STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. Building B. Wing	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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** 28733 Based on interview, record review and facility policy review, it was determined the facility failed to identify a change in condition for one (1) of thirteen (13) sampled residents. Review of Resident #8's clinical record revealed the facility admitted the resident with the diagnoses of Chronic Obstructive Pulmonary Disease, Essential Hypertension, and Heart Failure. Review of Resident #8's Nursing Documentation, dated [DATE] at 10:55 PM, revealed a shift note for Exacerbation of Respiratory Condition, which stated the resident's lungs were not clear and rhonchi were heard upon auscultation and the resident had a non-productive cough. However, this change in respiratory status was not communicated to the physician. On [DATE] at 12:06 AM, Resident #8 was out of bed, found to be unsteady on his/her feet, and experienced shortness of breathe. Nursing applied oxygen, assisted the resident to bed, raised head of bed up, administered steroids and pain medication. However, nursing did not notify the physician of a change in condition. Review of Resident #8's weights revealed, on [DATE], the resident weighed two-hundred and forty-five (245) pounds and [DATE], the resident's weight increased to two-hundred fifty-two (252) pounds. However, the facility did not notify the physician of Resident #8's seven (7) pound weight gain over a two-day period. Review of Resident #8's Blood Test results from a lab draw, on [DATE], revealed the resident's [NAME] Count was 14.4 (4.5 to 10.8 normal range/elevated white count indicated the body was working to destroy an infection) and nursing did not provide test results to the physician. In addition, Resident #8 declined therapy services on the morning of [DATE], and voiced concerns of not feeling well to staff. However, nursing did not assess the resident for respiratory or cardiovascular change in condition nor did they notify the physician. Later that afternoon staff found the resident unresponsive on the floor and life saving measures were performed. The resident was transferred to an acute care hospital and expired. The facility's failure to notify the physician of a resident's change in condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE] and was determined to exist on [DATE]. The facility was notified of the IJ on [DATE]. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility provided an Acceptable Allegation of Compliance (AOC) on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. The State Survey Agency verified the IJ was removed on [DATE], prior to exit on [DATE]. The Scope and Severity was lowered to a D while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systematic changes. The findings include Review of the facility's policy titled, Change in Condition: Notification of, revised [DATE], revealed a center must immediately inform the patient, consult with the patients's physician, and notify, consistent with his/her authority, the patient's Health Care Decision Maker (HCDM) where there was a significant change in the patient's physical, mental, or psychosocial status (that was, a deterioration in health, mental, or psychosocial status in either life-threatening conditions, or clinical complications); or a need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment) Review of Resident # 8's clinical record revealed the facility admitted the resident on [DATE] with the diagnoses of Chronic Obstructive Pulmonary Disease, Essential Hypertension, Heart Failure, Chronic Atrial Fibrillation, and Wedge Compression Fractures of the First, Second, and Third Vertebra. Review of Resident #8's weights obtained on [DATE], revealed the resident weighed two-hundred and forty-five (245) pounds. Resident #8's weight was obtained again, on [DATE], and increased to two-hundred fifty-two (252) pounds. However, the facility did not assess Resident #8's seven (7) pound weight gain over a two-day period nor did they notify the physician of the change in condition. On [DATE] at 12:06 AM, nursing documented Resident #8 was out of bed, found to be unsteady on his/her feet, and experienced shortness of breathe. Nursing noted the application of oxygen, assisted the resident to bed, raised head of bed up, administered steroids and pain medication. However, nursing did not notify the physician of a change in condition. Review of the Resident #8's Nursing Documentation, dated [DATE] at 10:55 PM, revealed a shift note for Exacerbation of Respiratory Condition. The Respiratory System was reviewed and nursing noted the resident's lungs were not clear and the right and left upper lobes had rhonchi and the resident had a non-productive cough. However, this change in respiratory status was not communicated to the physician per the facility's policy. Telephonic interview with Registered Nurse (RN) #5, on [DATE] at 6:36 PM, revealed Resident #8 had Chronic Obstructive Pulmonary Disease (COPD) and his/her breathing had gotten very bad. RN #5 stated the resident needed both the nebulizer treatment and the Prednisone medication for the breathing difficulty. She stated she did not notify the physician of Resident #8's difficulty breathing, need for the Prednisone, or the nebulizer treatment. She stated she did not follow facility policy related to physician notification related to the resident's change in respiratory status. Review of Resident #8's Blood Test results from a lab draw, on [DATE], revealed the resident's [NAME] Count