-3.5 cm x (no depth) and was scabbed; right inner ankle wound measured 2.5 cm x 4.5 cm x (no depth) and was scabbed. The Education Director did not stage the wounds during this skin assessment. This Wound Assessment was completed seventy-one (71) days after the last wound assessment, after Surveyor intervention. Interview, on 02/16/2022 at 1:40 PM, with the Education Director Nurse, revealed until January 2022 the wound nurse was responsible for all skin and wound assessment and documentation as well as rounding with the Physician to view the wounds. Additional interview revealed the nurses were responsible for the skin assessments and wound treatments at this time. She was unaware skin assessments and wound treatments were not being completed as ordered. She stated after the nurse completed a treatment or assessment, the nurse was responsible to document on the Treatment Administration Record (TAR) in the Electronic Medical Record. The following is a comparison of Resident #19's wounds noted in the Electronic Medical Record (EMR) for the Initial Wound assessment dated [DATE], which was completed 28 days after admission, and the next Wound Assessment, dated 02/16/2022, completed seventy-one (71) days after the last documented assessment, and after Surveyor intervention. Wound Assessment on 12/07/2021: 1. right gluteal cleft resolved on 12/7 2. right outer knee 2.0 cm x 1.5 cm x UTD 3. mid back 2.0 cm x 1.0 cm x depth was left blank 4. right outer calf 15 cm x 4.0 cm x 0.2 cm (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. right outer foot pinky 2.5 cm x 2.0 cm x 0.1 cm 6. right outer foot 1.5 x 1.5 x 0.2 Wound Assessment on 02/16/2022: 1. right gluteal cleft resolved 12/7 2. right outer knee nothing observed 3. mid back 7 cm x 7 cm x 0.5 cm, larger 4. right outer calf 22 cm x 1.0 cm x 2.5 cm larger and had increased depth appearance moist, pink-color, drainage-moderate serous (Clear). Surrounding tissue-discolored 5. right outer foot pinky dark spot observed 6. right outer foot dark spot observed 7. right great toe with scab 2.0 cm x 3.5 cm, NEW AREA 8. right inner ankle with scab 2.5 cm x 4.5 cm NEW AREA Continued review of the Wound Assessment revealed from 12/07/2021 until 02/16/2022, the wound to Resident #19's mid back became larger; the area to the right outer calf became larger and increased in depth; and new unidentified areas were found on the resident's Right great toe and Right inner ankle. Interview with Registered Nurse (RN) #1 on 02/19/2022 at 2:42 PM, revealed she was often assigned to Resident #19 and was unaware of any deterioration of the resident's wounds as she had not been completing Wound Assessments. She stated the nurses had not been trained to do Wound Assessments and she was not sure which staff member was responsible for completing them. Interview with Resident #19's Physician, on 02/24/2022 at 1:27 PM, revealed she was aware the resident sometimes refused care, especially wound treatments. However, she stated it was her expectation for staff to try to perform wound treatments, and to ensure wound measurements, staging and description of wounds were documented weekly. Further, it was her expectation that all wounds have a treatment in place, and Resident #19 should have had a treatment in place from admission related to pressure ulcers. 3. Record review revealed the facility admitted Resident #39 on 12/20/2021, with diagnoses that included: Pressure Ulcer of right buttock, unstageable; other, Chronic Pain; Polyneuropathy, unspecified; Pressure Ulcer of right buttock, Stage 3; Adult Failure to Thrive; Hyperglycemia, unspecified; and Acute Kidney Failure, unspecified. (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 Resident #39's Admission MDS assessment dated , 12/24/2021 revealed the facility assessed the resident as at risk for pressure ulcers, and with one (1) unstageable deep tissue injury (DTI) which were present on his/her admission on 12/21/2021. Continued review of the Admission MDS revealed a care plan had been developed for Resident #39's admission wounds. Further review revealed the facility assessed Resident #39 to have a BIMS score of six (6), indicating he/she was severely impaired in cognition. Review of the Braden Scale for Predicting Pressure Sore Risk for Resident #39, dated 01/31/2022, revealed the facility had assessed the resident as at high risk for pressure ulcers, as indicated by the total score of twelve (12). Review of the facility's initial Wound Assessment for Resident #39, dated 12/21/2022, revealed the resident had a wound measuring 12.2 cm in length x 7 cm in width x 0 cm depth. Continued review revealed the wound was noted as dry, black in color, and with macerated (skin exposed to moisture for too long which appears as soggy, soft, or whiter than usual). Further review the documentation noted no drainage, odor or pain had been present at the wound site. Review further revealed no documented evidence of the wound having been Staged or the location of the wound. Review of Resident #39's Comprehensive Care Plan, dated 12/21/2021, revealed the facility had care planned the resident for a Stage III Pressure Ulcer to the right buttock. Review revealed the interventions included for staff to assess the resident's skin and report redness, rashes, bruises, abrasion or skin breakdown. Continued review revealed the interventions also included: a pressure reduction cushion; air mattress as ordered; provide incontinence care as needed; provide wound care as ordered by the Physician; and treatment to the resident's buttocks as ordered. Review of the Physician's order, dated 01/07/2022, revealed an order for Santyl (debriding agent) External Ointment 250 unit/gm (collagenase) to be applied to Resident #39's buttock daily between 7:00 AM and 6:59 PM. Continued review of the 01/07/2022 Physician's order revealed the order also included to cleanse the wound to the right buttock with wound cleanser, pat dry, apply Silvadene cream (topical antimicrobial drug used as an adjunct for the prevention and treatment of wound sepsis) to the outer perimeter of the wound, and apply the Santyl ointment to the eschar the on wound. Further review of the 01/07/2022 Physician's order revealed the wound was to be covered with border gauze and change the dressing daily and as needed (prn). Continued review of Resident #39's medical record revealed the next documented Wound Assessment was eighteen (18) days later, was noted on a Physician's Note, dated 01/07/2022. Review of the Physician's Note revealed Resident #39 a telehealth wellness visit had been completed for the resident. Review of the Physician's Note revealed Resident #39 had an Unstageable (US) Wound on his/her sacral area, which was worse, deeper, and getting bigger with no tunneling or eschar. Further review of the Note revealed wound measurements documented as 4 cm in length x 2 cm in width. Review further revealed no documented evidence of the wound depth or color of the wound. Further review of Resident #39's medical record revealed a Wound assessment dated on 01/11/2022 at 5:03 PM by an unknown author, (four [4] days after the telehealth visit), which noted the resident's wound measurements where 11.8 cm in length x 6.8 cm in width x o cm in depth, and the wound was black in color, necrotic, with discolored tissue. Further review of the Wound Assessment revealed the wound had small/minimal drainage, no odor, and no pain, and the wound was not worse. Review further revealed no documented evidence of the wound's location or the Stage of the wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In addition, review of Resident #39's medical record revealed a Wound assessment dated [DATE] at 5:10 PM by an unknown author, which noted the wound as measuring 12.4 cm in length x 7.4 cm in width x 0 cm in depth. Continued review of the Wound Assessment revealed the tissue was broken, with moderate serosanguineous drainage, with an odor present, no pain and the wound noted as not worse. Further review revealed the Wound Assessment did not have the location of the wound or Stage of the wound documented. Review of the February 2022 MAR for Resident #39 revealed no documentation noting the Silvadene wound treatment as having been completed as ordered for the dates of the 2nd, 4th, 5th,11th,12th,13th, and 15th of that month, a total of seven (7) days. Further review revealed staff were to initial the time and date on the MAR after completing application of the Silvadene wound treatment; however, the area for staff's initials for those dates was blank. Review of the February 2022 TAR for Resident #39 revealed no documentation noting the ordered wound treatment, (cleanse wound, apply Silvadene and oil emulsion, wet to dry gauze twice daily on coccyx every 12 hours) had been completed at 9:00 AM for the dates of the 01/11/2022, 02/12/2022, 02/13/2022, 02/142022, and 02/15/2022, a total of five (5) days. Continued review of the February 2022 TAR revealed no documentation noting the ordered wound treatment had been completed at 9:00 PM for the dates of the 9th, 11th, 12th and 13th, a total of four (4) days. Further review revealed staff were to initial the time and date on the TAR after completing application of the ordered wound treatment; however, the area for staff's initials for those dates was blank. Interview with Resident #39, on 02/16/2022 at 11:30 AM, revealed the resident felt bad. Resident #39 stated he/she had sores on his/her bottom, and the areas hurt. Further interview revealed the resident was unable to state when the sores (wounds) were acquired; however, stated the nurses looked at the sores, just not daily. Observation, on 02/16/2022 at 11: 30 AM during care provided by Agency SRNA #1, revealed Resident #39 had two (2) dressings on his/her buttock. One (1) dressing (the top one) was dated 02/14/2022 (two [2] days previously); however, orders revealed the dressing was to have been changed daily. Interview with Agency SRNA #1 on 02/16/2022 at 11:30 AM, revealed she had worked at the facility for nine (9) months on the day shift, from 7:00 AM to 7:00 PM. She revealed she was assigned to Resident #39's care that day. Per interview, Resident #39 was total care for all his/her ADLS. Continued interview revealed Resident #39 had a really big bed sore on his/her [TRUNCATED]

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 22976 Based on observation, interview, and record review, it was determined the facility failed to ensure pain management was provided for one (1) of thirty-three (33) sampled residents (Resident #28). Resident #28 had Physician's Orders to receive Gabapentin (an anticonvulsant sometimes used for pain) for pain three (3) times per day. However, the facility failed to ensure the resident's pain medication was available. The facility failed to obtain a refill of the medication. From 01/19/2022 to 02/03/2022 (sixteen day period), Resident #28 did not receive the Gabapentin which resulted in complaints of pain to the resident's hands and difficulty in sleeping at night. The findings include: Interview with the Former Director of Nursing (DON) #3, on 02/07/2022 at 9:30 AM, revealed the facility did not have a policy for pain management, but it was the facility's procedure to assess residents regularly for any changes of condition, which included pain. In addition, he stated it was also the facility's procedure to administer medications as ordered or notify the physician of any changes in condition for new orders. Review of Resident #28's medical record revealed the facility admitted the resident, on 12/03/2021, with diagnoses of Diabetes Mellitus Type II, Acquired Absence of the Left Leg, and Surgical Site/Hardware Infection Status Post Antibiotic Spacer Placement to the Right Knee. Review of Resident #28's Admission Minimum Data Set (MDS) Assessment, dated 12/09/2021, revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15). The facility also assessed Resident #28 to have pain occasionally, rated as three (3) on a zero (0) to ten (10) scale with zero (0) being no pain and ten (10) being the worst pain. Review of Resident #28's Physician's Orders, dated 12/04/2021, revealed Resident #28 had an order to have Gabapentin (a Schedule V controlled substance) 100 milligrams (mg) three (3) times a day for pain. Review of the Medication Administration Record (MAR) and the declining inventory list (controlled substance administration record) revealed the resident was not administered Gabapentin three (3) times daily as ordered, from 01/19/2022 to 02/03/2022 (a period of sixteen days). Review of Resident #28's pain assessments, on the MAR, completed every shift from 01/18/2022 through 02/03/2022, revealed three (3) incidents where Resident #28 was documented to have pain. On 01/31/2022 at 7:00 AM, the resident's pain was rated as a four (4) with no description or frequency documented. Tylenol (pain reliever) 650 mg was administered and was documented as effective. On 02/01/2022 at 7:00 AM, the resident's pain was rated as a two (2), dull, and constant. Tylenol 650 mg was administered and was documented as effective. On 02/03/2022 at 7:00 AM, the resident's pain was rated as two (2), with no description documented. Tylenol 650 mg was administered and was documented as effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview of Resident #28 conducted during the initial tour, on 02/02/2022 at 10:49 AM, revealed the resident was awake, alert, and lying in bed on his/her back with the right leg in a brace. An interview on 02/02/2022 at 10:49 AM, with Resident #28 revealed the resident had not been receiving his/her Gabapentin as ordered and was having pain in his/her hands which was keeping him/her awake at night at times. Further interview revealed the resident could request other pain medications, but the Gabapentin worked better at relieving his/her pain. Further interview with Resident #28, on 02/10/2022 at 9:30 AM, revealed the resident did have narcotic pain medication available, but preferred not to take the narcotic. According to the resident, he/she preferred to take Gabapentin because Gabapentin relieved the pain in his/her hands. The resident stated when he/she was not getting the Gabapentin the pain was worse at night. Per the resident, he/she would rate the pain a six (6) on the zero (0) to ten (10) pain scale. Resident #28 stated the pain would wake him/her up and made it hard to sleep at night. Further interview revealed the resident had experienced a hard time sleeping every night since he/she started not receiving the Gabapentin as ordered. Interview with Kentucky Medication Aide (KMA #1), on 02/02/2022 at 10:50 AM, revealed the resident was out of Gabapentin, and the facility had been working on trying to get the resident's medication. The KMA stated she was unsure why the resident's medication had not been received from the pharmacy. Interview with Licensed Practical Nurse (LPN) #7, on 02/09/2022 at 1:50 PM, revealed she had ordered the Gabapentin for Resident #28 on 01/18/2022. She stated she checked the reorder tab in the computer, and the medication should have been delivered to the facility. Per the LPN, she was an agency nurse and did not have access to the emergency medication stock. Further interview revealed she was not aware the resident was having pain to his/her hands. LPN #7 stated if she had been aware of the resident's pain, she would have administered the resident an as needed (PRN) medication or called the physician. An interview with LPN #11, on 02/20/2022 at 3:35 AM, revealed she worked the night shift. She stated she was not aware Resident #28 was having pain in his/her hands or that the pain was keeping the resident awake. Further interview revealed she had been having a difficult time with pharmacy and obtaining medications. According to the LPN, Gabapentin was not in the emergency back up medication stock. Interview with the Unit Manager, on 02/02/2022 at 1:30 PM, revealed she thought the resident's physician had discontinued Resident #28's Gabapentin. The Unit Manager stated she thought that was why the resident had not received the medication. However, the Unit Manager stated she had failed to verify the status of Resident #28's Gabapentin. Interview with the Physician Assistant (PA), on 02/10/2022 at 3:55 PM, revealed the physician had evaluated Resident #28 and had discontinued the resident's Tramadol pain medication at the resident's request, but did not discontinue the resident's Gabapentin. According to the Physician Assistant, she would expect the resident to continue receiving Gabapentin as ordered for Diabetic Neuropathy pain (nerve pain). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with former DON (Director of Nursing) #3, on 02/21/2022 at 4:44 PM, revealed he was not aware Resident #28 was not receiving Gabapentin as ordered. DON #3 stated he had not received a request from the pharmacy for a physician's order to fill the medication. Interview with the Administrator, on 02/25/2022 at 12:57 PM, revealed she was not aware that Resident #28 was not receiving Gabapentin as ordered. Further interview with the Administrator revealed she would expect residents to receive medications as ordered to prevent pain, and the medications should be obtained from pharmacy when needed so residents could have medications as ordered.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. 22976 Based on interview and record review it was determined the facility failed to ensure one (1) of thirty-three (33) sampled residents (Resident #28) was free of significant medication errors. Resident #28 was prescribed Gabapentin (a Schedule V controlled medication) 100 milligrams (mg) three (3) times daily to treat pain related to Diabetic Neuropathy (nerve pain). The facility failed to obtain and administer the medication from 01/19/2022 to 02/03/2022, a period of sixteen (16) days. Interview with the resident revealed, because the Gabapentin was not administered, he/she had pain in his/her hands that kept him/her awake at night. The findings include: Interview with the Former Director of Nursing (DON) #3, on 02/07/2022 at 9:30 AM, revealed the facility did not have a policy for medication errors. According to the DON, he was not aware of any facility procedure related to medication errors. Review of the facility's pharmacy policy for reordering controlled substance medications, titled, Schedule II Controlled Substance Medication, revealed for non-emergency situations controlled medications would not be dispensed without a written prescription. According to the policy, the original signed prescription must be faxed to the pharmacy before medications were dispensed. Review of Resident #28's medical record revealed the facility admitted the resident, on 12/03/2021, with diagnoses of Diabetes Mellitus Type II, Acquired Absence of the Left Leg, and Surgical Site/Hardware Infection Status Post Antibiotic Spacer Placement to the Right Knee. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/09/2021, revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15). In addition, the facility assessed Resident #28 to have pain occasionally, which rated three (3) on a zero (0) to ten (10) scale, with zero (0) being no pain and ten (10) being the worst pain. Review of Resident #28's Physician's Orders, dated 12/04/2021, revealed orders for the resident to have Gabapentin 100 mg three (3) times a day for pain. Review of the Medication Administration Record (MAR) and the controlled substance administration record (declining inventory sheet) revealed the facility failed to provide and administer the resident's Gabapentin three (3) times daily as ordered from 01/19/2022 to 02/03/2022, a period of sixteen (16) days for a total of forty-eight (48) doses. Interview with Resident #28, on 02/10/2022 at 9:30 AM, revealed he/she had not been receiving his/her Gabapentin as ordered. According to the resident, the Gabapentin helped with the pain he/she had in his/her hands. Resident #28 stated that since he/she had not received the medication, he/she was having pain in his/her hands that was keeping him/her awake at night. Further interview revealed the resident could request other pain medications, but Gabapentin worked better at relieving his/her pain, especially when he/she received the medication as ordered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Kentucky Medication Aide (KMA #1), on 02/02/2022 at 10:50 AM, revealed Resident #28 was out of Gabapentin, and the facility had been working on trying to get the resident's medication. KMA #1 stated she was not sure why the facility had not received the medication from the pharmacy. She further stated if she had documented the medication as being administered to the resident, it would have been in error because the resident did not have the medication available. KMA #1 stated she would notify the nurse if the medication was not available. Interview with Licensed Practical Nurse (LPN) #7, on 02/09/2022 at 1:50 PM, revealed she had ordered Gabapentin for Resident #28, on 01/18/2022. LPN #7 stated she checked the reorder tab in the computer, and the medication should have come to the facility. According to the LPN, she was not aware the medication needed a new prescription from the physician to be reordered. She further stated she was not aware of the resident having any pain to his/her hands. LPN #7 stated if she had been aware, she would have administered the resident an as needed (PRN) pain medication or called the physician. Interview with LPN #11, on 02/20/2022 at 3:35 AM, revealed she worked the night shift and was not aware that Resident #28 was having pain in his/her hands that was keeping him/her awake. According to LPN #11, Gabapentin was not in the emergency backup system. LPN #11 stated Resident #28 not getting the medication could have been an over site. Interview with the Unit Manager, on 02/02/2022 at 1:30 PM, revealed she thought Resident #28's physician had discontinued Gabapentin and that was why the resident had not received the medication. However, interview with the Physician's Assistant, on 02/10/2022 at 3:55 PM, revealed the physician had evaluated Resident #28 and had discontinued the resident's Tramadol pain medication, but had not discontinued the resident's Gabapentin. According to the Physician's Assistant, she would expect Resident #28 to continue to receive Gabapentin as ordered for his/her Diabetic Neuropathy pain. Further interview revealed if she had been made aware a prescription was needed, she would have had one faxed to the pharmacy for the medication. Interview with the Pharmacist, on 02/10/2022 at 10:58 AM, revealed the pharmacy had requested a prescription from the facility on 01/19/2022, as required by the facility's policy. Continued interview revealed the pharmacy did not receive a physician's prescription for the Gabapentin and could not fill the order for the medication. According to the pharmacist, a nurse would have to obtain a prescription from the physician and fax the prescription to the pharmacy or, the physician would have to fax a prescription directly before the pharmacy could refill the medication and send the medication to the facility. Interview with former DON #3, on 02/21/2022 at 4:44 PM, revealed he was not aware that Resident #28 was not getting the Gabapentin as ordered. Continued interview revealed former DON #3 was not aware that the pharmacy had sent a prescription request to the facility and could not fill the medication without a new prescription from the physician. According to DON #3, a resident not getting pain medications as prescribed could cause the resident to be in pain. Interview with the Administrator, on 02/25/2022 at 12:57 PM, revealed she was not aware that Resident #28 was not receiving Gabapentin as ordered. Further interview with the Administrator revealed she would expect the residents to receive medications as ordered to prevent pain, and the medications should be obtained from pharmacy when needed so residents could have medications as ordered.