was 14.4 (4.5 to 10.8 normal range/elevated white count indicated the body was working to destroy an infection). However, nursing did not provide the abnormal test results to the ordering prescriber per facility policy. (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 RN #4, on [DATE] at 12:12 PM, revealed she was Resident #8 assigned nurse, on [DATE], and was familiar with his/her care needs. She stated she reviewed resident weights when there was a history of COPD or CHF in order to monitor for fluid retention. RN #4 stated if a resident retained fluid, the resident may exacerbate their COPD or worse; because fluid can cause respiratory issues. She stated weights should be obtained, and compared for an increase, or decrease. She stated she could not recall if she reviewed Resident #8's weights or blood test results, on [DATE]. RN #4 stated a significant weight gain or abnormal blood test results should be reported to the Nurse Practitioner, or the Physician, and documented in the nurses notes. Interview with the former [NAME] Hall Unit Manager (UM), on [DATE] at 3:15 PM, revealed her role as a nurse manager included monitoring resident weights and blood test results. She stated newly admitted residents weights were obtained daily for three (3) days. The purpose of daily weights assisted with the determination of fluid retention. The UM stated fluid retention had the potential to cause heart, lung, or respiratory complications. She stated if a resident had a history of respiratory disease or a change in respiratory status then nursing should monitor the residents' respiratory status by obtaining the oxygen saturation each shift. She stated she did not audit Resident #8's chart to ensure weights were obtained nor did she audit other new admissions. In addition, if a change in condition was identified nursing was to notify the physician. Interview with Advance Practice Registered Nurse (APRN), on [DATE] at 10:32 AM revealed nursing staff should have obtained resident #8's vital signs every shift for a minimum of seventy-two (72) hours. In addition, the staff should have called for an extended the order, if needed She stated the resident had Congestive Heart Failure and should have an order for weights. She stated the daily weights should have been implemented before breakfast upon admission. She stated she had not received a report that Resident #8 had gained weight gain. She revealed due to the resident's diagnoses she expected nursing to monitor for pneumonia and observe for any shortness of breath, increased respiration, or decreased oxygen saturation, cough and edema, with the respiratory assessment. She revealed she reviewed the chest x-ray results, dated [DATE], on [DATE]. She stated the chest x-ray, dated [DATE] had infiltrates consistent with the hospital x-ray, dated [DATE]. She stated Resident #8's white blood count (WBC) laboratory result, dated [DATE], increased to 14.4 (hospital result of 11.8, on [DATE]). The APRN stated if the facility had notified her of the elevated WBC she would have directed the nurses to monitor the resident for an infectious process and report any changes. On [DATE] at 3:06 PM, interview with the interim Center Nurse Executive (CNE), revealed she was still learning the facility's processes and could not speak to the care provided to Resident #8 nor to the ongoing audits for the recent deficiencies cited. She stated the facility did not conduct a mortality review after a resident expired in order to determine if the staff provided care and services according to standards of practice. She stated she could not speak to the resident's change in condition or staffs lack of physician notification. Interview with the Center Executive Director, on [DATE] at 4:55 PM, revealed she was ultimately responsible for the care and services provided in the facility. However, the Center Nurse Executive had direct oversight of nursing care. She stated the audits conducted for the recent deficiencies cited had not determined Resident #8's care had any issues. The facility implemented the following actions to remove the Immediate Jeopardy: 1. As of [DATE] Resident #8 no longer resided in the facility. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. All residents (85 of 85) were reassessed on [DATE], by the Center Nurse Executive (CNE), Assistant Director of Nursing (ADNS), Unit Manager (UM), Clinical Reimbursement Coordinator (CRC) Registered Nurse Supervisor RN, Advanced Registered Nurse Practitioner (ARNP) and/or Physician to determine if a change in condition had occurred. 3. The CNE, CED, ADNS, and UM completed reeducation by [DATE] with all facility staff to include contracted staff on the facility policy and procedures of the, Stop and Watch Tool.All Licensed Nurses including contracted staff completed reeducation by [DATE] on Change of Condition, Physician/Mid-Level Provider Notification of Change in a Resident's Condition. 4. A post-test was administered at the time of the re-education that required a passing score of 100%. The posttest was graded by the CNE, ADNS, and UM. Facility staff and contracted staff not available during this time of the re-education will be provided re-education including post-test by the CNE, CED, ADNS, UM, Minimum Data Set (MDS) Coordinator, and RN Supervisor. Newly hired facility staff and contracted staff will be provided education and a post-test during orientation by the CNE, ADNS, and/or the UM. 5. Clinical observation rounds including interviews of staff would be conducted daily by the CNE, ADNS, UM, MDS Coordinator and RN Supervisor to determine if residents have experienced a change in condition, consistent respiratory services were provided, and the Physician/ARNP were notified and the plan of care reflected the current needs of the resident daily for two (2) weeks including weekends and holidays the three (3) times a week for two (2) weeks then weekly for eight (8) weeks, then monthly for one (1) month then ongoing thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to ensure care plans reflect the residents status with any corrective action upon discovery. 