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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	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** 44001 Based on observation, interview, record review, review of the Centers for Disease Control and Prevention's (CDC), Vaccine Storage and Handling, review of product inserts for the Afluria Quadrivalent vaccine, and review of the facility's policies, it was determined the facility failed to ensure clinical staff maintained records for the disposition of controlled drugs in sufficient detail to enable an accurate reconciliation. The facility failed to store and destroy controlled drugs to ensure there was no potential for diversion or abuse. The facility failed to ensure medications were returned to the pharmacy after being discontinued or after a resident was deceased or discharged from the facility. The facility failed to ensure drugs, biologicals, and vaccines were stored per currently accepted professional principles; and, failed to ensure appropriate environmental controls to preserve their integrity for two (2) of two (2) medication storage rooms and three (3) of four (4) medication carts. Observation of the refrigerators in two (2) medication storage rooms centrally located for Halls A and B and Halls C, D, and E revealed medication was stored in the medication refrigerator doors, with a refrigerator temperature outside of the acceptable range of 36- 46 degrees Fahrenheit. Review of temperature logs for both refrigerators revealed staff failed to log temperatures consistently. Further observation revealed the vaccine storage refrigerator, located in the Education Training Director's (ETD) office, was not monitored for the appropriate environmental controls to preserve the integrity of fourteen (14) unopened boxes of flu vaccine. Observation of three (3) medication carts located on Halls B, C, D, and E revealed medications were not stored in the original, labeled packaging received from the pharmacy. Further observation revealed discontinued controlled drugs were stored in the Director of Nursing's (DON) office in a locked file cabinet drawer. However, observations throughout the survey revealed the DON's office was often open and unoccupied, leaving the controlled drugs not double locked. The findings include: Review of the Centers for Disease Control and Prevention's (CDC), Vaccine Storage and Handling, updated [DATE], revealed proper vaccine storage and handling played critical roles in efforts to prevent vaccine-preventable diseases. Vaccines exposed to storage temperatures outside the recommended ranges could have decreased efficacy, creating limited protection; and, exposure to temperatures 32 degrees Fahrenheit or colder could destroy potency. Per CDC recommendations, vaccine temperatures should be monitored and documented at least twice daily if the refrigerator did not have a temperature monitoring device, which read minimum and maximum temperatures. Further review revealed best practices for storage of vaccines was to ensure that vaccines were not stored on the top shelf, floor, or door of the refrigerator as the temperature in these areas may differ significantly from the temperature in the body of the unit. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Medication Storage, no date, revealed the purpose of the policy was to ensure that medications were stored safely, securely, and in a manner that ensured the integrity of the medications and the safety of the residents in accordance with the Kentucky Cabinet for Health and Family Service guidelines. Further review revealed medications requiring refrigeration would be stored at the appropriate temperature according to the pharmacy or manufacturer labeling. Additionally, the temperature of the medication refrigerators should be maintained between 36- and 46 degrees Fahrenheit. Per the policy, medications should be stored in the original, labeled packaging received from the pharmacy. Review of facility's policy, Schedule II Controlled Substance Medication, not dated, revealed the purpose of the policy was to provide guidelines for the facility to follow related to the handling of controlled substances within the facility, in a manner that promoted proper storage and compliance with state and federal regulations. Both liquid and solid oral doses (capsules and tablets) should have a corresponding inventory sheet. When a Controlled Substance was administered, the licensed nurse must document the dose given on the declining inventory sheet. Per the policy, Schedule II, III, IV, and V drugs shall not be accessible to any personnel other than designated medical personnel, licensed nurses, and the pharmacy. These drugs would be stored under double lock, separate from other medications. The keys to the locked storage, which contained Controlled Substances, must always be in the possession of a licensed nurse. Per the policy, Schedule II Controlled Substances were to be destroyed in accordance with federal regulations and witnessed by two (2) persons, each of whom shall be a licensed nurse or pharmacist. Review of facility's policy, Medication Disposal/Destruction, not dated, revealed the purpose of the policy was to ensure the facility would adhere to all federal, state, and local regulations related to medication disposal and destruction. The policy stated that until all Controlled Substances, which were discontinued, were destroyed, they must be stored under the supervision of the Director of Nursing and were to be destroyed in accordance with federal regulations. The policy stated that the facility would maintain a record of all discontinued medications for a period of three (3) years. Review of the facility's form, Refrigerator Temp Log, dated ,d+[DATE], for the A/B Hall medication refrigerator revealed the temperature log was incomplete. Refrigerator temperatures were not documented for eight (8) days - [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of the facility's form, Refrigerator Temp Log, dated ,d+[DATE], for the C/D/E Hall medication refrigerator revealed incomplete documentation for eight (8) days - [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Per the form, temperatures ranged between 32- degrees and 36-degrees Fahrenheit. A review of product inserts for the Afluria Quadrivalent vaccine (flu vaccine) revealed temperature storage should be between 36 and 46 degrees Fahrenheit. 1. Observation, on [DATE] at 3:44 PM, of the A/B Hall medication storage room revealed the medication storage refrigerator was not locked. The thermometer was located in the rear of the refrigerator on the top shelf, near the freezer compartment. The thermometer read 45 degrees Fahrenheit. Five (5) vials of Daptomycin (an antibiotic) 500 milligrams (mg) were stored in the refrigerator door. Two (2) insulin (a hormone which regulates blood glucose levels) pens were stored in the door. Additionally, one (1) vial of insulin Lispro belonged to a discharged resident, and one (1) vial of insulin Lispro belonged to a deceased resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Inspection of the A/B Hall Refrigerator, on [DATE] at 4:00 PM, revealed the refrigerated controlled drug lockbox had one (1) bottle of Lorazepam (an anti-anxiety medication, Schedule IV controlled substance) 2 milligrams/milliliter (mg/ml) oral concentrate; labeled as Cubex Refill (medication delivery system). The bottle was in a plastic bag, which was sticky on the outside and had liquid spillage on the inside of the bag. The bottle of Lorazepam 2 mg/ml did not have a declining inventory sheet, as required by the facility's policy. Eight (8) milliliters (ml) remained out of the original thirty (30) mls. 3. Observation, on [DATE] at 4:46 PM, of the C/D/E Hall medication storage room revealed the medication storage refrigerator was locked. The temperature of the refrigerator was 30- degrees Fahrenheit. The freezer section had a large amount of ice build-up. The narcotic lockbox was stored in the door of the refrigerator. Observation of the narcotic lockbox contents revealed one (1) vial of Lorazepam 2 mg/ml injectable and one (1) bottle of liquid Morphine Sulfate Oral Solution (Schedule II opioid medication to treat moderate to severe pain) 100 mg/5 ml; both labeled for Resident #66, who was deceased on [DATE]. Neither declining inventory sheet had a beginning balance; however, according to the prescription labels, the remaining balance of medication documented was correct. Continued observation of the lock box, on [DATE] at 4:46 PM, revealed one (1) bottle of Lorazepam 2 mg/ml oral concentrate was filled for a resident on [DATE], who had been discharged from the facility on [DATE]. There was no declining inventory sheet for this medication. Twenty (20) mls remained in the bottle. 4. Observation and interview with DON #3, on [DATE] at approximately 5:06 PM, revealed discontinued medications were placed in plastic bags in his office. He further stated that discontinued controlled medications were stored in a locked file cabinet in his office. Observation of the file cabinet revealed it was locked with a keyed lock. When asked to open the file drawer storing the discontinued controlled narcotics, DON #3 stated he did not have the keys on his person. He stated, I need to go out to my truck to get the keys. DON #3 retrieved the keys and opened the drawer. Observation of the drawer revealed it was filled with multiple cards of controlled drugs, pill bottles, and vials of injectable medication, which dated back to , d+[DATE]. Per interview with DON #3, he could not explain why the facility had such a large number of controlled drugs stored or why they had not been destroyed. DON #3 stated he just started as DON on [DATE] and should have destroyed the controlled medications. Continued interview with DON #3, on [DATE] at 5:06 PM, revealed if a controlled medication was expired or discontinued, it was the facility's protocol for the nurse to notify the DON. The DON would count the controlled drug with another nurse and lock it up in the DON's office until two (2) nurses could destroy the medication. DON #3 stated, Generally, controlled drugs should be destroyed immediately and was unable to state why they had not been destroyed. According to DON #3, it was his expectation that the nursing staff alerted him regarding any expired or discontinued scheduled narcotics on the day it was expired or discontinued to assure all controlled drugs were accounted for, stored, and destroyed properly. DON #3 further stated this was important to ensure the safety of all residents. 5. Observation of the medication storage refrigerator, located in the Education Training Director's (ETD) office, on [DATE] at 2:30 PM, revealed the temperature of the refrigerator was 46 degrees Fahrenheit. The thermometer was located on the middle shelf. There were fourteen (14) unopened vials of Afluria Quadrivalent vaccines stored in the refrigerator door. (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 the ETD, on [DATE] at 10:20 AM, revealed she was recently hired into the position of ETD. She stated she was responsible for monitoring vaccines. She stated she was not aware of a temperature monitoring log, as she had only been in the position of ETD for a couple of weeks. Further interview revealed that she did not know if all staff members who received vaccine deliveries and those who handled or administered vaccines were trained in vaccine-related practices to include storage and monitoring. She stated storing vaccines at the proper temperature was important to maintain the integrity of the vaccine, which was important for infection control and the safety of the residents. Continued interview with DON #3, on [DATE] at 5:06 PM, revealed he was unaware of the temperature range for medication storage and did not know that medications should not be stored on shelves in the refrigerator door. Interview with the Administrator, on [DATE] at 2:30 PM, revealed all vaccines were stored in the ETD's office, and the ETD was responsible for monitoring vaccines and documenting temperatures on the temperature log. Additionally, she stated she did not know if all staff members that received vaccine deliveries or those that handled or administered vaccines were trained in vaccine-related practices, to include storage and monitoring, but she would ask. The Administrator did not provide this information. 6. Observation of the B Hall medication cart, on [DATE] at 4:00 PM, revealed four (4) loose vials of Ipratropium Bromide/Albuterol inhalation solution (used to treat chronic obstructive pulmonary disease {COPD} and asthma) located in the bottom drawer of the cart. The vials were not in their protective foil pouch and were not stored in a box labeled with a resident's name. Additionally, there were three (3) opened protective foil packages of Ipratropium Bromide/Albuterol inhalation solution without dates and not stored in a box labeled with a resident's name. Five (5) loose Calcium Carbonate pill packages belonging to Resident #65 were found loose in the bottom drawer. Further, inspection revealed Resident #74's (discharged) Fluoxetine (used to treat depression) and Xarelto 20 mg capsules (used to prevent blood clots) and Resident #28's (discharged) Xarelto 10 mg with Aspirin (used to prevent blood clots) remained in the cart. Resident #3's Fluticasone Propionate nasal spray (a steroid used to treat allergies) package was opened but not dated. Resident #43's Ipratropium Bromide/Albuterol inhalation solution was opened, and undated. Resident #54, who resided on Hall C, had medication in Hall B's cart. Review of the medication cart's narcotic lockbox revealed one card with a total of thirty (30) Lorazepam 2 mg tablets belonging to Resident #22 was still on the cart. Resident #22 had been transferred to the hospital on [DATE]. 7. Observation of the C Hall medication cart, on [DATE] at 4:30 PM, revealed three (3) bottles of opened ophthalmic solution, with no open date, were loose in the cart and not in their original packaging. Further observation revealed one (1) Albuterol package opened with no open date noted. Interview with Kentucky Medication Aide #2 (KMA), on [DATE] at 2:48 PM, revealed the night nurse was responsible for monitoring the temperature of the medication refrigerators. She stated that the medication refrigerators should be between 36 and 46 degrees Fahrenheit. KMA #2 stated the DON would remove discontinued narcotics from the cart after a count was completed. She further stated that the KMAs/nurses were responsible for removing discontinued or deceased residents' medications from the medication cart. (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 KMA #1, on [DATE] at 4:23 PM, revealed each KMA or nurse assigned to the medication cart was responsible for removing discontinued or deceased residents' medications from the medication cart. She further stated that when a narcotic was discontinued, the KMA/nurse would let the DON know, so he could remove it from the cart. KMA #1 stated the night nurse was responsible for monitoring the temperature of the medication refrigerators. KMA #1 stated she did not know the temperature range for storing medications in a refrigerator. Interview with LPN #1, on [DATE] at 11:30 AM, revealed it was the responsibility of the nursing staff to ensure medications were stored according to the facility's policy. She stated the nurse or KMA assigned to the cart had the responsibility for maintaining it and ensuring it was stocked. She further stated if a resident was discharged or deceased , the nurse assigned to the medication cart was responsible for removing the medications. If controlled drugs needed to be removed and destroyed, the nurse should notify the DON immediately. Per the interview, she stated storing medications according to the manufacturer's recommendations and CDC guidelines were necessary for the safety of all residents. LPN #1 stated the medication refrigerator should be between 36 and 46 degrees Fahrenheit. Interview with LPN #8, on [DATE] at 3:01 PM, revealed the night nurse was responsible for monitoring the temperature of the medication refrigerators. However, he stated he did not know the temperature ranges for storing medications in a refrigerator. He stated nurses were responsible for removing discontinued medications from the medication cart. He further stated when a narcotic was discontinued, the nurse was to let the DON know. The DON would remove it from the cart after a count was completed and take it to be destroyed. Interview with LPN #14, on [DATE] at 5:30 PM, revealed the night nurse was responsible for monitoring and documenting the temperature of the medication refrigerators. When interviewed related to why the refrigerator's temperatures were not documented every night shift, LPN #14 could not recall why he had not documented the refrigerator temperatures. When interviewed related to the facility's policy regarding temperature monitoring, he stated it was to monitor the daily temperature to ensure it remained between 32- and 40- degrees Fahrenheit. He stated nurses were responsible for removing discontinued medications from the medication cart. He further stated that when a narcotic was discontinued the nurse was to inform the DON. The DON would remove it from the cart after a count was completed and take it to be destroyed. Interview with LPN #2, on [DATE] at 8:29 AM, revealed it was the responsibility of the nursing staff to ensure medications were stored according to the facility's policy. He stated that the nurse assigned to the medication cart was responsible for removing discontinued drugs and notifying the DON of controlled medications that needed to be removed and destroyed. Continued interview revealed storing medications according to the manufacturer's recommendations and CDC guidelines was necessary for the safety of all residents. Interview with Registered Nurse (RN) #1, on [DATE] at 4:04 PM, revealed it was the responsibility of the nursing staff to ensure medications were stored according to the facility's policy to ensure the safety of all residents. Interview with DON #3, on [DATE] at 5:06 PM, revealed it was his expectation that all nursing staff followed the facility's policies and procedures related to medication storage and labeling. The DON stated if an item was found to be expired, labeled, and or stored improperly, it was his expectation that nursing staff returned or discarded the medication according to the facility's policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Observations, on [DATE] at 8:30 AM, 9:50 AM, 1:13 PM, and 3:10 PM revealed the door to DON #5's office was unlocked and unattended resulting in the discontinued medications and controlled drugs unsecured by a double lock system. Observation of a count of discontinued controlled drugs, on [DATE] at 4:15 PM, with DON #5, revealed thirty-eight narcotic cards; four (4) bottles of controlled medications; and, three (3) vials of controlled injectables. Additional observation revealed four (4) gray storage bags filled with discontinued medication waiting for the pharmacy to pick up. Interview with the facility's Pharmacist, on [DATE] at 9:27 AM, revealed when a non-controlled medication had been discontinued, it should be removed from the cart and placed in a secure container in the medication room. Medications being sent back to the pharmacy should then be placed in sealable bags by licensed nurses and Kentucky Medication Aides (KMA). He stated it was the facility's responsibility to alert the pharmacy courier that there were medications to be returned. If the courier did not take the medications, the DON was to notify the pharmacy. Further interview revealed that discontinued controlled drugs should be counted and placed under double lock for destruction. Then they were to be destroyed according to the facility's policy. The Pharmacist stated standard practice was to log the controlled drugs and destroy them immediately, or at least in frequent intervals of no longer than two (2) weeks. He stated he would not expect that there would be a stockpile of controlled drugs slated for destruction and stored in the facility for over two (2) weeks. He stated the pharmacy made recommendations, but each facility should follow its policies according to regulatory processes. Interview with the Regional Quality Manager (RQM), on [DATE] at 5:18 PM, revealed all discontinued controlled drugs should be counted and then destroyed when two (2) nurses were available. She stated nurses were responsible for removing from the cart any discontinued medications and medications of deceased residents. The RQM could not explain why such a large number of controlled drugs were stored and not destroyed. Continued interview with the RQM, on [DATE] at 4:37 PM, revealed her expectation was that every controlled substance had a declining inventory sheet with an accurate accounting of the inventory and completed documentation of when the medication was given, to whom it was given, how much medication was administered, and by whom it was administered. Additionally, the RQM stated it was her expectation that each controlled substance was counted by two (2) nurses before and after each shift. Additional interview with the RQM, on [DATE] at 1:28 PM, revealed nursing staff, including the DON, should monitor the temperature of the medication refrigerators nightly to maintain the integrity of medications and vaccines. Further interview revealed the facility did not find declining inventory count sheets for the controlled drugs. She stated she could not determine who took the sheets. The RQM stated declining inventory controlled drug count sheets should remain with the medication at all times. Interview with DON #5, on [DATE] at 5:36 PM, revealed she was hired on [DATE]. She stated all controlled drugs had been destroyed after she started in the position of DON on [DATE]. She stated it was her expectation that nurses followed the facility's policy regarding medication storage, labeling and destruction of medications. Per interview all controlled medications should be double locked to include those in the DON's office for destructions. The DON's office should be locked when the DON was not in the office to ensure controlled medications remained double locked until destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional interview with the Administrator, on [DATE] at 1:57 PM, revealed the facility did not have a policy related to medication refrigerator temperatures. Per interview, the Administrator stated she was not clinical and the DON would be able to answer questions related to medication refrigerator temperatures, the storage of and destruction of controlled medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32635 Based on observation, interview, and review of the facility's policy, and the Serve Safe Food Handler Guide, dated 2011, it was determined the facility failed to store food properly in order to ensure food safety. Observation, on 02/15/2022, during the initial kitchen tour, at 11:00 AM, revealed shelves contained dry foods which were opened, and not labeled, or dated. Further observation on 02/15/2022 at 11:45 AM, during the lunch tray line, revealed a white substance hanging from the ceiling near the vent over the tray line. Additionally, observation, on 02/18/2022, of the residents' nourishment refrigerator temperature logs at both nurse's stations, revealed incomplete documentation. The findings include: Review of the facility's policy titled, Labeling and Dating, undated, revealed all foods should be dated upon receipt, before being stored. Labeling and dating ensured all foods were stored, rotated, and utilized in the First in First Out (FIFO) system. The food labels must include the food's name, date of preparation/receipt, and use by date. Interview with the Administrator, on 02/25/2022 at 1:57 PM, revealed the facility did not have a policy related to documentation of the nourishment refrigerators' temperatures. The Administrator did not offer additional information when interviewed related to her expectation regarding the need for nourishment refrigerators to have temperatures obtained and documented. According to the Serve Safe Food Handler Guide, dated 2011, the refrigerator operating temperature should be thirty six to forty (36-40) degrees Fahrenheit. 1. Observation during the initial kitchen tour, on 02/15/2022 at 11:00 AM, revealed food packages located in open cabinets were not labeled, or dated with an open date or use by date. The food packages included one half (1/2) package of yellow cake mix, and three fourths (3/4) package of marshmallows. Continued observation of the kitchen on 02/15/2022 at 2:10 PM, revealed three (3) bags of opened noodles with no label, no open date, or use by date, and an opened box of cereal with no label, open date or use by date. Observation on 02/15/2022 at 11:45 AM, of the lunch tray line, revealed a white substance hanging from the ceiling near the vent over the tray line. Interview with Cook #1, on 02/16/2022 at 2:50 PM, revealed food which had been opened should be labeled and dated with an open date and use by date. Further, the food item should be tossed if it was opened and not labeled. (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 Dietary Manager #1, on 02/16/2022 at 2:55 PM, revealed all foods should be labeled and dated with an open date and use by date. Food should be thrown out if it was not labeled and dated as food could grow bacteria, mold, or become watery. Further interview revealed the white substance over the tray line could cause cross contamination of the residents' food. Interview with Dietary Aide/Cook #2, on 02/16/2022 at 3:09 PM, revealed foods should have an open date and date received. Per interview, foods should be thrown out if opened with no label or open date and use by date. Further interview revealed food which was not labeled or dated correctly could become spoiled and if used could make the residents sick. Interview with the Administrator, on 02/19/2022 at 2:30 PM, revealed it was her expectation for Food Service to follow the facility's policy and procedure concerning labeling and dating food. She stated food should be labeled and dated with the received date and an open date. Further interview revealed she was not aware of the loose paint on the ceiling in the kitchen, above the tray line. She stated this should have been reported for repair. 2. Observation, on 02/16/2022 at 2:00 PM, revealed a nourishment refrigerator for the C-D-E Unit. Review of the form titled, Refrigerator temp log, dated 02/2022, revealed temperatures were not documented for seven (7) days, from 02/04/2022 through 02/10/2022. Observation on 02/16/2022 at 2:05 PM, revealed a nourishment refrigerator for the A-B Unit. Review of the form titled, Refrigerator temp log, dated 02/2022, revealed the temperatures were not documented for seven (7) days, 02/03/2022, 02/05/2022 - 02/07/2022, 02/10/2022, 02/12/2022 and 02/13/2022. Interview with Licensed Practical Nurse (LPN) #8, on 02/18/2022 at 5:30 PM, revealed the night nurse was responsible to record the temperature of the nourishment refrigerator. Further interview revealed the temperatures should be between thirty-two and forty (32-40) degrees Fahrenheit. Interview with LPN #14, on 02/18/2022 at 6:00 PM, who worked the night shift, revealed the night nurse was responsible to document the nourishment refrigerator temperature on the log every night. Per interview, the refrigerator temperature should be between thirty-six and forty-six (36-46) degrees Fahrenheit to maintain the food product. She stated the nurses would sometimes get busy and forget to obtain and document the temperatures. Interview with the Regional Quality Manager (RQM), the former acting Director of Nursing (DON), on 02/24/2022 at 1:28 PM, revealed nursing staff including the Assistant Director of Nursing (ADON), and the Director of Nursing (DON) should monitor to ensure the nourishment refrigerators' temperatures were documented, in order to ensure the food did not spoil or freeze. Per interview, the temperature of the nourishment refrigerators should be about thirty-four to forty-one (34-41) degrees Fahrenheit.

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39953 Based on interview, record review, and review of the facility's Administrator's and Director of Nursing's Job Descriptions, it was determined the facility failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to maintain substantial compliance, after the 05/21/2020, Abbreviated Survey, in the areas of 42 CFR 483.10 Notification of Change (F580); 42 CFR 483.25 Quality of Care (F684); 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657); and 42 CFR 483.70 Resident Records-Identifiable Information (F842). During the 05/21/2020 survey, F580, F657 and F684 were cited at the Immediate Jeopardy level. Observations, interview, and record review revealed the facility's administration failed to use its resources to provide quality care and services to meet the needs of the residents. (Refer to F580, F656, F657, F684, F686, F692, F842, F867, F880, and F886) In addition, the facility's administration failed to ensure the facility maintained the standard levels of care and services for its residents. (Refer to F658, F695, F761 and F812). The facility's failure to be administered in a manner that enabled the effective use of its resources has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. The findings include: (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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's, Job Description for the Administrator, undated, revealed the Administrator's operational responsibilities included the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that governed nursing facilities to assure the highest degree of quality of care would be provided to residents at all times. Continued review revealed the Administrator's essential functions included facility and compliance management, and facility staffing and retention. The Administrator was responsible to ensure excellent care for residents was maintained by overseeing and monitoring resident care services delivered. Per review of the Job Description, the Administrator worked with and supervised personnel in the facility to provide opportunity for instruction, guidance, and counsel as necessary to ensure a complete understanding of responsibilities. Further review revealed the Administrator would ensure the maintenance of accurate medical records for auditing and regulatory compliance within appropriate approved guidelines. Review of the facility's Job Description for the Director of Nursing (DON), undated, revealed the DON's responsibilities were to plan, organize, develop, and direct the overall operation of the facility's nursing department, in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities, as directed by the Administrator, to assure the highest degree of quality of care was provided for residents at all times. Continued review revealed the essential functions of the DON position included supervision and evaluation of all nursing services provided in the facility. The DON was responsible for ensuring that the medical records and reports concerning resident care were maintained. Further review revealed the responsibility of the DON included determining staffing needs and to ensure orientation and training of nursing services personnel. In addition, the DON was also responsible for communicating to the Administrator, nursing concerns and identified problem areas with the developed plans of action to address the concerns/problem areas. Interview with the facility's [NAME] President of Operations (VPO), on 02/25/2022 at 10:30 AM, revealed there was not a job description for the Regional Quality Manager (RQM) position. Interview with the Regional Quality Manager (RQM), on 02/24/2022 at 12:22 PM, revealed she provided oversight of the clinical processes in the facility. She stated she provided clinical resources and support for the Director of Nursing (DON) and the Administrator through Quality Assurance (QA) review. Review of the 05/21/2020 Abbreviated Survey's Plan of Correction, and the 03/04/2022 findings revealed the facility failed to maintain compliance and be administrated in a manner to provide quality care and services. The facility was cited at actual harm and Immediate Jeopardy on both surveys. The facility was previously cited deficiencies, on 05/21/2020 related to notification to the provider secondary to a change in a resident's conditions; providing care to residents per standards of practice; revisions to the care plan with changes in a resident and their necessary care; pain management with a resident's change in condition; and maintaining accurate and consistent medical documentation/records. The same areas of deficient practice were identified on the 03/04/2022 survey. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with Director of Nursing (DON) #1, on 02/25/2022 at 1:00 PM, revealed she had been the DON at the facility from the spring of 2020 until mid-November 2021. Continued interview revealed her job was to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently. She stated the Regional Quality Manager (RQM) had been present in the building weekly and provided resources and education directly for her. Further interview revealed, she was uncertain if her job description or responsibilities had been reviewed with her upon hire. DON #1 further stated the RQM's involvement in Quality Assurance (QA) reviews in the facility was how deficient practices were identified. Per interview, the DON was responsible for addressing deficient practices identified by the RQM. Interview with the Regional Quality Manager (RQM), on 02/24/2022 at 12:22 PM, revealed she had been the RQM for one (1) and a half years at the facility and had been the acting DON #2, from December 23, 2021, until January 24, 2022. However, she had been out of the facility most of December 2021. Per interview, she was not part of the administration of the facility while acting as the DON, or as the RQM. Continued interview revealed she had no power in the facility for making changes in either role. However, she started her job was to provide clinical resources and support to the DON and the Administrator through the ongoing QA review. Further interview revealed she had gone over the DON #1's job responsibilities with her and had also discussed with her the state and federal regulations. Interview with DON #3, on 02/16/2022 at 2:15 PM, revealed he had been in the DON role for only one (1) month, from January 24, 2022, until February 18, 2022. Per interview, the Administrator had reviewed his DON job description and responsibilities with him upon hire, and he was considered part of the facility's Administration. Continued interview revealed he had been responsible for the overall operations of the facility's nursing department while in the DON role. However, he stated he had no long-term care background experience and had not received training from the facility related to the responsibilities of the DON role. Continued interview revealed he was told upon hire he would receive training from another DON at a sister facility; however, he had not been provided that training. In addition, he stated he was not familiar with the state and federal regulations for long-term care. He further stated he had been responsible for the care needs of the facility's residents and the supervision of its nursing staff. DON #3 stated that he ensured residents received the necessary care and services and provided the supervision of nursing staff as required through the department's morning clinical meeting. He stated that in the meetings orders, change in condition, incidents, admissions/transfers/discharges, etc., that occurred within the last twenty-four (24) hours were reviewed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with the Administrator, on 02/25/2022 at 1:00 PM, revealed she had been in the role for four (4) months and had a temporary license. She stated she was responsible for ensuring the facility was 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. Continued interview revealed her job description was reviewed with her by the VPO when she was hired into the Administrator role. Per interview, she had the State Operational Manual in her office to use as a resource. The Administrator stated she was responsible for the care needs of the facility's residents and for the supervision of its staff. She stated she was the DON's direct supervisor. The Administrator revealed she believed the facility addressed the identified 05/21/2020 Survey concerns through its Quality Assurance (QA) program. Further interview revealed she was not aware of any continued audits related to the notification of change, care plans, quality of care, and resident records. The Administrator further revealed she had not reviewed the facility's previous survey results, nor the QA documents prior to accepting the role of Administrator. She stated that she had not reviewed the previous survey results because it occurred when she was a social worker and not an Administrator at the facility. Further interview revealed she ensured her responsibilities were accomplished through ongoing quality reviews completed by the RQM and DON. She stated that she talked with the VP of Ops, RQM and DON daily about what was going on in the facility. Continued interview revealed she relied on the RQM's and DON's oversight of clinical processes in the facility to ensure all clinical staff and processes were in place, per the Policy and Procedure. In addition, interview on 02/25/2022 at 1:00 PM, with the Administrator revealed she was not aware of any of the deficiencies cited during the current survey having been addressed in the facility's QA Committee meetings: Interview with the former VPO, on 02/25/2022 at 2:51 PM, revealed her current role was to provide support for the facility's Administrator. Continued interview revealed she was unaware of concerns that had been identified within the facility, prior to the State Survey Agency's (SSA) arrival in the facility for the current survey. She stated she had been the VPO for six (6) years and had provided oversight for the Administrator. The VPO revealed she was in contact with the Administrator daily and was present in the facility twice a month to provide support and resources. Per the VPO, the facility had experienced changes in leadership, specifically the Administrator, and the DON. Further interview revealed she had worked with the Administrator to help her understand the Administrator role as she transitioned into the new role. The VPO further stated she would continue to provide oversight of the Administrator and would be watching over the daily operations of the facility.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 39953 Based on interview, record review, and review of the facility's policy, it was determined the facility's Governing Body failed to ensure facility policies were implemented regarding management and operation of the facility. The Governing Body failed to ensure compliance in the areas of 42 CFR 483.10 Resident Rights,F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657; 42 CFR 483.25 Quality of Care, F684 and F697; and 42 CFR 483.70 Administration, F842 during the 05/21/2020 Abbreviated Survey. Continued non-compliance was cited during this Survey at 42 CFR 483.10 Resident Rights, F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657; 42 CFR 483.25 Quality of Care, F684 and F697; and 42 CFR 483.70 Administration, F842. The facility's failure to ensure the Governing Body implemented policies has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. Refer to F580, F656, F657, F684, F686, F692, F697, F726, F835, F837, F842, F867 and F880 The findings include: (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's policy titled, Governing Body, undated, revealed the Governing Body consists of the [NAME] President of Operations (VP of Ops), the Regional Quality Manager (RQM), the Administrator and the Director of Nursing (DON). Per policy, the VP of Ops would be notified of state reportable events, falls with injury and unusual event/occurrences, and Statement of Deficiency/Plan of Correction status. Additionally, the VP of Ops, the RQM, and the DON would conduct routine follow up to include staffing, reportable events, Statement of Deficiency/Plan of Correction (SOD/POC) status, and policy and procedure. Continued review revealed the RQM and the DON would review general clinical issues such as risks, acute readmissions, interventions, systems, tracking/trending, and SOD/POC status. The Governing body would review the facility operational status including Regulatory Compliance, Quality Measure Improvement, Staff Development, and Census Development. Further, the Governing body would review the Clinical Score Card including evaluation of Quality Assurance (QA), infection, tracking/trending, investigations, outcomes, and hospital readmissions. The Governing body would also schedule meetings for all the Regional, Administrators, and the DONs to review education, policy/procedure updates and annual mock surveys. Review of the Statements of Deficiencies (SOD) for the Abbreviated Survey dated 05/21/2020, revealed Immediate Jeopardy was cited at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684) all at a S/S of a J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684). Deficient practice was also cited at 42 CFR 483.25, F697 at a S/S of a G and 42 CFR 483.70 Administration, F842 at a S/S of a D. An acceptable Allegation of Compliance was received on 05/13/2020, which alleged removal of Immediate Jeopardy on 05/13/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/13/2020 as alleged. However, the Governing Body failed to ensure compliance was maintained. During this Survey, repeat deficiencies from the Abbreviated Survey dated 05/21/2020 include 42 CFR 483. 10 Resident Rights, F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657; 42 CFR 483. 25 Quality of Care, F684 and F697; and 42 CFR 483.70 Administration, F842. Immediate Jeopardy (IJ) was cited at 42 CFR 483.10 Resident Rights, F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656 and F657; 42 CFR 483.25 Quality of Care, F684, F686 and F692; all a Scope and Severity (S/S) of a J. Additionally, Immediate Jeopardy (IJ) was cited at 42 CFR 483.70 Administration, F835 and F837 at a S/S of an L, and F842 at a S/S of a J; 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a S/S of an L; and 42 CFR 483.80 Infection Control, F880, at a S/S of an L. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684, F686, F692) and 42 CFR 483.45 Pharmacy Services (F760), at a s/s of an F. Interview with the [NAME] President of Operations, on 02/23/2022 at 11:56 AM, and 02/25/2022 at 10:30 AM, revealed when the company ownership changed in 2018, she no longer had a job description. Further interview revealed there was not a job description for the Regional Quality Manager (RQM). (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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's, Job Description for the Administrator, undated, revealed the Administrator's operational responsibilities included the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulation that governed nursing facilities to assure the highest degree of quality of care would be provided to residents at all times. Continued review revealed the Administrator's essential functions included facility and compliance management, and facility staffing and retention. Review revealed the Administrator was responsible to ensure excellent care for residents was maintained by overseeing and monitoring resident care services delivered. Per review of the Job Description, the Administrator worked with and supervised personnel in the facility to provide opportunity for instruction, guidance, and counsel as necessary to ensure complete understanding of responsibilities. Further review revealed the Administrator would ensure the maintenance of accurate medical records for auditing and regulatory compliance within appropriate approved guidelines. Review of the the facility's, Job Description for the Director of Nursing (DON), undated, revealed the DON's responsibilities were to plan, organize, develop, and direct the overall operation of the facility's nursing department, in accordance with current federal, state, and local standards, guidelines, and regulation that govern nursing facilities, as directed by the Administrator, to assure the highest degree of quality of care was provided for residents at all times. Continued review revealed the essential functions of the DON position included supervision and evaluation of all nursing services provided in the facility. Per review of the DON's Job Description, the DON was responsible for ensuring the medical records and reports concerning resident care were maintained. Further review revealed the responsibility of the DON included determining staffing needs and to ensure orientation and training of nursing services personnel. In addition, review revealed the DON was also responsible for communicating to the Administrator, nursing concerns and identified problem areas with the developed plans of action to address the concerns/problem areas. Interview with Director of Nursing (DON) #1, on 02/25/2022 at 1:00 PM, revealed she was the DON at the facility from the spring of 2020 until mid-November 2021. Additionally, the Governing Body would include the Administrator and the RQM as she reported to them. Further, DON #1 revealed she was aware of the deficiencies cited during the Abbreviated Survey, on 05/21/2020. However, she was not aware of continued audits related to those deficient areas. Further she relied on the RQM to identify clinical areas of deficiency and to give direction to achieve regulatory compliance. Interview with the Regional Quality Manager (RQM), on 02/25/2022 at 12:45 PM, revealed she had been the RQM for one and a half years at the facility and was the acting DON #2, from December 23, 2021 until January 24, 2022. Additionally, she was part of the Governing Body, as per the facility's policy. Per interview, she audited clinical systems, Quality Indicators and reviewed the overall operational status of the nursing department. She stated she also provided weekly clinical support and Quality Assurance (QA) reports to the DON and the Administrator. Further, she reviewed regulatory compliance with the DON and the Administrator. Continued interview revealed she was aware of the deficiencies cited during the last Abbreviated Survey dated 05/21/2020. However, she was not fully aware of the extent of clinical systemic issues that were currently occurring in the facility. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with the Administrator, on 02/25/2022 at 1:00 PM, revealed she had worked at the facility in her role, for four (4) months and had a temporary license. Per interview, she was unfamiliar with who the Governing Body was and their responsibilities. However, she stated it was her responsibility as the Administrator, to ensure all processes established in the facility were maintained, to include the Quality Assurance and Assessment/ Quality Assessment Performance Improvement (QAA/QAPI) program. Continued interview revealed the Administrator was not aware of the previous Plan of Correction for the Abbreviated Survey in May of 2020, which occurred prior to her role at the facility as the Administrator. Further, she was not aware of clinical systemic issues at the facility and stated she was not clinical as she was a social worker until she became the Administrator. Interview with the [NAME] President of Operations (VP of Ops), on 02/25/2022 at 2:50 PM, revealed she had been in the role since 2016. Per interview, as VP of Ops she was part of the Governing Body, as per the facility's policy. She stated her current role was to provide support to the Administrator. Continued interview revealed the facility was required to maintain their own policies and procedures to meet regulatory requirement. Per interview, the facility's policies and procedures were from the previous company. She stated she provided resources and help getting these policies and procedures implemented, but did not make clinical decisions. Further interview with the VP of Ops, revealed she was unaware of the concerns identified within the facility, but would offer support and resources as needed. Continued interview with the [NAME] President of Operations, on 02/25/2022 at 2:50 PM, revealed she was not involved in the monthly Quality Assurance (QA) meetings and did not give the facility direction on their QA. However, she was aware of the QA action plans and any concerns discussed in QA, as she reviewed the facility's QA on a shared drive and also discussed QA with the Administrator. Additionally, neither the Administrator or the RQM communicated the concerns related to deficient practices which were identified by the State Survey Agency (SSA), prior to the SSA arrival into the facility. Per interview, the facility should have had systems/audits in place to identify issues with clinical practices and reported them to her to ensure follow up review and correction. The VP of Ops stated she would provide oversight to the Administrator and monitor the facility's daily operations with routine visits.