6. The CED, CNE, ADNS and/or Social Service Director would conduct ten (10) employee interviews daily to determine staff were aware of the centers process of the, Stop and Watch Tool and to report a change in condition to a licensed nurse to ensure prompt intervention when a resident experiences a change in condition daily for two (2) weeks including holidays, then three (3) times a week for two (2) weeks then weekly for eight (8) weeks, then monthly times one (1) month, then ongoing thereafter as determined by the QAPI Committee to ensure care plans reflect the residents status with any corrective action upon discovery. The results of the interviews and audits would be reviewed daily to determine the physician had been notified and the residents' plan of care reflects the current needs of the resident by the CED or CNE with corrective action upon discovery. 7. The CED, CAN and or ADNS would submit the results of the audit findings to the QAPI Committee monthly times six (6) months which consists of the CED, CNE, ADON, Medical Director, Social Service Director, Food Service Director, Dietician, Health Information Manager, Activity Director and Certified Nursing Aides (CNA) for any additional follow up and/or in-servicing until the concern is resolved and ongoing thereafter as determined by the QAPI Committee. The SSA validated the facility implemented the following actions: 1. Record review revealed Resident #8 no longer lived in the facility. 2. Record review of the Daily Census dated [DATE] revealed eighty-five (85) of eighty-five (85) residents were assessed for a change in condition. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on [DATE] at 3:00 PM, with the CNE revealed eighty-four (84) of eighty-four (84) residents to be well-groomed and in no apparent distress. Interview with the CNE, on [DATE] at 11:45 AM, revealed on [DATE] all of the residents were reassessed for any changes in condition. She stated the facility had developed a survey status tool. Interview with MDS Coordinator #3 on [DATE] revealed she had assisted with the assessments of all the residents on [DATE] to include respiratory assessments, and daily weights as ordered, and Advanced Directives/Code Status as per care plan were followed and the physician or the Advanced Registered Nurse Practitioner (ARNP) were notified if a change in condition had occurred. Record review revealed an audit, dated [DATE], was completed on each resident (85 of 85 residents) to determine care was provided per resident plan of care to include respiratory assessments, daily weights as ordered, Advanced Directives/Code Status as per care plan were followed and the physician or the Advanced Registered Nurse Practitioner (ARNP) were notified if a change in condition occurred. 3. Record review revealed staff re-education regarding the Stop and Watch Tool was initiated and completed by the facility by [DATE] to include contracted staff as verified by the employee roster and signed post-tests. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 9:45 AM, revealed the Stop and Watch tool could be implemented by any employee who notices any changes in a resident. She said the tool was to be completed, and handed to the nurse. She stated she had been trained on the Stop and Watch tool by the Administrator. Interview with Registered Nurse #6, on [DATE] at 9:00 AM, revealed she was trained on the Stop and Watch tool. She stated it was a form every employee needed to fill out if they see a change in a resident. She stated the forms were kept at the nursing stations, and once the form had been completed and signed, it was given to the nurse. Continued interview revealed a change in condition in a resident's respiratory status would be labored breathing. She revealed she would assess the resident's respiratory status immediately to include oxygen saturation, breath sounds, and rate and depth of the respirations. She stated if a resident stopped breathing, she would check the Code Status and begin cardiopulmonary resuscitation immediately if the resident was a full code, and notify the Medical Physician (MD). She stated the facility had re-educated staff on principles of tracheostomy care and sterile technique as well as daily quizzes regarding change in condition, MD notification, clinical signs of irreversible death, Stop and Watch early warning tool, emergency cart and emergency cart checklist, health care decision making, person-centered care plans, heights/weights and respiratory management. Interview with Registered Nurse (RN) # 7, on [DATE] at 9:10 AM, revealed she had completed recent training on the Stop and Watch tool, and change of resident condition. She stated the Stop and Watch tool could be completed by any employee who sees a change in a resident. She stated the tool was to be completed by the employee and given directly to the nurse. She stated a change of condition was defined as anything new going on with a resident. She revealed an assessment and physician notification should be completed whenever a resident had a change in condition as well and updating the individualized care plan. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 9:20 AM, with Certified Nursing Assistant (CNA) #24 revealed she had recently viewed a video with follow up questions on the Stop and Watch tool. She stated if any staff observe something new with a resident, they were to complete the Stop and Watch tool, and give it to the nurse immediately. She stated anytime a resident was discovered not breathing the nurse should be notified immediately. Interview on [DATE] at 9:25 AM, with CNA #25 revealed she had received training on the Stop and Watch tool. She stated she was also quizzed on the Stop and Watch tool. She revealed the tool was used to report any changes in a resident to the nurse and anytime a resident stopped breathing or became unconscious, the nurse was to be called immediately. Interview on [DATE] at 9:30 AM, with CNA# 26, revealed she had been educated on the Stop and Watch tool. She stated she had done training on the computer, received written information and took a quiz. She stated anytime staff see something, they should say something. She revealed the Stop and Watch Tool was a form staff completed and give to the nurse whenever they see a change in a resident. She stated if a resident became unresponsive she would immediately notify the nurse and take the resident's vital signs. Interview with Dietary Aide #1, on [DATE] at 9:45 AM, revealed she had received training on the Stop and Watch tool. She stated if staff see something wrong with a resident, they should report it to the nurse immediately using the tool. She stated she was educated during a staff meeting and had to pass a test. Interview with the Director of Rehabilitation Services, on [DATE] at 9:50 AM,. revealed she had been in-serviced on the Stop and Watch tool via the computer with a paper test to follow. She defined Stop and Watch as looking for any changes in actions, medical status or anytime a resident did not feel well. She stated the Stop and Watch tool should be completed and given to the nurse. She stated a resident's code status is on their chart or in the Point Care Click (PCC) system. Interview with Physical Therapy Assistant #1, on [DATE] at 10:05 AM, revealed he had received training on the Stop and Watch tool. He stated he watched training on the computer then completed a posttest. He stated the tool should be filled out anytime a resident seems to have a change in status and given directly to the nurse. He stated if a resident became unresponsive, staff should get the nurse immediately. Interview with Licensed Practical Nurse (LPN) #14, on [DATE] at 10:15 AM, revealed the Stop and Watch tool could be used by any employee to notify the nurse of any resident condition changes. She stated she had been in-serviced on the Stop and Watch tool by watching a video and completing a posttest. She stated she had also received training on change of condition, and MD notification. She stated the facility had quizzed her on resident change of condition, and when to notify the MD. Interview with RN #8, on [DATE] at 10:30 AM, revealed the Stop and Watch tool alerts the nurses to changes in a resident's condition. She stated any employee and utilize the tool, and it was a piece of paper located at each nursing station they can fill out and hand to the nurse. She stated she received individual training by the facility and completed a post-test. She stated the facility management frequently quizzed staff on Stop and Watch, and reporting of a resident change of condition to the MD. She stated reporting any resident changes to the MD was very important. (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 CNA #27, on [DATE] at 11:10 AM, revealed the Stop and Watch form should be filled out by any employee if they observe a change in a resident, and given to the nurse. She stated some changes could be a decrease in appetite or increased confusion. She stated she had received training on the Stop and Watch tool and taken a post-test. She stated the facility management frequently quizzed staff on the use of the tool. Interview with CNA #28, on [DATE] at 11:25 AM, revealed she had been trained on the Stop and Watch tool. She stated she had viewed a video and taken a post-test. She stated anytime a resident had a change in condition, a Stop and Watch form should be completed and given to the nurse. She stated anytime a resident was unresponsive, the nurse should immediately be notified. Interview with Housekeeper #2, on [DATE] at 11:30 AM,. revealed she was aware of the Stop and Watch program. She stated anytime a resident did not seem to be in their normal state, a Stop and Watch form should be filled out and given to the nurse. She stated she kept the forms on her housekeeping cart. She revealed the Administration has frequently quizzed her on the Stop and Watch tool. Record review revealed all licensed nurses to include contract staff completed re-education by [DATE] on change of condition, and physician/mid-level provider notification of change in a resident's condition. Facility staff and contracted staff not available during this time of the re-education were provided re-education to include a post-test. Newly hired staff and contracted staff received education and post-test during orientation. Interview with Minimum Data Set (MDS) Nurse #3, on [DATE] at 1:00 PM, revealed the facility had provided education to her in regards to how and when to perform a respiratory assessment on a resident followed by a post-test which had to be passed with a 100% She stated the facility had also educated her on death pronouncement, the Stop