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	185262	A. Building B. Wing	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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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 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 ensure resident records were complete, and staff accurately documented care and services provided for six (6) of thirty-three (33) sampled residents (Residents #19, #28, #39, #47, #63, and #428). The facility admitted Resident #19, on [DATE], with two (2) Stage III Pressure Ulcers to the outside of the right foot; a wound to the right outer leg on the side of the knee; a wound to the mid spinal area; and, a wound to the right outer leg. However, at times, the facility failed to consistently document the care and assessment of the ulcers, as orders. The resident's wounds were not documented on from [DATE] until [DATE] (28 day). The facility admitted Resident #39 on [DATE] with a Stage III Pressure Ulcer to the right buttock. Documentation revealed a lapse in weekly wound assessments with no documented evidence that the facility conducted the resident's wound assessments until [DATE] (18 days later). Record review revealed the facility admitted Resident #47 on [DATE]. Resident #47's Physician's Orders, dated [DATE], revealed orders for weekly skin inspections. However, there was no documentation that the facility conducted the skin assessments including measurements and the progression of the resident's pressure areas from [DATE] until [DATE]. Assessment on [DATE], revealed the ulcers had declined and the resident had developed Osteomyelitis (a bone Infection). The facility admitted Resident #63 on [DATE] with a Stage II Pressure Ulcer to the coccyx and staples to the left above the knee amputation. However, the facility failed to document assessments of the resident's areas until [DATE], thirty-four (34) days after admission to the facility, at which time the wounds had declined. The facility failed to ensure Resident #428's food and fluid intake was completely and accurately documented for seventeen (17) days, from [DATE] until [DATE]. Resident #428 was admitted to an acute care hospital on [DATE]. Resident #428's admission diagnoses were Acute Kidney Injury secondary to Severe Dehydration and Severe Malnutrition. In addition, Resident #28 did not have accurate documentation concerning administration of Gabapentin (a Schedule V pain medication given for the resident's Diabetic Neuropathy) on the Medication Administration Record (MAR). The MAR revealed documentation that the resident received Gabapentin for thirteen (13) days when he/she did not because the facility had failed to obtain the medication. The resident's medication was not in the facility. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to ensure medical records were accurately maintained has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE], 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on [DATE]. An acceptable Immediate Jeopardy Removal Plan was received on [DATE], which alleged removal of the Immediate Jeopardy effective [DATE]. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on [DATE]. The Immediate Jeopardy is ongoing. Refer to F692, F697 and F761. The findings include: Review of the facility's,Skin Care Standard of Practice Policy, dated ,d+[DATE], revealed the facility would assess all residents on admission, readmission, quarterly, and with each change in condition that would compromise the skin. Per the policy, the baseline skin assessment would be completed within 24 hours of admission and documented in the medical record. Staging and measuring of the wound would be completed by the assigned nurse to maintain continuity in documentation of progression of would healing. 1. Review of Resident #19's medical record revealed the facility admitted the resident, on [DATE], with diagnoses that included Osteomyelitis, Methicillin Resistant Staphylococcus Aureus (MRSA), Pressure Ulcer, Paraplegia, and Hypothyroidism. The facility admitted Resident #19 with Pressure Ulcers to his/her back and right leg. Review of Resident #19's Admission Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident to be at risk for pressure ulcers. Resident #19 had two (2) Stage III pressure ulcers that were present on admission on [DATE]. In addition, Resident #19's Brief Interview for Mental Status' (BIMS) score was fifteen (15) of fifteen (15), which indicated the resident's cognition was intact. Review of Resident #19's Care Plan, dated [DATE], revealed the resident had two (2) Stage III pressure ulcers on the outside of the right foot; one (1) on the right outer leg by the side of the knee; one (1) on the mid-back spine; and, one (1) on the right outer leg. Staff were to provide wound care and treatments as ordered by the physician. Review of Resident #19's [DATE] Treatment Administration Record (TAR) revealed inconsistency (did not document) in documentation for the intervention of wound treatment to the two (2) Stage III Pressure Ulcers on the outside of the right foot. The treatment consisted of using wound cleanser, pat dry, apply Santyl (a topical medication to promote wound healing) and cover with border gauze daily at 7:00 AM. However, the treatment was not signed (blank) to indicate the treatments were completed at 7:00 AM on [DATE] and [DATE]. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #19's February 2022 TAR, revealed inconsistency (blanks) in documentation for the intervention of wound treatment to apply skin prep to scar tissue at the right gluteal cleft for prevention of breakdown (daily) at 7:00 AM, However, the treatment was not signed (blank) to indicate the treatments were completed for fourteen (14) days including [DATE] - [DATE]; [DATE] - [DATE]; [DATE]; [DATE]; [DATE] - [DATE]; and [DATE]. Review of Resident #19's February 2022 TAR revealed inconsistency in documentation for monitoring of the resident's wound and wound treatment on his/her mid back. The TAR was not signed (blank) to indicate this monitoring/treatment was done at 7:00 AM for seven (7) days including [DATE], [DATE], [DATE], [DATE] - [DATE], and [DATE]. Review of Resident #19's February 2022 TAR revealed inconsistency in documentation for wound treatment with an air mattress. Further review revealed this intervention was not signed (blank) at 7:00 AM for six (6) days, including [DATE], [DATE], [DATE] and [DATE] - [DATE], to indicate the resident had an air mattress. Interview with Resident #19, on [DATE] at 9:41 AM, revealed he/she did not receive the wound care treatment like the doctor had ordered. The resident stated he/she did not have a bandage on his/her back. An observation, during the interview, revealed there was no bandage on the resident's back, and the resident's leg was wrapped in kerlex dated [DATE]. Per the TAR, Resident #19's bandage was to be changed on [DATE]. Record review revealed the dressing change was documented as changed on [DATE]. However, an observation made on [DATE] revealed the bandage had not been changed since [DATE]. Interview with Licensed Practical Nurse (LPN) #4, on [DATE] at 3:26 PM, revealed she did not think Resident #19 had any treatments. She stated she thought the resident might have a treatment on his/her foot two (2) times a week or every three (3) days. She stated if the resident refused, she just charted it and told the Administrator. Interview with Registered Nurse (RN) #1, on [DATE] at 11:20 AM, revealed she did wound care on Resident #19, on [DATE], but she had no explanation why it was not charted. 2. Review of Resident #39's medical record revealed the facility admitted the resident, on [DATE], with diagnoses that included Essential (Primary) Hypertension; Other Chronic Pain; Polyneuropathy, Unspecified; Pressure Ulcer of the Right Buttock, Stage III; Adult Failure to Thrive, Pressure Ulcer of the Right Buttock/Unstageable; and Acute Kidney Failure, Unspecified. Review of Resident #39's Admission MDS Assessment, dated [DATE], revealed the facility assessed Resident #39 to be at risk for pressure ulcers. The resident had one (1) unstageable deep tissue injury that was present on admission on [DATE]. A care plan was developed. In addition, Resident #39 had a BIMS' score of six (6) of fifteen (15), indicating severe cognitive impairment. Review of Resident #39's Care Plan, dated [DATE], revealed the resident had a Stage III pressure ulcer of the right buttock. Staff was to provide wound care as ordered by the physician; air mattress as ordered; and treatment to buttocks. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the February 2022 Medication Administration Record (MAR) for Resident #39 revealed no documentation noting the Silvadene wound treatment as having been completed as ordered for the 2nd, 4th, 5th, 11th, 12th, 13th, and 15th of that month, a total of seven (7) days. Further review revealed staff were to initial the time and date on the MAR after completing application of the Silvadene wound treatment. However, the area for staff's initials for those dates was blank. Review of the February 2022 TAR for Resident #39 revealed no documentation noting the ordered wound treatment (cleanse wound, apply Silvadene and oil emulsion, wet to dry gauze twice daily on coccyx every 12 hours) had been completed at 9:00 AM for the dates of the 11th, 12th, 13th, 14th, and 15th, a total of five (5) days. Continued review of the February 2022 TAR revealed no documentation noting the ordered wound treatment had been completed at 9:00 PM for the 9th, 11th, 12th and 13th, a total of four (4) days. Further review revealed staff were to initial the time and date on the TAR after completing application of the ordered wound treatment; however, the area for staff's initials for those dates was blank. Interview with Resident #39, on [DATE] at 11:25 AM revealed the resident felt bad. The resident additionally stated he/she had sores on his/her bottom, and they hurt. Resident #39 stated the nurses looked at the sores, but not daily. Interview with LPN #7 (an agency nurse), on [DATE] at 1:35 PM, revealed she had been to the facility eight (8) times and had not received any training from her agency or the facility on wound care, wound assessment, or documentation of wounds. Additionally, she did not know the treatment order for Resident #39's wounds. 3. Review of Resident #63's medical record revealed the facility admitted the resident, on [DATE], with diagnoses that included Acquired Absence of Left Leg Above Knee, Acute Respiratory Failure with Hypoxia, and Peripheral Vascular Disease, Unspecified. Review of Resident #63's Admission MDS Assessment, dated [DATE], revealed the facility assessed Resident #63 to be at risk for pressure ulcers. Resident #63 had one Stage II Pressure Ulcer on the coccyx and a surgical wound that was present on admission on [DATE]. In addition, the facility assessed Resident #63 with a BIMS' score of fifteen (15) of fifteen (15), which indicated intact cognition. Review of Resident #63's Baseline Care Plan, dated [DATE], revealed the resident had a Stage II Pressure Ulcer to his/her coccyx and an above the knee (AKA) amputation to the left lower extremity. Continued review revealed staff were to provide wound care and treatment as ordered by the Physician; and, provide a pressure reduction mattress. Review of Resident #63's [DATE] TAR revealed no documented evidence of staff's initials to indicate Resident #63's coccyx wound treatment had been provided on the 14th, 15th, 16th, 18th, 20th, 24th, 25th, and on the 28th, for a total of eight (8) days. Review of Resident #63's [DATE] TAR revealed no documented evidence of staff's initial to indicate wound monitoring of Resident #63's left AKA had been provided on the 18th, 20th, 24th, and 28th, a total of four (4) days. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #63's February 2022 TAR revealed no documented evidence of staff's initials to indicate the wound treatment ordered for Resident #63's coccyx had been provided on the 1st, 2nd, 3rd, 4th, 5th, 8th, 12th, 13th, 15th, 16th and 18th, a total of eleven (11) days. Review of the February 2022 TAR revealed no documented evidence of staff's initials to indicate Resident #63's wound treatment/monitoring for his/her left AKA had been provided as ordered for the 1st, 2nd, 3rd, 4th, 5th, 8th, 12th, 13th, 15th, 16th, 18th, a total of eleven (11) days. Interview with Resident #63, on [DATE] at 1:25 PM, revealed his/her wound care at the facility had been irregular. Resident #63 stated, that it was supposed to be done to his/her stump twice daily and his/her coccyx daily. However, Yesterday the resident's wound treatments had been missed. Resident #63 stated his/her stump treatment was a daytime treatment, but the stump treatment was not done until 2:00 AM that morning. Interview with Licensed Practical Nurse (LPN) #12, on [DATE] at 4:15 PM, revealed there was no reason why the MAR/TAR's were incomplete. She stated if the wound treatments were done, they needed to be documented. 4. Review of Resident #47's closed medical record revealed the facility admitted the resident on [DATE] with diagnoses that included Malignant Neoplasm of the Brain and Lung, Diabetes Mellitus Type II, and Dementia with Behavioral Disturbance. Review of Resident #47's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed the resident as having a BIMS' score of five (5) of fifteen (15), which indicated severe cognitive impairment. Additional review revealed the facility assessed the resident as at risk for developing a pressure ulcer and as having one (1) Stage IV pressure ulcer and three (3) suspected Deep Tissue Injuries (DTIs) on his/her feet. Review of Resident #47's Physician's Orders revealed the resident was ordered to have wound care daily and as need for wounds to the left and right feet. Review of Resident #47's Care Plan, dated [DATE], revealed the resident had a problem with impaired skin integrity including a DTI to the left heel, an unstageable pressure ulcer to the right outer foot, and a DTI to the left outer foot. Interventions included: treatments as ordered; treatment to the DTI to the right outer foot and monitor until resolved; treatment to the left heel as ordered; and, treatment to the left outer foot as ordered. Review of the [DATE] TAR for Resident #47's wound care revealed the resident's ordered wound treatments were not documented as being completed on [DATE], [DATE], [DATE], [DATE], and [DATE], a total of five (5) days. Review of the February 2022 TAR for Resident #47's wound care revealed the resident's ordered wound treatments were not documented as being completed on [DATE] - [DATE]; [DATE] - [DATE], and [DATE], a total of seven (7) days. In addition, there was no documented evidence of weekly skin assessments or Wound Evaluations for measurements/staging documented from [DATE] until [DATE], over a month later, when the State Survey Agency (SSA) Surveyor asked to observe a skin assessment for Resident #47. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #47's Physician's Orders, dated [DATE], revealed orders to clean the wound to the right foot with wound cleanser, apply Santyl and cover with a nonstick foam dressing. However, there was no documented evidence of a wound to the right foot during this timeframe. Interview with LPN #4, on [DATE] at 9:45 AM, revealed when she was assigned to Resident #47 she might not have done the resident's treatments. She stated she could not remember and was not aware of the resident's wounds getting worse. Also, she stated sometimes treatments would be documented and deleted out of the electronic medical record (EMR) because the computer system had problems. 5. Review of Resident #428's closed medical record revealed the facility admitted the resident on [DATE] with diagnoses which included Dementia, Delirium, Delusional Disorder, and Encephalopathy. Review of Resident #428's most recent Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident to be severely cognitively impaired with a BIMS' score of five (5) of fifteen. Further review revealed the facility assessed the resident to require the extensive assistance of two (2) staff for transfers, bed mobility, and toileting. Continued review revealed the facility assessed the resident as always incontinent of bowel and bladder. Review of Resident #428's Food and Fluid intake documentation for [DATE] revealed the resident's food and fluid intake was not documented on [DATE]. The lunch meal was not documented on [DATE]; lunch and supper meal not documented on [DATE]; lunch and supper were not documented on [DATE]; lunch and supper not documented on [DATE]; no meal intakes were documented on [DATE], [DATE]; no meal intakes were documented, for breakfast and lunch was not documented on [DATE], no meal intake was documented on [DATE]; breakfast and lunch were not documented on [DATE], breakfast and lunch was not documented on [DATE]; no meal intake was documented on [DATE]; breakfast was not documented on [DATE]; breakfast was not documented on [DATE]; and lunch was not documented on [DATE]. No meal intake was documented on [DATE]; and, breakfast was not documented on [DATE]. Review of the Hospital Record for Resident #428 revealed the resident was transferred to an acute care hospital on [DATE] and admitted with diagnoses that included Acute Kidney Injury due to Severe Dehydration, Sepsis due to Pneumonia, Severe Malnutrition, Acute Respiratory Failure, and COVID-19 Viral Infection. Resident #428 died at the hospital on [DATE]. Interview with State Registered Nurse Aide (SRNA #4) on [DATE] at 2:14 PM revealed he could remember being told to push fluids for Resident #428 but could not remember who told him. SRNA #4 stated all the residents on the Covid Unit were being encouraged to eat and drink but, he could not recall documenting the extra fluids in the system. Interview with SRNA #5 on [DATE] at 2:35 PM revealed Resident #428 required assistance with feeding. SRNA #5 stated she had problems charting intakes in the system. She stated she worked with a lot of agency SRNAs, who did not have a log in to document food and fluid intakes in the electronic medical record system. An interview with SRNA #7 on [DATE] at 10:30 AM revealed she worked on the floor at times and documented meals intakes for Resident #428. She stated at times the computer would not allow her to document. SRNA #7 stated when information was entered on the computer it would be deleted out. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with SRNA #8, on [DATE] at 10:13 AM, revealed the SRNA often took care of Resident #428. However, he did not have a computer log in PASSWORD?to document food and fluid intake. 6. Review of the medical record for Resident #28 revealed the facility admitted the resident on [DATE] with diagnoses that included Diabetes Type 2. Orders were received for Gabapentin 100 mg (milligrams) three time daily for diabetic neuropathy pain. Review of Resident #28's Medication Administration Record (MAR) for [DATE] and February 2022 revealed the resident's Gabapentin was documented as being administered on [DATE] -[DATE]; [DATE]-[DATE]; and, on [DATE]-[DATE]. However, the resident did not have Gabapentin available at the facility to be administered during this time. Interview with Kentucky Medication Aide (KMA) #1 on [DATE] at 4:41 PM revealed if she had marked the medication as being administered on [DATE]-[DATE] for Resident #28 it would have been an oversight. She stated the medication was not available. Interview with Licensed Practical Nurse LPN #4 on [DATE] at 9:45 AM revealed if she was working with only a KMA to assist she may not get all medications documented. She further stated if she had documented a medication as given that was not available it was by accident. Interview with Licensed Practical Nurse (LPN) LPN #7, on [DATE] at 8:35 AM revealed she was an agency nurse and if she didn't document medications as being administered, she may have given the medications and did not document it. LPN #7 stated if the medication was not available, she may have not documented in the medical record or forgot to make a note. Interview with Director of Nursing (DON) #3, on [DATE] at 4:44 PM, revealed he had started at the facility in [DATE]. Further interview revealed he was not aware Resident #47 had pressure ulcers, nor was he aware skin assessments and wound measurements for Resident #47 were not being completed or documented. According to the DON, he was new to long term care, was in training, and was monitoring residents by making rounds in the facility, but was still trying to learn and did not monitor for anything specific. Interview with the Director of Education, on [DATE] at 10:19 AM, revealed she had made rounds with the Physician, on [DATE], and transcribed treatment orders for Resident #47's wound care. She stated she mistakenly got the left foot wound and the right foot wound mixed up and was not aware why Santyl was ordered for a wound to the right foot when the Physician wanted skin prep only applied to the wound. The Director of Education stated she could not explain why the treatment order was not specific or accurate to which wound and the location of the wound. Interview with the Medical Director, on [DATE] at 1:27 PM, revealed she was concerned that wound care and measurements were not getting completed and documented in the medical record. Further interview revealed she intended for the unstageable wound to Resident #47's right foot to be treated with skin prep to keep the wound closed. Per interview, the order dated [DATE], to clean the wound to the right foot with wound cleanser, apply Santyl, and cover with a nonstick foam dressing should not have been ordered. The Medical Director stated she did look at the notes and tried to track down a time line for Resident #47's wounds and noted two (2) of the resident's wounds had deteriorated. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Director of Education, on [DATE] at 1:40 PM, revealed she had worked at the facility since [DATE]. However, she had been in her current role since February 2022. Per the interview, she stated the wound nurse, when she was at the facility, was responsible for all skin and wound assessments and documentation as well as rounding with the physician for wounds. She stated, after completion of a wound treatment or assessment, the nurse was responsible to document it on the TAR and MAR in the electronic medical record (EMR). Interview with the Regional Quality Manager (RQM), who was a Registered Nurse (RN), on [DATE] at 3:00 PM, revealed documentation of wound treatments on the TAR and the MAR and wound assessments was essential to determine the effectiveness of skin/wound care the residents received. Additional interview with the Regional Quality Manager, on [DATE] at 12:22 PM, revealed there were no excuses for the wound treatments not being completed and documented on the TAR. Interview with Director of Nursing (DON) #4, on [DATE] at 2:15 PM, revealed skin and wound assessments should be accurately and thoroughly completed and documented weekly in the EMR, by the assigned nurse responsible for the resident. Continued interview with the Medical Director, on [DATE] at 1:27 PM, revealed she noticed a change in the quality of documentation after the wound nurse left, as agency nurses were not invested in providing the best care possible. According to the Medical Director many of the residents' wounds got worse. The Medical Director stated it was unsafe to practice in such an environment with wound treatments not being done or documented, and she could not defend the facility for any of this. Interview with the Administrator, on [DATE] at 12:58 PM, revealed if a nurse did not follow Physician's Orders for wound treatments, the wound could get worse. She stated she would expect staff to complete the wound treatments and document it. She stated she expected nursing to follow the Physician's Orders and accurately and completely document to take credit for their work. 44371 22976

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32635 Based on observation, interview, record review, review of facility policy, and review of the facility's Plan of Correction submitted for 05/21/2020 survey, it was determined the facility failed to have effective processes in place to address system failures through regularly scheduled Quality Assurance Performance Improvement (QAPI) meetings. As a result, the facility failed to identify quality of care deficiencies, failed to develop and implement plans of action to correct identified quality of care deficiencies, and failed to ensure standards for quality of care regarding performance improvement measures were achieved and sustained. This was evidenced by deficient practice cited at F580, F657, F684, and F842, which had previously been cited on 05/21/2020. During the 05/21/2020 survey, Immediate Jeopardy was identified at 42.CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657); 42 CFR 483.25 Quality of Care (F684); and 42 CFR 483.70 Resident Records-Identifiable Information (F842). The facility submitted an acceptable Plan of Correction (POC) alleging compliance as of 05/13/2020. However, the facility failed to maintain substantial compliance resulting in current deficient practice being cited at the Immediate Jeopardy level in the same areas. The facility's failure to have an effective Quality Assusrance Program in place has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. Refer to F580, F657, F684, and F842 The findings include: Review of the facility's policy titled, QAPI Plan Standard of Practice, dated 06/2020, revealed the purpose of the Quality Assurance and Performance Improvement (QAPI) program was to provide overall guidance to the facility, to provide excellence in quality of care and support quality of life through patient centered care. Continued review revealed the facility conducted an annual Facility Assessment review, systematic performance evaluation, problem analysis and implementation of improvement strategies to achieve its quality goals. Further review revealed the scope of the facility's QAPI activities was to include all service areas and be supported by the facility's QAPI Interdisciplinary Team (IDT) members. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Job Description for the Administrator, undated, revealed the Administrator was responsible for the facility's day-to-day functions in accordance with current federal, state, and local standards, guidelines, and regulation that governed nursing facilities to assure the highest degree of quality of care was provided at all times for residents. Continued review revealed the essential functions of the Administrator position included facility and compliance management, and facility staffing and retention. Review revealed the Administrator was responsible for ensuring excellent care of facility residents which was maintained through the overseeing and monitoring of patient care services being delivered. Further review revealed the Administrator was to work with and supervise facility personnel in order to provide opportunity for instruction, guidance, and counseling as necessary to ensure personnel had complete understanding of their responsibilities. Review further revealed the Administrator ensured the maintenance of accurate medical records for auditing and regulatory compliance within appropriate approved guidelines. Review of the Acceptable Plan of Correction (POC), for the Abbreviated Survey dated 05/21/2020, revealed for the deficient practice which had been cited at F580, the facility had provided education for licensed nurses regarding physician notification with changes of condition in residents, and the documentation required for physician notifications. Continued review of the POC revealed for the deficient practice cited at F684, the facility implemented resident skin inspections to include new/undocumented skin impairments and pain assessment. Further review of the POC revealed for the deficient practice cited at F842, residents' care plans were updated with new interventions related to a change in resident status in the electronic medical record. The POC review revealed for the deficient practice cited at F657, the facility provided education for licensed nurses related to the regulatory requirement that resident care plans were to be updated when a change of condition occurred for a resident. Further review of the Plan of Correction (POC), for the survey dated 05/21/2020, revealed the DON, Unit Manager or Wound Nurse, or weekend Registered Nurse (RN) supervisor would review the audits initiated on 05/08/2020 on a daily basis for Physician orders. Review of the POC further revealed for the audits which had been initiated for validating updated care plan and skin/wound assessments, the DON, Unit Manager or Wound Nurse, or weekend Registered Nurse (RN) supervisor would review the audits until the facility achieved regulatory compliance. In addition, the POC review additionally revealed the results of the facility's monitoring/auditing would be reviewed a minimum of weekly in the facility's QAPI meetings being held to track the facility's progress toward regulatory compliance. Finally, review of the POC for the 05/21/2020 survey revealed the QAPI meetings included, but were not limited to the: Administrator, Director of Nursing, Unit Managers, Human Resources, Business Office Manager, Social Services Director, Activities Director, Dietary Manager, Minimum Data Set (MDS) Coordinator and Medical Records. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's Quality Assurance (QA) Committee meeting documentation revealed meetings held on 05/05/2021, 05/26/2021, which were concerning mock surveys results and actions, with the attendees noted as former Administrator #1, Medical Director, Director of Nursing (DON) #1 and current Administrator (#2), who had been the former Social Services Director (SSD). The same attendees were noted for the 06/12/2021, and 07/30/2021 meetings, and for the 08/03/2021, and 08/26/2021 meetings the attendees included former Administrator #1, DON #1 and current Administrator #2 (former SSD). Continued review revealed for the 09/17/2021, and 10/15/2021 meetings the attendees included Administrator #2 and former Registered Nurse (RN)/Education Training Director #2. Review of the 11/23/2021, and 11/30/2021 meetings revealed the attendees included Administrator #2, and DON #1. Further review revealed Administrator #2, DON #2 were noted as attending the 12/30/2021 meeting, and the Medical Director noted as attending by phone. Interview on 02/22/2022 at 5:18 PM, with former Wound Nurse #1 revealed she had informed the Administrator in November 2021, that there were issues with the facility's wound care and treatment and documentation. Continued interview revealed at that time the facility implemented changes to its weekly skin assessment protocol and direct care nurses were provided a schedule for skin assessments and responsibility to complete the assessments weekly. According to the Wound Nurse, she had worked as a direct care nurse, Unit Manager and the Wound Nurse in the months of November 2021 and December 2021. She revealed; however, she was responsible for weekly wound assessments and wound care for residents who had wounds. Further interview with the former Wound Nurse #1, on 02/22/2022 at 5:18 PM, revealed she had been working one hundred and twenty (120) to one hundred and fifty (150) hours per week in November and December 2021 and had not been able to complete her Wound Nurse care duties. She stated she had informed the Administrator #2, at that time, that she could not do what needed to be done with residents' wounds. The Wound Nurse stated she had also informed Administrator #2 at the same time that she had identified direct care nurses were not completing the documentation for things such as assessment and treatment administration records. Further interview revealed the Administrator #2 asked her to complete a skin sweep of all residents' skin status in the facility in January 2022, which she had completed and documented. The Wound Nurse stated she provided the hand-written reports to the Administrator after completing the skin sweep. She further revealed she had become frustrated with the situation and no longer worked as a full-time nurse at the facility. Continued interview revealed she had not worked at the facility since 01/24/2022. In addition, the Wound Nurse revealed she attended the Daily Clinical Reports (DCR) meetings, to discuss and review anything new with residents in the past twenty-four (24) hours and check to see if everything had been done related to the resident's care. She further stated she could not attend every DCR meeting due to working on the units as assigned. Interview with the Assistant Minimum Data Set (MDS) Coordinator #1, on 02/24/2022 at 8:55 AM, revealed Monday through Friday, she attended the DCR meetings. Continued interview revealed in the DCR meetings Physicians' orders, labs, residents' skin assessment progress notes were reviewed, and residents' care plans updated. The MDS Coordinator revealed she attended the facility's monthly QAPI meetings, where she made changes to residents' care plans. Further interview revealed she had not identified any issues concerning the care plans. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with Registered Nurse (RN) #1, the Director of Nursing (DON) on 02/25/2022 at 12:21 PM, revealed she was responsible for completing the facility's Quarterly review of residents' falls. She revealed her responsibilities also included: attending weekly resident falls meetings; performing audits of residents' laboratory (lab) results; and reviewing new and discontinued Physician's orders in the DCR meetings. Continued interview revealed she attended the facility's Interdisciplinary Team (IDT) meetings and discussed changes in residents' conditions, residents' medication refusals, followed up to ensure skin and wound care had been completed, and residents' care plans revised as necessary. She stated the DON's position was to assist in ensuring the facility was administered in a manner which enabled it to use its resources effectively and efficiently. The DON further revealed she took part in the facility's monthly QAPI meetings, QAPI Committee members, including herself, had not identified any issues with the residents' wounds. Interview on 02/25/2022 at 1:00 PM, 02/25/2022 at 4:56 PM and 02/25/2022 at 6:09 PM, with Administrator #2 revealed around the time of the 05/21/2020 Abbreviated Survey she had participated in the facility's Quality Assurance (QA) program as the Social Services Director (SSD). Interview revealed; however, she could not recall what had been audited at that time, or when the facility had achieved compliance as she had not been a clinical person for the deficient practice cited at F580, F657, F684, and F842. She stated the POC dated 05/21/2020 had been reviewed in the facility's QA Committee meetings. Continued interview revealed when she had been hired as the Administrator, in November 2021, she was not made aware of any ongoing audits regarding the facility's previous POCs. An additional interview with the Administrator on 02/25/2022 at 1:00 PM; 4:56 PM, and 6:09 PM, revealed she assumed the ongoing audits that were discussed in the QA Committee meetings, and that the facility had achieved regulatory compliance. She revealed the facility's QA Committee had not identified concerns in those areas since she had become the Administrator. The Administrator revealed she relied on the clinical leads, the DON and Regional Quality Manager (RQM), to bring any concerns to the QA Committee's and her attention. Further interview revealed; however, she was not aware of any concerns with the clinical practices within the facility. She further stated she was not familiar with the facility's Governing Body or that the Governing Body was responsible for establishing and implementing policies regarding the management and operation of the facility. In addition, the Administrator revealed it was her responsibility to ensure all facility processes established by the [NAME] President of Operations (VPO) were maintained including the facility's Quality Assessment and Assurance (QAA) and QAPI programs. Interview with the Regional Quality Manager (RQM) on 02/24/2022 at 12:22 PM, revealed she was aware of the concerns regarding residents' wounds, weights, and clinical documentation within the facility and had informed the Administrator of the concerns. Interview revealed the RQM stated she reviewed the facility's systems, processes, Quality Indicators, and made recommendations to the Administrator and DON. Per interview, the RQM reviewed documentation for quality indicators and the nursing departments process, such as falls, skin, weights, labs, etc. She then compiled the review into a report she provided to the DON and the Administrator, per email or verbal report, weekly. Continued interview revealed if concerns were identified in her review, she would discuss her findings with the DON and the Administrator and strongly recommended a process on how to make change; but it was ultimately up to the Administrator and the DON to implement the change. In January, 2022, she identified wound/skin assessment were not documented/completed weekly in the medical record. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Further interview with the RQM, on 02/24/2022 at 12:22 PM, revealed; however, any changes that would be made, after discussing the concerns with the Administrator, were ultimately up to the Administrator and the DON. Continued interview revealed the facility's resident wound system was broken due to the lack of documentation by nursing staff. She stated she had informed the Administrator of identified concerns regarding the lack of documentation for residents' wounds and wound care. Further interview revealed for the facility's QA, the DON was supposed to audit resident's labs to ensure none were missed, and audit residents' skin and wounds weekly. The RQM revealed; however, the facility had no documented evidence of audit sheets for 05/21/2020 through 12/2021. She further revealed due to the high turnover of facility DON's from 12/23/2021 to 02/24/2022, the audits had not been completed and had not been available for review in the DCR meetings. Interview on 02/25/22 at 3:00 PM, with the [NAME] President of Operations (VPO), revealed she had worked in her role since 2016 and she provided oversight and support for the Administrator. The VPO stated the RQM notified the Administrator of any clinical areas of concern for the facility. Continued interview revealed the RQM audited the facility's QA processes through use of a clinical score card, which had been conducted on 05/2021. The VPO revealed if any issues were identified by the RQM, the issues were worked through in the facility's QA process. She stated the RQM visited the building weekly and reported any identified concerns from the visits to her (VPO). Further interview revealed the RQM had not communicated any identified concerns regarding residents' wounds or the facility's wound process. She further revealed the facility had a process in place to audit residents' wounds weekly and determine if wound treatment had been completed as per the facility's policy. In addition, the VPO further stated the RQM reviewed the documentation in residents' electronic medical record for any omissions and reported any documentation issues or other identified issues to the DON. Interview on 02/24/2022 at 1:30 PM, with the facility's Medical Director revealed she participated with the Administration and DON and other leadership personnel to oversee any clinical issues regarding medical care. Continued interview revealed she took part in the facility's regular QA meetings and had provided her input during that process. The Medical Director revealed there had not been any routine QA meetings for 01/2022 and 02/2022 until the occurrence of the facility's standard survey. She stated the facility's Administration was responsible for the oversight of its resources to ensure and maintain best care practices for residents. Further interview revealed the Medical Director had identified lapses in the facility's documentation of residents' wound assessments which were to be documented in order to know if a resident's wound had improved or worsened. In addition, the Medical Director stated she had identified the inconsistent documentation in residents' Medication Administration Records (MARs) and Treatment Administration Records (TARs) and had informed the Administrator of that information.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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, 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, including COVID-19. The facility further failed to implement recommended interventions as per the Centers for Medicare and Medicaid Services (CMS), the Center for Disease Control and Prevention (CDC), and the Kentucky Department for Public Health (Health Department) State guidelines for COVID-19, which affected all residents. Observations, on 02/15/2022 through 02/25/2022, of multiple areas of the facility, and multiple facility personnel revealed the facility failed to ensure staff fully and consistently implemented their infection control processes and followed the facility's policies and the CDC's guidelines for infection prevention and control (IPC). Staff failed to wear the appropriate personal protective equipment (PPE) in droplet precaution isolation rooms, and observations revealed staff failed to clean and disinfect shared resident equipment. Additionally, facility staff failed to ensure visitors observed social distancing and wore appropriate source control, such as masks, in accordance with national standards while in the facility. Interviews with multiple staff revealed lapses in education and communication regarding standards of practice, facility policies and current CDC recommendations related to IPC. Furthermore, the facility failed to establish and maintain an effectiveinfection 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, including COVID-19 routine audits for IPC compliance were performed, and failed to ensure all facility staff received current, evidence-based education on IPC practices to prevent the spread of COVID-19. The facility failed to ensure the continual oversight by a qualified Infection Preventionist. Additionally, the facility failed to ensure an ongoing system of infection surveillance designed to detect, investigate the source, evaluate the impact of interventions, educate on the spread of infectious disease, and report communicable diseases. The facility's failure to establish and maintain an infection prevention and control program has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Refer to F882 and F886 The findings include: Review of the CDC's COVID-19 Nursing Homes and Long-Term Care Facilities, updated 11/09/2021, revealed healthcare settings should continue to use community transmission rates and continue to follow CDC's infection prevention and control recommendations for healthcare settings. Review of the CDC's COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, updated 02/02/2022, revealed older adults living in congregate settings were at high risk of being affected by SARS-CoV-2. Continued review revealed a strong IPC program was critical to protect residents. Further review revealed even as nursing homes resumed normal practices, they must sustain core IPC practices and remain vigilant in order to prevent the spread of SARS-CoV-2, and protect residents from severe infections, hospitalization s, and death. Continued review of the CDC's document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 02/02/2022, revealed dedicated medical equipment was to be used when caring for a patient with suspected or confirmed SARS-CoV-2 infection. Further review revealed all non-dedicated, non-disposable medical equipment used for for a patient suspected or confirmed to have the SARS-CoV-2 virus, should be cleaned and disinfected according to the manufacturer's instructions and facility policies before use on another patient. Review of the CDC's Clean Hands Count for Healthcare Providers, reviewed 01/08/2021, revealed hand hygiene reduces the spread of infection and disease to patients. Alcohol-based hand rub (ABHR) and washing hands with soap and water were the two (2) methods for hand hygiene. Continued review revealed multiple opportunities for hand hygiene to occur during a single care episode. Further examination revealed the clinical indications for the use of hand hygiene included immediately before touching a patient, after touching a patient or the patient's immediate environment, when staff has visibly soiled hands, and before preparing or handling medications or food. Review of the facility's policy titled, Infection Prevention and Control Policy and Procedures: Novel Coronavirus (2020-nCoV), revised 03/19/2021, revealed the purpose of the policy was to establish and maintain an infection prevention and control program, which incorporated education and surveillance, to reduce the risk of transmission of COVID-19. Per policy review, the facility was to implement actions according to the CDC, CMS, and the State Cabinet for Health and Family Services (CHFS) recommendations. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's policy titled, Policies and Practices - Infection Control, undated, revealed the purpose of the policy was to maintain a safe, sanitary, and comfortable environment, and to help prevent and manage transmission of diseases and infections. Per the policy review, the facility was to prevent, detect, investigate, and control infections, and maintain a safe environment for personnel, residents, and visitors. Continued review revealed additional purposes of the policy noted it was to establish guidelines for implementing transmission-based isolation precautions (TBP); and maintain records of incidents and corrective actions related to infections. Review of the policy revealed the facility's Quality Assurance and Performance Improvement (QAPI) Committee, through the facility's Infection Control Committee, was to help departments and managers ensure IPC practices were implemented and followed. Further review revealed all facility personnel were to be trained on IPC policies and practices upon hire and periodically thereafter, to the appropriate degree of direct resident contact and job responsibilities. Review of the policy further revealed the Director of Nursing Services (DNS) and the Infection Preventionist (IP) were responsible for disseminating information about IPC policies and practices to facility personnel. 1. Review of the facility's Hand Washing handout, undated, revealed training for how to conduct hand hygiene. Continued review revealed however, the handout did not instruct staff on when hand hygiene was required to be performed while providing resident care. Review of the facility's, In-Service Training Record, dated 04/2021, revealed seventy-three (73) staff members were trained on donning and doffing personal protective equipment (PPE) and hand-hygiene. Review of the facility's, In-Service Training Record, date 07/29/2021, revealed seven (7) out of twenty (20) nurses had been trained on hand-hygiene, wearing gloves, and donning and doffing of PPE. 2. Review of the CMS, Center for Clinical Standards and Quality/Survey and Certification Group QSO-20-38-NH Memo titled, Testing of Staff and Residents During an Outbreak Investigation, revised 09/10/2021, revealed a new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident, triggered an outbreak investigation. Continued review revealed upon identification of a single new case of COVID-19 infection in any staff or residents, testing was to begin immediately. Per the Memo, facilities were to use their community transmission level as the trigger for staff testing frequency, and communities with a high (red) rate of transmission, twice weekly testing of staff was required. Further review revealed facilities were to monitor their level of community transmission every other week, and adjust the frequency of performing staff testing accordingly. In addition, the QSO-20-38-NH Memo, revealed the guidance represented the minimum testing expected. Review of the State Department for Public Health's Long-Term Care Facility COVID-19 County Indicator Map for transmission level from 01/25/2022 to 02/25/2022, revealed the facility's county community activity rate was noted as high (red zone), which required the facility to test staff and residents two (2) times a week for COVID-19. Review of the facility's Infection Surveillance program documentation, provided by the Administrator on 02/17/2022, revealed it was a map of the facility. Continued review revealed the COVID-19 Isolation rooms were highlighted in yellow, with no other rooms of residents with infections highlighted. Review of the map revealed there was no corresponding documentation or legend on the map to explain how to read the map. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's COVID-19 employee testing records revealed all staff had been tested weekly on the following dates: 01/25/2022, 02/01/2022, 02/08/2022, 02/15/2022, despite the fact the county community COVID-19 activity map was in the red zone, and the facility was experiencing an outbreak, which required twice weekly testing. Further review of COVID-19 employee teasing results revealed the facility identified two (2) staff were positive on 12/31/2021; one (1) staff was positive on 01/07/2022; one (1) staff was positive on 01/09/2022; one (1) staff was positive on 01/11/2022; two (2) staff were positive 01/12/2022; and one (1) staff on 01/13/2022; one (1) staff was positive on 01/30/2022; one (1) staff was positive on 01/31/2022; one (1) staff was positive on 02/02/2022; one (1) staff was positive on 02/03/2022; two (2) staff were positive 02/04/2022; one (1) staff was positive on 02/06/2022; two (2) staff were positive on 02/07/2022; and two (2) staff were positive 02/09/2022. However, there was no documented evidence the facility conducted COVID-19 testing twice per week despite the fact the county community COVID-19 activity map was in the red zone, and the facility was experiencing an outbreak, which required twice weekly testing. Review of the facility's, Resident Vaccination List, undated, revealed the facility had seventy-seven (77) residents. Continued review revealed sixty-four (64) fully vaccinated residents; three (3) residents who had received only one (1) dose of the vaccine; and nine (9) residents who had refused vaccination. Review of the facility's documentation for resident's COVID-19 exposure and positive cases as of 02/07/2022, revealed fifteen (15) residents had tested positive for the COVID-19 virus and twelve (12) residents had experienced direct exposure to COVID-19. The SSA requested resident testing results for December 2021, January 2022 and February 2022, however, December 2021 and January 2022 results were not received. Review of the facility's resident testing results, from 02/02/2022 to 02/25/2022, revealed the following results for COVID-19 testing: thirteen (13) residents tested positive on 02/02/2022; two (2) residents tested positive on 02/03/2022; four (4) residents tested positive on 02/15/2022; and one (1) additional resident tested positive on 02/21/2022. 3. Observation of the facility, on 02/15/2022 at 10:30 AM, revealed there was no sign posted on the facility's entrance door alerting visitors to the presence of COVID-19 in the building. Observation revealed no sign posted on or near the entrance door leading to the COVID-19 Unit. Continued observation revealed no observation of educational signage posted regarding hand hygiene practices. Observation of the facility's B, C, D, and E Halls revealed no visible signage posted related to IPC practices. Further observation of Hall B revealed no visible IPC signs posted, except for resident rooms [ROOM NUMBERS], which were Droplet Precautions isolation rooms. 4. Interview with the Administrator, on 02/22/2022 at 3:12 PM, revealed the facility did not have a policy related hand hygiene. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation of Hall D during meal service, on 02/15/2022 at 12:30 PM, revealed State Registered Nurse Aide (SRNA) #23 failed to perform hand hygiene after serving meals to residents in rooms [ROOM NUMBERS], and before placing a meal tray down in room [ROOM NUMBER]. Observation revealed SRNA #23 take a meal tray into room [ROOM NUMBER]. She came out of the room and did not perform hand hygiene. She pulled another tray from the meal cart and entered room [ROOM NUMBER]. She placed Resident #37's tray on the bedside table, moved the table, removed the plate cover, set up the place settings, and took the lid off the resident's coffee cup. Before leaving room [ROOM NUMBER], SRNA #23 touched the end of Resident #37's bed and bed lines. She exited the room without performing hand hygiene. After leaving room [ROOM NUMBER], SRNA #23 obtained another meal tray and entered room [ROOM NUMBER], placing the meal tray on the bedside table. SRNA did not set up the meal tray. SRNA #23 exited room [ROOM NUMBER] and performed hand hygiene using ABHR from the wall dispenser in the hall. Interview with SRNA #23, on 02/15/2022 at 12:35 PM, revealed she only delivered the meal trays and had not provided care for residents. Interview further revealed she was not aware she should use alcohol-based hand rub (ABHR) after each meal tray passed. Furthermore, SRNA #23 stated there was no risk of cross contamination because she did not provide care to the residents when passing out trays. 5. Review of the CDC's COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, updated 02/02/2022, revealed that health care personnel in areas with moderate to substantial community transmission should wear eye protection in addition to N95 or equivalent masks while in resident care areas and while providing resident care. 5(a). Observation on 02/18/2022 at 3:19 PM, of Licensed Practical Nurse (LPN) #8 revealed while the facility had COVID-19 positive residents in the facility, LPN #8 was wearing a surgical mask pulled down below his nose while administering medications to residents. Interview with LPN #8, on 02/18/2022 at 3:19 PM, revealed it was difficult to see when wearing a face shield or goggles LPN #8 stated he realized however, that was not an excuse, and should have been wearing the appropriate PPE correctly according to the facility's policy during the ongoing COVID-19 outbreak. He stated knew wearing the appropriate PPE prevented the spread of infection. LPN #8 stated further that he had not received recent education on IPC policies or practices. 5(b). Observation of SRNA #10, on 02/24/2022 at 12:59 PM revealed she was in a patient care area, near the nursing station. Continue observation revealed she had her mask pulled down below her nose. Additional observation of SRNA #10 on 03/03/2022 at 5:17 PM, revealed she had her mask pulled below her chin while standing at the computer in a resident care area. Interview on 03/02/2022 at 12:59 PM, with SRNA #10 revealed she had not realized she was not wearing her mask correctly. She stated she had difficulty breathing when the mask covered her nose. According to SRNA #10, she had not received education and training on IPC practices and PPE for several months. Additional interview with SRNA #10 on 03/04/2022 at 5:17 PM, revealed she was unaware she had not been wearing her mask correctly. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	5(c). Observation on 03/04/2022 at 1:01 PM, of SRNA #25 revealed she was wearing her mask pulled down below her nose while providing care in room [ROOM NUMBER]. Continued observation revealed SRNA #25 came out of resident room [ROOM NUMBER] and without performing hand hygiene, proceeded to the clean linen cart where she was observed to remove linen. She then walked into resident room [ROOM NUMBER]. Further observation revealed SRNA #25 did not perform hand hygiene before entering room [ROOM NUMBER]. The Surveyor attempted interview with SRNA #25, on 03/04/2022 at 1:01 PM, at the time of observation; however, SRNA #25 stated I am too busy. I have to get these residents back to bed, and walked into resident room [ROOM NUMBER] closing the door. Interview with LPN #1, on 02/22/2022 at 9:30 AM, revealed as part of the facility's IPC program and facility policy, all staff were required to wear a KN95 masks while in the facility while there was a current outbreak of COVID-19. She further stated all PPE was to be worn appropriately. The KN95 should fit well, covering the mouth and nose at all times. 6. Review of the manufacturer's instructions for the Point-of-Care COVID-19 test kit, utilized by the facility, revealed the testing instructions required the specimen be an anterior nasal swab obtained from both nostrils. Observation of the Minimum Data Set (MDS) Nurse, on 02/20/22 at 10:22 AM, revealed she was performing a Point-of-Care (POC) COVID-19 test on Resident #17. Continued observation revealed the MDS Nurse swabbed only one (1) of Resident #17's nostrils when performing the test and not both nostrils per the manufacturer's recommendations and instructions. Interview, on 02/20/22 at 10:50 AM, with the MDS Nurse revealed she routinely performed COVID-19 testing on the facility's residents and staff. She stated she received training on COVID-19 Rapid Testing in Point-of-Care Settings; however, she could not recall the specific training program she had completed. The MDS Nurse stated per the manufacturer's instructions, she should have swabbed both of Resident #17's nostrils when performing the COVID-19 AG testing to ensure that a false-negative result was not obtained. She stated normally she swabbed both the nostrils, but when she reviewed the procedure prior to performing the testing with the Regional Quality Manager (RQM), the RQM instructed her to only swab one (1) nostril. Interview, on 02/20/22 at 10:50 AM, with the RQM revealed she had instructed the MDS Nurse to swab only one (1) nostril when performing the test. Further interview revealed she had also received training on completing COVID-19 Rapid Testing in Point-of-Care Settings. 7. Interview with the Administrator, on 02/22/2022 at 3:12 PM, revealed the facility did not have a respiratory policy or an Infection Control policy related to respiratory use and/or equipment. 7(a). Observation of Resident #26, on 02/16/2022 at 5:20 PM, revealed the resident was receiving oxygen at five (5) liters per minute (LPM) via a nasal cannula (NC) without humidification. Further observation revealed there was no date on the oxygen tubing to indicate when it had been placed in use. Observation further revealed the oxygen tubing was stretched from Resident #26's oxygen concentrator and lying on the floor leading to the resident's bed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7(b). Observation of Resident #50, on 02/23/22 at 12:07 PM, revealed he/she was receiving oxygen at two (2) LPM via a NC. Continued observation revealed the oxygen tubing was not dated, and was lying on the floor. Observation revealed Resident #50 had an oral suctioning catheter lying uncovered on his/her bedside table. Observation of the suction canister revealed it was overfilled and undated. Further observation revealed Resident #50's nebulizer (breathing treatment) machine with dust on it, and a build up of a crusty substance on the mouthpiece. In addition, observation revealed the nebulizer mouthpiece had what appeared to be food particles on the mouthpiece reservoir with the mouthpiece lying on the bedside table, and the tubing, which was not dated, lying across the floor. 7(c). Observation of Resident #8, on 02/23/22 at 12:28 PM, revealed the resident was receiving oxygen at two (2) LPM via a NC. Continued observation revealed the undated oxygen tubing was lying on the floor. Additional observation revealed Resident #8's nasal cannula was crusted with sinus debris. Interview with LPN #1, on 02/22/2022 at 9:30 AM, revealed it was the responsibility of the Respiratory Specialist (RS) to manage residents' oxygen concentrators and tubing. She stated the facility did not have that position staffed, and as a result, the nursing staff was responsible for changing residents' oxygen tubing weekly. LPN #1 further stated all oxygen tubing should have been dated with date it was changed. Interview with RN #1, on 02/22/2022 at 9:30 AM, revealed it was the Respiratory Specialist's (RS) responsibility to manage residents' oxygen concentrators and tubing. According to RN #1, if the facility did not have the position staffed, nursing staff was responsible for changing residents' oxygen tubing weekly. Continued interview revealed the RS position was not filled and nursing was responsible. Further interview revealed oxygen tubing was to be dated with the date it was changed. 8. Interview with the Administrator, on 02/22/2022 at 3:12 PM, revealed the facility did not have a policy related to emptying, cleaning, storage or Infection Control of bedpans and urinals. 8(a). Observation of Resident #50's room, on 02/16/2022 at 8:46 AM, revealed two (2) urinals, one (1) of which contained an amber color liquid, located on the floor near the resident's bed. Observation revealed one (1) urinal appeared empty; however, looked as if it had not been rinsed out. Further observation revealed neither urinal had been dated or marked with the resident's name. Interview with Resident #50, on 02/16/2022 at 8:46 AM, revealed staff did not routinely empty his/her urinals when they came into the resident's room. Resident #50 further stated when he/she finished using the urinal, the staff often just placed the urinal on the floor if it was not full of urine. 8(b). Observation of Resident #17's room, on 02/20/2022 at 10:30 AM, revealed two (2) urinals located on the resident's bedside table. Observation revealed one (1) urinal was half-filled with amber colored liquid, and the second urinal had a small amount amber colored liquid in the bottom of the urinal, with drops of amber colored liquid substance on the outside of the urinal. In addition, observation revealed the urinals were not dated or labeled with the resident's name. Interview with Resident #17, on 02/20/2022 at 11:30 AM, revealed staff did not empty his/her urinals unless he/she asked them to do so. Continued interview revealed staff often put his/her meal tray on the bedside table right beside the urinals. Resident #17 further stated when that happened, he/she lost his/her appetite from smelling the urine. Further interview revealed Resident #17 would move his/her meal tray off the bedside table and place the tray on his/her bed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with SRNA #1, on 02/20/2022 at 3:14 PM, revealed urinals were emptied on a regular basis and as requested by the residents. She stated she could not explain why Resident #17's urinals had not been emptied for several hours. SRNA #1 further stated Resident #17's meal trays were placed on his/her bed and not on the bedside table because the resident liked having the tray on the bed. 9. Review of the facility's policy, Visitation Guidance Protocol, revised 11/12/2021, revealed the purpose of the policy was to ensure safe visitation by adhering to the core principles of COVID-19 infection prevention and control practices to mitigate the risk of infection spread. Further review revealed hand-hygiene, use of face masks that covered the mouth and the nose, and social distancing were to be requested of all visitors. Additionally, visitors were to wear source control (the use of respirators or well-fitting a facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing) while around other residents or health care personnel regardless of vaccination status. Observation on the facility's Hall E, on 02/19/2021 at approximately 4:10 PM, revealed four (4) visitors, one (1) adult and three (3) children entering resident room [ROOM NUMBER]. Observation revealed the adult visitor stayed in room [ROOM NUMBER] with the door closed; however, the three (3) children remained outside of the room in Hall E. Continued observation revealed one (1) of the children appeared under the age of two (2) years and would not be required to wear a mask. However, the two (2) other children appeared as over two (2) years of age and were required to wear a mask. Observation revealed the two (2) older children were wearing masks; however, their masks were not covering their noses. Further observation revealed the three (3) children were sitting and/or lying on the floor or walking up and down Hall E. Observation further revealed the nursing staff present on the hall were not actively redirecting and educating visitors to follow the facility's current IPC processes. When the State Survey Agency (SSA) Surveyor notified Kentucky Medication Aide (KMA) #2 that visitors were not wearing their masks appropriately, and several children were sitting/lying on the floor outside of the room [ROOM NUMBER], she shrugged her shoulders. In addition, observation revealed KMA #2 failed to educate or redirect the visitors on the facility's IPC practices while the visitors were present within the facility. Interview with KMA #2, on 02/19/2022 at approximately 4:15 PM, revealed staff could not tell residents' family members what to do. She further stated visitors were given IPC education material when they checked into the facility. 10. Observation of resident room [ROOM NUMBER] on, 02/21/2022 at 8:45 AM, revealed signage on the door alerting staff and visitors Resident #36, who resided in the room, was on Droplet Precautions. Continued observation revealed Resident #36's room door also had signage instructing staff and visitors to see the nurse before entering room [ROOM NUMBER]. Observations throughout the day on 02/21/2022 and 02/22/2022 revealed the door to room [ROOM NUMBER] remained open. Further observation throughout the day on 02/21/2022 and 02/22/2022, revealed no PPE storage container was set up outside of room [ROOM NUMBER] for staff to obtain the appropriate PPE to don prior to entering the room, and no biohazard receptacles for contaminated linen and trash observed inside room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	10(a). Observation of SRNA #14, on 02/21/2022 at 1:33 PM, revealed she was inside resident room [ROOM NUMBER] gathering resident belongings. Continued observation revealed the signage on the resident's door indicated the resident was in Droplet Precaution Isolation. Further observation revealed SRNA #14 was not wearing PPE for the Droplet Precautions. SRNA #14 exited room [ROOM NUMBER], a Droplet Precautions isolation room, carrying items held against her uniform. Observation revealed SRNA #14, without performing hand hygiene, exited resident room [ROOM NUMBER] and walked through the community hallway to another unit. Further observation revealed room [ROOM NUMBER]'s door remained wide open with Droplet Precaution signage present; however, no PPE cart was observed outside of the door. Interview with SRNA #14, on 02/21/2022 at 1:33 PM, revealed she had been taking personal items from resident room [ROOM NUMBER] to the COVID-19 isolation unit because a resident had just tested positive for COVID-19. Per the interview, Resident #36 in room [ROOM NUMBER], was not COVID-19 positive, but had been placed on Droplet Precautions after his/her roommate tested positive for COVID-19. Continued interview revealed she did not touch the resident's belongings. Further, SRNA #14 stated she was a contract agency employee and she had not received IPC training while working at the facility. 10(b). Observation of Housekeeper #2, on 02/21/2022 at 2:24 PM, revealed he entered resident room [ROOM NUMBER], a Droplet Isolation precautions room without donning appropriate PPE. Continued observation revealed no PPE container or supplies was observed outside the room door. Continued observation revealed Housekeeper #2 checked a waste receptacle for trash, and moved the receptacle closer to the resident. When the Housekeeper exited the room, he failed to perform hand hygiene. Interview with Housekeeper #2, on 02/21/2022 at 2:30 PM, revealed he had worked at the facility for two (2) years. Housekeeper #2 stated he had not noticed the Droplet Precaution signage on the door when he entered room [ROOM NUMBER] without wearing the appropriate PPE. Continued interview revealed he did not recall hearing that room [ROOM NUMBER] had been transitioned into a Transmission Based Precaution (TBP) room due Resident #36 having been exposed to COVID-19. He stated he had entered room [ROOM NUMBER] to check for trash, did not realize he had not performed hand hygiene upon exiting the room. Per interview, Housekeeper #2 stated he did not know were to find the appropriate PPE to don prior to entering room [ROOM NUMBER], as there was no PPE container located outside of the room. Further interview revealed he had IPC in-service training last month, which had included handwashing, the use of PPE, and donning and doffing of PPE procedures. Interview with the Housekeeping/Laundry Supervisor, on 02/23/2022 at 4:35 PM, revealed it was her expectation laundry and housekeeping staff wore masks at all times while in the facility. She stated it was important for staff to follow the facility's IPC practices to prevent the spread of infection. 10(c). Observation of SRNA #13, on 02/22/2022 at 10:06 AM, revealed she entered resident room [ROOM NUMBER], a Droplet Isolation precautions room without donning appropriate PPE, and no PPE container or PPE supplies were observed outside the room. Continued observation revealed when SRNA #13 exited room [ROOM NUMBER], she failed to perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with SRNA #13, on 02/22/2022 at 10:10 AM, revealed she had no idea Resident #36 in room [ROOM NUMBER] had been placed on Droplet Precautions, even though signage on the room door stated Droplet Precautions. She stated, after learning that information, she should have donned full PPE before entering and used ABHR prior to exiting the room. Continued interview revealed she had not been made aware Resident #36 was on Droplet Precautions during morning report. Further interview revealed SRNA #13 was a contract agency employee and she stated she had not received IPC training while working at the facility. 10(d). Observation of SRNA #12, on 02/22/2022 at 10:31 AM, revealed she entered resident room [ROOM NUMBER], a Droplet Precaution room without donning the appropriate PPE. Observation revealed no PPE container located outside room [ROOM NUMBER]'s door. Further observation revealed when SRNA #12 exited room [ROOM NUMBER], she failed to perform hand hygiene. Interview with SRNA #12, on 02/22/2022 at 10:35 AM, revealed she had not been aware Resident #36 in room [ROOM NUMBER] was placed on Droplet Precautions, even though the room door had Droplet Precaution signage on it. She stated she had not provided resident care; however, she should have donned full PPE before entering, after she learned of the Droplet Precautions. Further interview revealed she should have performed hand hygiene before entering and upon exiting the room. SRNA #12 further revealed she was also assigned to perform care for residents on the COVID-19 Isolation Unit.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44001 Based on observation, interviews, record review, review of the facility's policy and review of the Centers' for Disease Control and Prevention guidance, it was determined the facility failed to ensure the continual oversight by a qualified Infection Preventionist for its infection control program. On 02/03/2022, the facility's Infection Preventionist (IP) resigned. The facility designated staff which included the Director of Nursing (DON) #3, DON #4, and Education Training Director #1 to cover the IP position during the month of February, 2022. However, the facility was unable to provide documentation these staff were trained and qualified to serve as the Infection Preventionist. Record review revealed the facility experienced an outbreak of COVID-19 infection in January and February of 2022 and per interviews, the management staff, to include staff assigned to the IP responsibilities, were unfamiliar with the resident and staff testing requirements. Refer to F-880 and F-886 The findings include: Review of the CDC's COVID-19 Nursing Homes and Long-Term Care Facilities, updated 11/09/2021, revealed healthcare settings should continue to use community transmission rates and continue to follow CDC's infection prevention and control recommendations for healthcare settings. Review of the Centers for Disease Control and Prevention's (CDC) COVID-19 Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated 02/02/2022, for Nursing Homes and Long-Term Care Facilities, revealed older adults living in congregate settings were at high risk of being affected by SARS-CoV-2. A strong Infection Prevention and Control (IPC) program is critical to protect residents, even as nursing homes resume normal practices, they must sustain core IPC practices, and remain vigilant in order to prevent spread and protect residents from severe infections, hospitalization s, and death. Review of the CDC's, Nursing Home Infection Preventionist Training, reviewed 06/10/2020, revealed training was designed for individuals responsible for infection prevention and control (IPC) programs in nursing homes. The course was produced by CDC in collaboration with the Centers for Medicare & Medicaid Services (CMS), to ensure the nurse specialized as an IP, has continual oversight of the core activities of the facility's IPC programs, and follows recommended IPC practices to reduce pathogen transmission, health care associated (HCA) infections, and antibiotic resistance Review of the facility's policy, Infection Prevention and Control Policy and Procedures: Novel Coronavirus (2020-nCoV), revised 03/19/2021, revealed the purpose of the policy was to establish and maintain an infection prevention and control program, which incorporated education and surveillance, to reduce the risk of transmission of COVID-19. SSA requested Administrator provide all Infection Preventionist (IP) Certification of Completion for the CDC's Nursing Home Infection Prevention Course on 02/17/2022. However, no IP qualifications documentation was provided for Director of Nursing (DON) #3 or Regional Quality Manager (RQM)/DON #4. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Regional Nurse Manager/Director of Nursing (RNM/DON) #2, on 02/24/2022 at 1:28 PM, revealed DON #1 resigned on 12/23/2021. She stated that on 12/24/2021 she assumed responsibility of the DON position until 01/24/2022. During the time RNM/DON #2 was DON, the facility had an IP. She stated IP #2 resigned the first week of February 2022. On 01/24/2022, DON #3 was hired and he assumed responsibility of the IP when IP #2 resigned in February. Continued interview revealed when DON #3 resigned, on 02/18/2022, the RQM became the DON/IP #4 for one day, until the facility hired the current DON/IP #5. Interview with Director of Nursing (DON) #3, on 02/18/2022 at 5:06 PM, revealed he was acting Director of Nursing and IP from 01/24/2022 to 02/18/2022. DON #3 stated he had never worked in the role of an IP. He further stated that he was unfamiliar with the CDC's guidelines governing IPC and the responsibilities of an IP. DON #3 stated he was unsure of the facility's IPC program and the duties required of him as the IP. Additionally, the facility experienced an outbreak of COVID-19 infection of staff and residents in January and February of 2022. DON #3 was unfamiliar with the resident and staff testing requirements during an outbreak. Interview with DON #4 (who was also the Corporate Regional Quality Manger), on 02/20/2022 at 11:45 AM, revealed that she assumed responsibility of the DON position to include the IP responsibilities on 02/18/2022 for one day, until DON #5 was hired. However there was no documented evidence the Regional Quality Manager/DON #4 completed the CDC's Nursing Home Infection Preventionist Training. Review of the Education Training Director (ETD/IP) #1's CDC's Nursing Home Infection Prevention Course training documentation, revealed the ETD/IP had only completed Modules One through Twelve A of the course's Twenty-three module and submodules program. Further review of the ETD/IP #1 training records revealed there was no completion certificate from the CDC certifying the ETD/IP had completed all of the required training. Interview with the ETD/IP #1, on 02/24/2022 at 10:20 AM, revealed she had recently been hired into the position of ETD and would also be taking over the position of IP. Continued interview revealed the facility's former IP, resigned on 02/03/2022 and until ETD/IP #1 assumed IP responsibilities on 02/21/2022, DON #3 and DON #4 had been the acting IP. Per interview, the ETD/IP #1 stated she had completed the CDC's IP training course on 02/20/2022; however, she stated she had not yet received her Certificate of Completion from the CDC training website. Interview with the ETD/IP #1 revealed she was not familiar with the facility's IPC policies or the CDC's guidelines related to IPC or the role of the IP. Continued interview revealed the facility experienced an outbreak of COVID-19 of staff and residents in January and February of 2022; however, ETD/IP #1 was unfamiliar with the resident and staff testing requirements during and outbreak. Review of ETD/IP #2 training documentation revealed she completed the CDC's Nursing Home Infection Prevention Course on 05/04/2021. (continued on next page)