and Watch tool and steps to take when a resident had a change of condition. She stated the licensed personnel had also received training on breath sounds, how to give proper tracheostomy care, MD and family notification with any change of condition. She stated the respiratory assessment training included breath sounds, and sterile technique when suctioning a tracheostomy. She stated the facility had made observations on staff when they performed suctioning on a tracheostomy for sterile technique. She stated she had been in-serviced in regards to updating care plans daily, as needed. She stated any change of condition required the care plan to be updated. She stated she had also participated in providing education to the nurses. Interview with the Unit Manager from the North Nursing Unit, on [DATE] at 1:20 PM, revealed the Stop and Watch tool was to be used by everyone. She stated the form should be filled out and given to the nurse. That way, we can assess that resident quicker and treat as necessary. She stated at the end of each day, the Stop and Watch forms are given to the Director of Nursing (DON). She stated education had also been provided to staff in regards to change of resident condition. She stated the nurses needed to complete a Change of Condition report, and notify the doctor. She stated the nurses would complete follow up charting on the change of condition for three days. 4. Record review revealed all licensed nurses to include contract staff completed re-education by [DATE] on change of condition and physician/mid-level provider notification of change in a resident's condition. Facility staff and contracted staff not available during this time of the re-education were provided re-education to include a posttest. Newly hired staff and contracted staff received education and post-test during orientation. (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 Registered Nurse #6, on [DATE] at 9:00 AM, revealed she had been trained on the Stop and Watch tool. She stated it was a form any employee needed to fill out if they see a change in a resident. She stated the forms are kept at the nursing stations, and once the form had been completed and signed, it was given to the nurse. She stated she responds immediately to the Stop and Watch notification. Continued interview revealed a change in condition in a resident's respiratory status would be labored breathing. She revealed she would assess the resident's respiratory status immediately to include oxygen saturation, breath sounds, and rate and depth of the respirations. She stated if a resident stopped breathing, she would check the Code Status and begin cardiopulmonary resuscitation immediately if the resident was a full code, and notify the Medical Physician (MD). She stated the facility had re-educated staff on principles of tracheostomy care and sterile technique as well as daily quizzes regarding change in condition, MD notification, clinical signs of irreversible death, Stop and Watch early warning tool, emergency cart and emergency cart checklist, health care decision making, person-centered care plans, heights/weights and respiratory management. Interview with Registered Nurse (RN) # 7, on [DATE] at 9:10 AM, revealed she had completed recent training on the Stop and Watch tool, and change of resident condition. She stated the Stop and Watch tool can be completed by any employee who sees a change in a resident. She said the tool was to be completed by the employee and given directly to the nurse. She stated the nurse should respond to the notification immediately. She stated a change of condition was defined as anything new going on with a resident. She revealed an assessment and physician notification should be completed whenever a resident had a change in condition as well and updating the individualized care plan. Interview with Licensed Practical Nurse (LPN) #14, on [DATE] at 10:15 AM, revealed the Stop and Watch tool could be used by any employee to notify the nurse of any resident condition changes. She stated she had been in-serviced on the Stop and Watch tool by watching a video and completing a posttest. She stated she had also received training on change of condition, and MD notification. She stated the facility had quizzed her on resident change of condition, and when to notify the MD. Interview with RN #8, on [DATE] at 10:30 AM, revealed the Stop and Watch tool alerts the nurses to changes in a resident's condition. She stated any employee and utilize the tool, and it was a piece of paper located at each nursing station they can fill out and hand to the nurse. She stated she received individual training by the facility and completed a post-test. She stated the facility management frequently quizzed staff on Stop and Watch, and reporting of a resident change of condition to the MD. She stated reporting any resident changes to the MD was very important. 5. Record review revealed Clinical Observation rounds to include staff interviews were conducted daily by the facility. The Clinical Observation rounds determined if residents had experienced a change in condition, consistent respiratory services, and the Physician/ARNP had been notified daily for two (2) weeks. Clinical Observation rounds noted complete for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Interview with the CNE, on [DATE] at 11:45 AM,. revealed she performed clinical observation rounds on each resident daily to assess for a change in condition and if the physician had been notified and the care plan updated. 