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Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the ETD/IP #2, on 03/04/2022 at 4:45 PM, revealed she was hired as the facility's ETD on 02/28/2022, and assumed the role of the facility's IP. She stated she had been trained as an IP and had been working in that capacity for her former employer since May 2021. Interview revealed the ETD/IP #2 stated she did not know the community's transmission level and she was unaware that the community's COVID-19 activity rate was tied to testing intervals. Further interview revealed she was not aware of the facility's county's current COVID-19 infection positivity rate and that the county's community COVID-19 activity rate had been in the red zone . Interview further revealed it was her expectation that all clinical staff would follow the current CDC guidelines, and the facility would follow CDC guidelines related to infection prevention and control, and COVID-19 protocols. She stated it was important to prevent and control infection within the facility. Review of DON #5's training documentation revealed she had completed the CDC's Nursing Home Infection Prevention Course on 10/16/2020. Interview with DON #5, on 03/04/2022 at 5:36 PM, revealed she was a trained IP and had assumed the responsibilities of the IP on 02/19/2021 until the facility hired the new ETD/IP on 02/28/2022. Per the DON, ETD/IP #2 had assumed the position of IP. Continued interview revealed DON #5 did not know the community's COVID-19 transmission level and was unaware the community's COVID-19 activity rate was tied to testing intervals. She stated oversight of an experienced IP who has completed the appropriate training was essential to a IPC program. Interview with the Administrator, on 02/22/2022 at 2:10 PM, revealed the materials and resources utilized for staffs' in-service training included videos, handouts, and demonstration observations. The Administrator stated that PPE Donning/Doffing posters were located on walls in areas where PPE was required for staff's reference. The Administrator stated staff could refer to handouts and research updates on Google, if they needed to reference materials. Interview with the Administrator, on 02/25/2022 at 1:00 PM, revealed she had been at the facility since 10/28/2021. She stated that she looked to her Regional Nurse Manager (RNM), RQM, and DON for oversight. The Administrator stated she was not clinical and would defer clinical expectations to her DON. An additional interview with Administrator, on 03/04/2022 at 6:15 PM, revealed all clinical staff had been educated on PPE, hand hygiene, and IPC practices. The Administrator stated the facility had recently hired a new Infection Preventionist, who had experience in education and training. Continued interview revealed currently there were signs on resident's doors who were on TBP, regarding PPE, and which informed staff and visitors to see the nurse before entering. The Administrator stated staff and visitors should see the nurse as indicated by the sign on the door, and the nurse would provide training for staff on what they needed to do prior to going into the room of a resident on TBP. The Administrator stated it was important for all facility staff to follow IPC policies for the safety of the residents and staff to help prevent cross contamination.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39953 44001 Based on observation, record review, interviews, review of facility policy and Centers for Disease Control guidance, the facility failed to conduct COVID-19 testing, twice weekly, for staff and residents based on the Community's COVID-19 Transmission Levels and the facility's COVID-19 outbreak status. The facility failed to monitor their level of community transmission every other week and adjust the frequency of performing testing accordingly. The facility failed to immediately test a resident, upon request, who presented with symptoms consistent with COVID-19. Furthermore, the facility failed to ensure staff conducted COVID-19 rapid testing in a manner consistent with current standards of practice for conducting COVID-19 tests for one (1) of thirty-three (33) sampled residents (Resident #17). Observation of COVID-19 testing revealed the facility failed to provide COVID-19 testing immediately upon request for a resident who complained of COVID-19 like symptoms. Observation of a COVID-19 point-of-care rapid test on 02/20/2022 revealed the nurse failed to perform the test according to the manufacturer's instruction. Additional interview and review of the facility's infection surveillance documentation revealed the facility failed to ensure COVID-19 testing frequency correlated with the community's COVID-19 activity level and the current COVID-19 outbreak status of the facility. Furthermore, there was no documentation provided, which showed the facility kept bi-weekly logs of the Community's COVID-19 Transmission Levels as per Center for Disease Control and Prevention's (CDC) guidelines. The findings include: Review of the CDC's COVID-19 Nursing Homes and Long-Term Care Facilities, updated 11/09/2021, revealed healthcare settings should continue to use community transmission rates and continue to follow CDC's infection prevention and control recommendations for healthcare settings. Review of the Center for Disease Control and Preventions (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, Section New Infection in Healthcare Personnel or Residents, updated 02/02/2022, revealed because of the risk of unrecognized infection among residents, a single new case of COVID-19 infection in any health care personnel (HCP) or a nursing home onset COVID-19 infection in a resident should be evaluated as a potential outbreak. According to the recommendations, the facility should perform testing for all residents and HCP, regardless of vaccination status. Review of a previous update of the Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, dated 09/10/2021, included testing of residents and HCP based on an outbreak response at a facility-wide or unit level. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Centers for Medicaid and Medicare Services (CMS) Center for Clinical Standards and Quality/Survey and Certification Group QSO-20-38-NH Memo Testing of Staff and Residents During an Outbreak Investigation, revised 09/10/2021, revealed a new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Per the memo, facilities should use their community transmission level as the trigger for staff testing frequency. For communities with a high (red) rate of transmission, twice weekly testing of staff was required. Furthermore, facilities should monitor their level of community transmission every other week and adjust the frequency of performing staff testing accordingly. Per the QSO-20-38-NH memo, this guidance represents the minimum testing expected. Further Review of the CMS's QSO-20-38-NH Memo, revised 09/10/2021, revealed COVID-19 staff testing was based on the facility's county level of community transmission. Furthermore, testing of all vaccinated and unvaccinated staff, and all vaccinated and unvaccinated residents, must occur if there was an outbreak of COVID-19 in the facility. According to CMS, an outbreak was defined as equal to greater than one (1) resident or health care personnel (HCP) with suspected or confirmed SARS-CoV-2 infection. Review of the Centers for Disease Control and Prevention's (CDC) Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings, updated 01/19/2022, revealed proper specimen collection and handling was critical for all COVID-19 testing, including those tests performed in point-of-care settings. A specimen that was not collected or handled correctly could lead to an inaccurate or unreliable test result. Review of the CDC's website on COVID-19 Testing, updated 08/02/2021, revealed, All instructions for performing the COVID-19 test must be followed. Furthermore, those who test should read the complete manufacturer's instructions before using the test. Review of the Kentucky Department for Public Health's (KDPH) Long-Term Care Facility COVID-19 bi-weekly County Indicator Map from 01/25/2022 to 03/03/2022 revealed the facility's community activity rate was high (red zone) requiring staff and resident testing two times a week. Per the recommended practice, facilities were to print the map on the 1st and 3rd Thursdays of each month after 8:00 PM Eastern Time to include in the Provider's documentation related to testing frequency compliance. The facility should check the map for the most current color assigned to the county in which the facility was located. Based on the levels of community COVID-19 activity, testing frequency was to begin on the following Monday. Review of the facility's policy, Policies and Practices - Infection Control, no date, revealed the facility would detect and control infections to maintain a safe, sanitary, and comfortable environment, and to help prevent and manage transmission of diseases and infections. Review of the facility's Point of Care Testing Protocol, no date, revealed testing of employees would continue according to the mandated testing protocol based on county positivity rates using Point-of- Care (POC) tests. Residents who presented with symptoms, would be tested with a POC rapid test. Review of the manufacturer's instructions for the Point-of-Care COVID-19 test kit, utilized by the facility, revealed the testing instructions required the specimen be an anterior nasal swab obtained from both nostrils. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer to F-880 and F-882 The findings include: 1. Review of the Kentucky Department for Public Health's (KDPH) Long-Term Care Facility COVID-19 bi-weekly County Indicator Map from 01/25/2022 to 03/03/2022 revealed the [NAME] County, Kentucky community activity rate was high (red zone) requiring staff and resident testing two times a week. Review of facility testing documentation revealed no logs were kept of the community's transmission level as per Center for Disease Control and Prevention's (CDC) guidelines. Review of the facility's employee testing records revealed staff was tested weekly on 01/25/2022, 02/01/2022, 02/08/2022, 02/15/2022, despite the fact the county indicator map was in the red zone and the facility was experiencing an outbreak, requiring twice weekly testing. Facility staff testing results revealed the facility identified two (2) staff to be positive for COVID-19 on 12/31/2022; one (1) staff on 01/07/2022; one (1) staff on 01/09/2022; one (1) staff on 01/11/2022; one (1) staff on 01/12/2022; one (1) staff on 01/13/2022; one (1) staff on 01/30/2022; one (1) staff on 01/31/2022; one (1) staff on 02/02/2022; one (1) staff on 02/03/2022; two (2) staff on 02/04/2022; one (1) staff on 02/06/2022; and one (1) staff on 02/09/2022. Review of the facility's resident testing results revealed on 02/02/2022, the facility identified thirteen (13) residents to be positive for COVID-19 indicating an outbreak in the facility. On 02/03/2022, two (2) additional residents were identified to be positive for COVID-19. Review of documentation provided by the facility did not demonstrate residents had been testing on other dates between 02/03/2022 and 02/15/2022. On 02/15/2022, four (4) additional residents were identified to be positive for COVID-19. No further scheduled resident testing occurred from 02/15/2022 to 02/24/2022. And on 02/21/2022, one (1) resident who was symptomatic was tested and was identified to be positive for COVID-19. On 02/25/2022 all residents were tested , and no COVID-19 positive cases identified. Interview with the Education and Training Director (ETD) #1, on 02/24/2022 at 10:20 AM, revealed she had recently been hired into the position of ETD and would also be taking over the position of Infection Preventionist (IP). Continued interview revealed the facility's former IP left on 02/03/2022 and, as of 02/21/2022, DON #4 had been the interim IP. Per interview, the ETD had completed the CDC's IP training course on 02/20/2022; however, she stated she had not yet received her Certificate of Completion from the CDC training website. Interview with the ETD revealed she had not had time to review the COVID-19 testing requirements. She stated she was not familiar with facility policies or the CDC's guidelines on COVID-19 testing protocol. The ETD stated COVID-19 testing was conducted weekly, every four (4) to seven (7) days for everyone, except those residents or staff who have had COVID-19 within the last couple of months. She stated she also performs staff COVID-19 testing and was trained to perform COVID-19 point-of-care rapid tests in 2020 by the education director at the time. Continued interview revealed she was unaware of what the CDC's recommendations were for COVID-19 testing during an outbreak. Further interview revealed she did not know the county's community transmission level and was unaware the community's COVID-19 activity rate was tied to testing intervals. The EDT stated she was not sure when residents had last been tests. Per the interview, the EDT stated the Administrator determined when to test Residents. She stated she believed staff were last tested on [DATE]. She could not state how many, if any, tested positive for COVID-19. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the ETD/IP #2, on 03/04/2022 at 4:45 PM, revealed she had been hired as the facility's ETD on 02/28/2022, but in addition had the role of IP for the facility. She stated she had been trained as an IP and had been working in that capacity for her former employer since May 2021. Interview revealed the ETD/IP revealed she did not know the community transmission level and was unaware the community's COVID-19 activity rate was tied to testing intervals. Furthermore, she was not aware of the facility's county's current COVID-19 infection positivity rate and the facility's community COVID-19 activity rate was in the red zone. Interview further revealed it was her expectation all clinical staff would follow the current CDC guidelines, and the facility would follow CDC guidelines related to infection prevention and control, and COVID-19 protocols. She stated it was important to test staff and residents per the guidelines to prevent and control infection within the facility. Interview with DON #5, on 03/04/2022 at 5:36 PM, revealed the facility had hired an experienced ETD who began working on 02/28/2022. Per the DON, the current ETD had assumed the position of IP. DON #5 did not know the community transmission level and was unaware the community's COVID-19 activity rate was tied to testing intervals. She stated staff were tested every four (4) to seven (7) days for everyone, except those residents or staff who have had COVID-19 within the last couple of months. The DON stated she did not know the last time staff was tested , but one-hundred percent (100%) of staff were vaccinated. She stated all residents tested negative for COVID-19 on 02/25/2022. She stated testing residents and staff was important to help stop the spread of COVID-19 in the facility. Interview with the Administrator, on 02/25/2022 at 1:00 PM, revealed her first day as Facility Administrator was 10/28/2021. She stated she looked to her Regional Nurse Manager as a clinical resource and for oversight of clinical documentation, care, and regulations. The Administrator stated COVID testing should occur every four (4) to seven (7) days. She stated the facility tested staff for COVID-19 on 02/15/2022. The Administrator stated she received emails from the state or somebody to notify her of how often to test residents for COVID-19. She further stated she does not check the state's Long-Term Care Facility COVID-19 county indicator map for testing schedule. The administrator stated she was not clinical and would defer clinical expectations to her DON. 2. Review of Resident #17's Medical Record revealed the facility initially admitted the resident on 07/01/2012, and readmitted on [DATE] with diagnoses to include, Type 2 Diabetes Chronic Pain, Hemiplegia, Unspecified Cerebral Vascular Disease, Contractures, and Convulsions. Review of Resident #17's Annual Minimum Data Set (MDS) Assessment, dated 11/12/2021, revealed he/she had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Interview with Resident #17, on 02/20/2022 at approximately 10:15 AM, revealed the resident had resided at the facility for twelve (12) years. Per the interview, Resident #17 was recently moved to Hall A and put on droplet precautions after his/her roommate tested positive for COVID-19. Resident #17 stated he/she was worried regarding the facility's handling of COVID-19. Resident #17 stated he/she had concerns the facility was not openly communicating COVID-19 outbreaks to the residents. Further interview revealed Resident #17 was tested on [DATE] due his/her roommate testing positive. Resident #17 stated the test was negative for COVID-19. However, late in the evening, on 02/19/2022, he/she developed a slight sore throat and mild body aches. When he/she woke up experiencing the same symptoms, on the morning of 02/20/2022, he/she requested staff to do a COVID-19 rapid test. Resident #17 stated he/she made the request to an aide, whose name he/she could not recall. Per interview, Resident #17 stated the test had not yet been performed. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Resident #17, on 02/20/2022 at 12:00 PM, revealed he/she began having COVID-19 like symptoms on the evening of 02/19/2022. Resident #17 stated he/she had a slight sore throat and body aches. The resident stated he/she told a staff member on the evening of 02/19/2022 about his/her symptoms; however, he did not receive a PoC COVID-19 test that night. The resident did not recall the name or title of the person with whom spoke, but thought it was a nurse. Before breakfast, on 02/20/2022 Resident #17 stated he/she again requested a COVID-19 test because his/her symptoms remained. The resident was concerned he was COVID-19 positive because his/her roommate had COVID-19 and was currently in the COVID-19 isolation unit. Per the interview, he/she could not recall if the request was made to an aide or nurse. He/she stated it wasn't until lunchtime, on 02/20/2022, a nurse performed his/her COVID-19 test. Interview with SRNA #1, 02/20/2022 at 1:30 PM, the SRNA assigned to provide care to Resident #17 on 02/20/2022, revealed she was not aware of Resident #17's symptoms or his/her request to be tested . SRNA#1 stated if a resident has COVID-19 symptoms or complains of any COVID-19 like symptoms, she would notify the nurse. Interview with the MDS Nurse, on 02/20/2022 at 11:30 AM, revealed residents were observed for COVID-19 symptoms every shift, and vital signs, including temperatures were taken daily. If COVID-19 was suspected, the resident would be tested . She stated she was not aware of Resident #17's symptoms or his/her request to be tested on [DATE] and was not made aware until she was informed by the Regional Quality Manager (RQM) at around 10:30 AM on 02/20/2022. Interview with RQM, on 02/20/2022 at 1:10 PM, revealed when she was made aware of Resident #17's symptoms and his/her request to be tested , she immediately notified the MDS Nurse to test Resident #17. She stated the MDS nurse was the only staff member on duty at the time trained to do Point-of-Care COVID-19 testing of residents. 3. Observation of COVID-19 testing on Resident #17, on 02/20/2022 at approximately 11:30 AM, revealed LPN/MDS Nurse failed to perform a point-of-care COVID-19 rapid test on the resident according to the manufacturer's instruction. Observation revealed the MDS Nurse swabbed only one (1) of Resident #17's nostrils when performing the test. Interview with the MDS Nurse, on 02/20/2022, at 11:15 AM, revealed to obtain a proper specimen, the resident's head should be back tilted back. The swab should be inserted into the resident's nostril, until resistance is met at the turbinates. The swab is then rotated five (5) times against the wall of the nose and remove swab from the nostril. Interview, on 02/20/2022 at 11:50 AM, with the MDS Nurse revealed she performed COVID-19 testing on the facility's residents and staff. She stated she received training to perform point-of-care COVID-19 rapid testing; however, she could not recall the specific training program she had completed. The MDS Nurse stated per review of the manufacturer's instructions for the COVID-19 test kit utilized by the facility the manufacturer required a specimen collection from the anterior nasal swab be obtained from both nostrils. She stated normally she swabbed both the nostrils, but when she reviewed the procedure prior to performing the testing with the Regional Quality Manager (RQM), the RQM instructed her to only swab only one (1) nostril. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the RQM, on 02/20/2022 at 11:50 AM, revealed the MDS nurse came to her to review the testing procedure, she instructed the MDS Nurse to swab only one (1) nostril when performing the test. She stated she took responsibility for the MDS Nurse's error. According to the RQM, she received training on performing a COVID-19 rapid test. Additionally, the RQM revealed after the MDS Nurse discussed with her that she only swabbed one of Resident #17's nostrils, a second COVID-19 rapid test, swabbing both nostrils, was completed, with negative results. Interview with DON #5, on 03/04/2022 at 5:36 PM, revealed that the facility tested residents and staff every four (4) to seven (7) days. She stated the facility follows CDC recommendations for testing. Per interview, she was not aware of the community transmission level and was unaware the community's COVID-19 activity rate was tied to testing intervals. Interview with the Administrator, on 03/04/2022 at 3:15 PM, revealed when asked if staff had been tested for COVID-19 since 02/15/2022, she stated one-hundred percent (100%) of staff were vaccinated and did not need to be tested . The Administrator stated the facility was following CMS's QSO-20-38-NH Memo, revised 09/10/2021 for staff and resident testing. Continued interview revealed the Administrator did not know the community transmission level and was unaware the community's COVID-19 activity rate was tied to testing intervals. Per the interview, the Administrator was unaware testing of all vaccinated and unvaccinated staff, and all vaccinated and unvaccinated residents, must occur if there was an outbreak of COVID-19 in the facility.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 44001 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure every resident had a communication system which would relay a call directly to a staff member or a centralized staff work location when residents were in their rooms, the restroom, and in bathing areas. This deficiant practice affected nine (9) out of thirty-three (33) sampled residents. (Residents #8, #14, #32, #37, #44, #50, #54, 59 and #278). On 11/30/2021, the facility's call light system failed, affecting all residents on Halls C, D and E. The residents were provided with handheld bells on 11/30/2021. Observation and interviews with residents revealed the handheld bells were difficult to hear, especially if the resident's room door was closed or, if the resident was in the bathroom. The clinical staff was to round every thirty (30) minutes to check on all residents on the C, D and E Halls on 12/01/2021 through 12/03/2021 in order to provide extra monitoring of the residents. However, there was no documented evidence this monitoring was being performed consistently, as per the Supervision Flow Sheets submitted for review. On 12/03/2021, the facility had a wireless call light system installed for only thirty-one (31) residents on halls C, D and E. When a resident used the wireless system by pushing a button, an alarm (like a doorbell) would sound at the nurse's station; however, it did not light up outside a specific room nor, could the alarm be heard away from the nurse's station. The findings include: Review of the facility's policy, titled Resident Rights, undated, revealed residents have a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. Interview with the Administrator, on 03/02/2022 at 11:00 AM, revealed the facility did not have a Call Light System Policy. Interview with the Director of Maintenance (DOM), on 02/25/2022 at 12:20 PM, revealed when the call light system failed on 11/30/2021, the facility's Corporate Office approved a service company to do the repairs. He stated the service company attempted the repairs, but determined the system was obsolete. The DOM stated, due to the age of the system, there were no parts available to repair the system. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DOM, on 02/25/2022 at 12:20 PM, revealed residents on Halls C, D, and E, were provided handheld bells to ring for assistance as a temporary solution. Per interview, all residents on Halls C, D, and E were also provided with the wireless call light system. He stated the wireless system included a device with a button, which when pressed by the resident, would activate the base station at the nurse's station and a brief alarm (like a doorbell) would sound. He further stated the base station would light up at the nurse's station with a digital display of the resident's room and bed number. However, he stated there was no light outside the resident's room when the device was activated, nor could staff hear the alarm if the were not at the nurse's station. Per interview, if staff was not at the nurse's station, they would not be notified of the resident's need for assistance. Further, the facility had no manufacturer's documentation related to the wireless call light system. The DOM stated clinical staff was to round every fifteen (15) minutes to check on all residents on Halls C, D, and E in order to provide extra monitoring of the residents. Review of the Supervision Flow Sheets, dated 12/01/2021 to 12/03/2021, for residents residing on Halls C, D, and E, revealed staff were required to perform thirty (30) minute checks around the clock on all residents. Staff were to comment using an alphabetical key, which indicated whether the resident was (A) agitated, (Q) quiet, (T) tearful, (O) other, (C) comatose, (R) restless, (W) withdrawn, (P) pacing, (S) sleeping, or (E) exit seeking. Additionally, the documentation required the resident's location, and the staff's initials. Record review revealed the facility only provided the State Survey Agency (SSA) with Residents #8, #14, #50 and #54's Supervision Flow Sheets, dated 12/01/2021 through 12/03/2021 for review. Review of Resident #8's Supervision Flow Sheet dated 12/01/2021, revealed no documented evidence of staff monitoring the resident from 12:00 AM until 6:30 AM, {six (6) and a half hours}. Continued review revealed staff documented monitoring of Resident #8 from 7:00 AM until 3:00 PM every thirty (30) minutes on 12/01/2021; however, there was no indication of the location of the resident during this time interval. Further review revealed no documented evidence of staff monitoring of Resident #8 on 12/01/2021 from 3:30 PM until 12/02/2021 at 12:00 AM {eight (8) and a half hours}. Review of Resident #14's Supervision Flow Sheet dated 12/02/2021, revealed staff documented monitoring every thirty (30) minutes, from 12:00 midnight until 6:30 AM; however, there was no indication of the location of the resident. Continued review revealed on 12/02/2021 from 7:00 AM until 6:30 PM, there was no documented evidence the resident was monitored every thirty (30) minutes. Further review revealed staff documented monitoring of Resident #14 on 12/02/2021 from 7:00 PM until 11:30 PM, for thirty (30) minute checks; however, the resident's location was not documented. Review of Resident #14's Supervision Flow Sheet dated 12/03/2021, revealed staff documented monitoring of the resident every thirty (30) minutes, from 12:00 AM until 7:00 AM; however, there was no indication of the location of the resident during the thirty (30) minute checks. Continued review revealed staff documented monitoring of Resident #14 every thirty (30) minutes, on 12/03/2021 from 7:30 AM until 11:30 PM; however, there was no indication of the resident's location for this timeframe. (continued on next page)

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Madison Health and Rehabilitation Center	131 Meadowlark Drive Richmond, KY 40475

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's Supervision Flow Sheet dated 12/01/2021, revealed staff documented monitoring of the resident every thirty (30) minutes, from 12:00 AM to 6:30 AM; and, on 12/01/2021 from 7:00 AM until 7:00 PM, staff documented monitoring of Resident #50; however, the resident's location was not documented for these time frames. Further review revealed staff documented monitoring of the resident on 12/01/2021 from 7:30 PM until 11:30 PM; however, the resident's location was not documented. Review of Resident #50's Supervision Flow Sheet, dated 12/02/2021, revealed staff documented monitoring of the resident every thirty (30) minutes, from 12:00 AM to 7:00 AM; however, the resident's location was not documented. Continued review revealed on 12/02/2021 from 7:30 AM until 7:00 PM; and, from 7:30 PM until 11:30 PM. However, there was no documented location for the resident. Review of Resident #54's Supervision Flow Sheet dated 12/01/2021, revealed no documented evidence staff monitored Resident #54 from 12:00 AM to 6:30 AM, {six (6) hours and thirty (30) minutes}. Continued review revealed staff documented monitoring of Resident #54 every thirty (30) minutes, on 12/01/2021 from 7:00 AM to 3:00 PM. Further review revealed on 12/01/2021 from 3:30 PM until 11:30 PM, there was no documented evidence staff monitored the resident. Further review of Resident #54's Supervision Flow Sheet, dated 12/02/2021, revealed staff documented monitoring of the resident every thirty (30) minutes, from 12:00 AM until 7:00 AM; however, staff did not indicate the resident's location. Continued review revealed on 12/02/2021 from 7:30 AM until 6:30 PM, there was no documented evidence the resident was monitored. Further review revealed staff documented monitoring Resident #54 from 7:00 PM to 11:30 PM; however, there was no indication of the resident's location. Review of Resident #54's Supervision Flow Sheet, dated 12/03/2021, revealed staff documented monitoring the resident every thirty (30) minutes, from 12:00 AM until 7:00 AM and indicated the resident's location. Continued review revealed from 7:30 AM until 6:30 PM staff did monitor; however, staff did not indicate the location of the resident. Further review revealed on 12/03/2021, staff documented monitoring of Resident #54 from 7:00 PM to 11:30 PM; however, there was no indication of the resident's location. During the Group Interview on 02/16/2022 at 2:00 PM, Residents #14, #37, and #44 all stated the call lights were not working on Halls C, D, and E, and had not worked for several months. Each resident further stated the facility had provided them with a handheld bell to ring for staff assistance. Residents #14, #37, and #44 stated the handheld bell was an ineffective device to use to call staff as most staff did not hear the bell, especially if their door was closed. Furthermore, residents could not ring it for long periods, and they got tired of ringing the bell waiting for staff. 1. Review of Resident #14's medical record revealed the facility readmitted the resident on 12/25/2021, with diagnoses that included Cerebral Infarction with Hemiplegia and Hemiparesis affecting the right and left sides, Type 2 Diabetes Mellitus, Dysarthria, Dysphagia and Anxiety Disorder. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's Quarterly Minimum Data Set (MDS) Assessment, dated 11/18/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated the resident was cognitively intact. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) persons for bed mobility, total assistance of two plus (2+) persons for transfers, total assist of two plus (2+) persons for toileting; and, always incontinent of bladder and frequently incontinent of bowel. Additional interview with Resident #14, 02/16/2022 at 2:00 PM, revealed he/she resided on the D Hall and had to use the handheld bell to alert staff if needing assistance. Per interview, staff would not come when he/she rang the hand held bell at night because staff closed his/her door, and the staff could not hear the bell. During the interview, the resident stated there was no wireless system in his/her room. 2. Review of Resident #32's medical record revealed the facility admitted the resident on 12/25/2021, with diagnoses that included Cerebral Infarction with Hemiplegia and Hemiparesis affecting the right and left sides, Type 2 Diabetes Mellitus, Dysarthria, Dysphagia and Anxiety Disorder. Review of Resident #32's Quarterly MDS Assessment, dated 11/18/2021, revealed the facility assessed the resident as having a BIMS' score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as requiring assist of one (1) person for bed mobility, one (1) person for transfers, one (1) person for toileting, and as always continent of bowel and bladder. Observation of Resident #32's wireless call light system on 03/03/2022 at 3:10 PM, on the D Hall, revealed the wireless device was about two (2) inches in diameter and similar to a key fob, but with only a single button, that when pressed, would display a tiny red blinking light. The wireless device was located out of the resident's reach on top of a chest of drawers. Interview with Resident #32 at the time of observation, revealed he/she did have a wireless device, but he/she was told that his/her wireless device was not connected, and a staff member assured him/her they would return to make it operational. Observation, during the interview, revealed when Resident #32's device was pushed, a tiny red light flashed, but there was no audible sound. The device was pressed multiple times to test, and each time it was pressed the red light blinked. After five (5) minutes, the call light system's base station at the nurse's station was checked, and it did not display a notification on the screen, or an audible alarm to indicate Resident #32's wireless device had been activated. The SSA Representative notified Kentucky Medication Aide (KMA) #2 on 03/03/2022 at 3:30 PM, of the resident's need for assist. 3. Review of Resident #37's medical record revealed the facility readmitted the resident on 05/18/2021, with diagnoses to include Coronary Artery Disease, Hypertension, Cerebral Infarction, Hemiplegia, and Seizure Disorders. Review of Resident #37's Annual MDS Assessment, dated 12/22/2021 revealed the facility assessed the resident as having a BIMS' score of thirteen (13) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as requiring assist of one (1) person for bed mobility, one (1) person for transfers, one (1) person for toileting, and as always continent of bowel and bladder. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #37, on 03/03/2022 at 3:05 PM, who resided on the D Hall, revealed he/she had no knowledge of a wireless call system. Resident #37 stated he/she did not have a wireless device. Further, Resident #37 voiced concern that the handheld bells did not work. He/she stated, These call bells are a joke. They never come when you ring them anyway. Per interview, he/she had voiced complaints related to having to use the handheld bell for assistance, but the situation had not changed. The resident could not recall who he/she had spoken to about this matter. During the interview, observations were made of the resident's room and a wireless device was not observed. 4. Review of Resident #44's medical record revealed the facility admitted the resident on 06/25/2021, with diagnoses that included Heart Failure, Hypertension, and Renal Insufficiency. Review of Resident #44's Quarterly MDS Assessment, dated 12/27/2021 revealed the facility assessed the resident as having a BIMS score of thirteen (13) out of fifteen (15), indicating intact cognition. Further review revealed the facility assessed the resident as requiring extensive assist of two plus (2+) persons for bed mobility, total assistance of two plus (2+) persons for transfers, two plus (2+) persons for toileting, and as always continent of bowel and bladder. Interview with Resident #44, on 03/03/2022 at 3:05 PM, who resided on the D Hall, revealed he/she had no knowledge of a wireless call device. Resident #44 was only aware he/she could use the handheld bell. He/she further stated staff did not hear the bell. Per interview, he/she had spoken to staff related to his/her concerns with having to use the handheld bell for assistance, but could not recall who he/she had talked to about this. A wireless call device was not observed in Resident #44's room. 5. Review of Resident #50's medical record revealed the facility readmitted the resident on 01/27/2022, with diagnoses that included Cerebral Vascular Accident, Aphasia, and Hemiplegia. Review of Resident #50's Quarterly MDS Assessment, dated 12/21/2021, revealed the facility assessed the resident as having a BIMS' score of fourteen (14) out of fifteen (15), which indicated intact cognition. Further review revealed the facility assessed the resident as requiring extensive assist of two plus (2+) persons for bed mobility, total assistance of two plus (2+) persons for transfers, total assist of one (1) person for toileting, and, as always incontinent of bowel and bladder. Observation on 03/03/2022 at 3:10 PM, revealed while on the D Hall, Resident #50 rang his/her handheld bell while the SSA Representative was in another resident's room. At 3:20 PM, ten (10) minutes later, when the SSA Representative left the other resident's room, Resident #50 was still ringing the handheld bell. Interview on 03/03/2022 at 3:20 PM, with Resident #50, revealed his/her arm got tired ringing the handheld bell and he/she stated no staff had come to his/her room to check on him/her. Resident #50 stated he/she had knowledge of a wireless call system and was given a wireless device and it worked. The resident pointed to the nightstand, beyond his/her reach, to show the location of the device. Further observation revealed when Resident #50's wireless device was pushed, a tiny red light flashed and there was no audible sound. After five (5) minutes passed and no staff member came to assist the resident, the SSA Representative checked the call light system's base station at the nurse's station. Observation revealed it did not display a notification on the screen, or an audible alarm to indicate Resident #50's wireless device had been activated. The SSA Representative notified a staff member of the resident's request for assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #59's medical record revealed the facility admitted the resident on 01/11/2022, with diagnoses that included Coronary Artery Disease, Hypertension, Atrial Fibrillation, Anxiety Disorder, and Depression. Review of Resident #59's Quarterly MDS Assessment, dated 12/27/2021 revealed the facility assessed the resident as having a BIMS' score of seven (07) out of fifteen (15), indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring no assistance for bed mobility, no assistance for transfers, for toileting, and as always continent of bowel and bladder. Interview with Resident #59, on 03/02/2022 at 1:45 PM, revealed the call lights were not working. Resident #59 stated, How am I supposed to call when staff don't hear the bell or come when you need assistance? The resident stated medication was sometimes necessary at night for pain; however, he/she was forced to wait for staff to make rounds to check on his/her roommate in order to ask the State Registered Nurse Aide (SRNA) to notify a nurse that he/she needed medications for pain. Resident #59 was unaware of any wireless call system. Observation of the resident's room during the interview revealed no wireless device call system. 7. Review of Resident #278's medical record revealed the facility admitted the resident on 12/16/2021, with diagnoses that included Type 2 Diabetes Mellitus, Acute and Chronic Respiratory failure, Emphysema, Weakness, and Anxiety Disorder. Review of Resident #278's Admission MDS Assessment, dated 12/19/2021, revealed the facility assessed the resident as having a BIMS score of twelve (12) out of fifteen (15), indicating moderate cognitive impairment. Further review revealed the facility assessed the resident as requiring no assistance from staff for bed mobility, transfers, or toileting, and as always continent of bowel and bladder. Interview with Resident #278's Responsible Party (RP), on 02/22/2022 at 1:20 PM, revealed she was very concerned that some areas of the facility did not have a functioning call light system. She stated handheld bells were provided to residents for assistance, but many times staff did not respond. She further stated on several occasions her family member waited approximately twenty (20) minutes for assistance, despite staff stating they would round every fifteen (15) to thirty (30) minutes. Further interview revealed after returning to the facility following a recent hospitalization , Resident #278 was moved to another hall, which had a functioning call light system. Resident #278's RP stated she was relieved to know her family member now had a working call light. Resident #278's RP requested the SSA Representative not interview the resident as he/she had just returned from the hospital. Interview with Kentucky Medical Aide (KMA) #2, on 03/03/2022 at 10:25 AM, revealed she was able to hear the handheld bells at the nurse's station on halls C, D, and E and she was unaware of any concerns with the wireless call light system. She further stated staff also make rounds on all residents every thirty (30) minutes; however, KMA #2 stated routine rounding was not documented. Interview with State Registered Nurse Aide (SRNA) #23, on 03/03/2022 at 10:35 AM, revealed this was her first day at the facility. SRNA #23 stated staff made rounds on all residents every thirty (30) minutes; however routine rounding was not documented. Interview with the DOM on 02/25/2022 at 12:20 PM, revealed on 01/17/2022, the service company was given approval to install the Tech 120 Call Light System. The DOM stated he was told installation would be scheduled for the week of 03/07/2022, baring no further delay in the acquisition of parts. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional interview with the DOM, on 03/03/2022 at 1:20 PM, and on 03/04/2022 at 10:50 AM, revealed on 12/03/2021, the wireless call light system was loaned to the facility to use until installation of a permanent system was completed. The DOM stated he had not received any concerns from staff related to the temporary wireless call system currently in place. Furthermore, he stated he was not aware of any complaints from residents or families regarding issues of timeliness for staff assistance. He stated the system was tested on ce at installation for performance. Continued interview revealed he had not performed audits, nor had he monitored the wireless system since the installation. The DOM stated he looked into the issue of the wireless system not functioning for some residents, but found no issues. Further interview revealed the DOM was not aware the wireless system was not available to use for several residents, nor was he aware Resident #32 and Resident #50's wireless system was not working properly until notified by the SSA. According to the DOM, the importance of a functioning call system was to ensure residents' needs were met. Interview with Director of Nursing (DON) #5 (current DON), on 03/03/2022 at 2:10 PM, revealed she was new to the position of DON. She further stated she had no knowledge of the installation of a new call light system and was only aware of system repairs being discussed by the Administrator and DOM. DON #5 stated staff performed routine rounds on the C/D/E Halls every thirty (30) minutes. However, she was not aware of any special rounding documentation required for staff to complete other than their normal chart documentation. She further stated she was not aware of any resident complaints regarding the handheld bells or the wireless call light system for residents on the C, D and E Halls. Continued interview revealed it was her expectation residents had an effective system to alert staff when they needed assistance. Interview with the Administrator, on 03/02/2022 at 11:00 AM, on 03/03/2022 at 2:20 PM, and on 03/04/2022 at 3:10 PM, revealed she had no concerns with handheld call bells being utilized to notify staff of residents needing assistance or reliance on a wireless call light system, even though the wireless call light system was only beneficial if staff was in the nurse's station. Per interview, the handheld call bells used in conjunction with the wireless call system was effective in alerting staff of a resident needing assistance. When interviewed related to why some residents were unaware of the wireless call system, or did not have a wireless call light, she stated when installation of the wireless system was completed on 12/03/2021, there were only thirty-one (31) devices available. She stated not all residents were provided a wireless device. However, every resident on the C, D and E Halls were provided with the handheld bells in order to notify staff when assistance was needed. Continued interview with the Administrator, revealed she had received no reported concerns or complaints concerning handheld call bells or the wireless call system from residents, family members or staff. Further interview revealed there had been no audits performed to check if the handheld bells and the wireless call light system was effective to ensure residents' needs were met. The Administrator stated she was unaware of any audits to ensure the wireless call system was working properly for residents that received the wireless device. She stated staff was to make rounds on residents residing on Halls C, D, and E every thirty (30) minutes, not every (15) fifteen minutes as stated by the DOM. During interview related to the lack of documentation on the Supervision Flow Sheets submitted for review, she stated some staff members used their own pieces of paper to document the thirty (30) minute checks and those notes were not kept by the facility as a part of the permanent record. Per interview, documentation on the Supervision Flow Sheets was only for three (3) days and ceased on 12/03/2021 when the wireless call system was placed.