6. Record review revealed the facility conducted ten (10) employee interviews daily on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], 1nd [DATE] to determine staff were aware of the Stop and Watch Tool daily for two weeks including holidays. (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 Licensed Practical Nurse (LPN) #14, on [DATE] at 10:15 AM, revealed the Stop and Watch tool could be used by any employee to notify the nurse of any resident condition changes. She stated she had been in-serviced on the Stop and Watch tool by watching a video and completing a posttest. She stated she had also received training on change of condition, and MD notification. She stated the facility had quizzed her on resident change of condition, and when to notify the MD. Interview with CNA #27, on [DATE] at 11:10 AM, revealed the Stop and Watch form should be filled out by any employee if they observe a change in a resident, and given to the nurse. She stated some changes could be a decrease in appetite or increased confusion. She stated she had received training on the Stop and Watch tool and taken a post-test. She stated the facility management frequently quizzed staff on the use of the tool. Interview with the CNE on [DATE] revealed ten (10) employees were interviewed daily on the Stop and Watch Tool, and its purpose. 7. Record review revealed the results of the audit findings were submitted and discussed in the Quality Assurance Performance Improvement Committee on [DATE] and [DATE]. Interview with the Chief Nursing Executive (CNE), on [DATE] at 1:45 PM, revealed staff education started with the Plan of Correction (PoC) and assessment of the Statement of Deficiency Form to help identify the educational needs of the staff and what audit tools were needed to be initiated. She stated the Stop and Watch Tool gave the facility an actual way to track changes in resident condition. She stated staff notified her of any changes in a resident condition and what interventions were initiated. She stated this data was reviewed in the Daily Afternoon Meeting which consisted of the CNE, Social Worker (SW), Unit Managers, ADON, Administrator, and sometimes the Therapy Department. She stated the Morning Meeting commences daily after morning rounds, and review of the Twenty-Four (24) Report. She stated the Morning Meeting reviewed any new changes of condition, interventions and assure MD notification. She stated the results of the audits were then discussed in QAPI Interview with the Center Executive Director (CED), on [DATE] at 3:40 PM, revealed she was ultimately responsible for the center. She revealed the Quality Assurance Performance Improvement (QAPI) Committee meets monthly and as needed. She stated the attendees are the Medical Director, the Chief Nursing Executive (CNE), Unit Managers, one (1) licensed nurse, one (1) Certified Nursing Assistant (CNA), Social Services Director, Activities, Minimum Data Set (MDS) Nurse, Dietician, Advanced Registered Nurse Practitioner (ARNP), Dietary Manager, Housekeeping Manager and Therapy. She stated the committee reviewed monthly reports that pulled from QAPI data, which gave them a percentage on where the facility was on various issues. She stated the QAPI also pull trends from grievances and self-identification through process review and in the discussion of outcomes. She stated facility plans are generated through the QAPI process. She stated she felt the facility had provided staff with education they needed to do their jobs more effectively. She stated quizzes and repetition of the education related to cardiac/respiratory arrest, the CPR Flowsheet, Death Pronouncement, Emergency Cart Check List and Advanced Directives has increased staff knowledge. Audits are being completed and used as our tools for effectiveness. She stated the QAPI plan was to continue to audit to assure staff understa [TRUNCATED]

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Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and facility policy review it was determined the facility failed to have an effective system to protect residents from sexual abuse for one (1) three (3) of a total sample of fifty-six (56) residents (Resident #26). Interview and record review revealed the facility failed to assess Residents #5 and #26 for the capacity to consent to sexual relations. Nor did the facility conduct behavior monitoring of Resident #5, to ensure Resident #26 and other residents were protected from potential sexual abuse. Review of Resident #5's nursing progress notes, first noted on 09/13/18, revealed the resident exhibited inappropriate sexual behavior to self in public areas and also directed this behavior towards Resident #26. Review of the Psychiatric Periodic Evaluation, dated 10/05/18, revealed Resident #5 was aware that a person could not be able to give consent and therefore could not be a willing participant in sexual behavior, and the resident's judgment in the matter seems to be somewhat impaired. Interview with the Center Nurse Executive (CNE) revealed Resident #5 and #26 were close friends and had a history of sexual interactions. She stated, Just because you have a mental disability does not mean you cannot make a decision about giving consent. However, the facility did not have a policy or procedure regarding the process to assess residents for the capacity to consent to sexual interactions, nor did the facility care plan this behavior or obtain family consents for a sexual relationship between Resident #5 and #26. The facility's failure to protect a resident from sexual abuse has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 08/13/19 and was determined to exist on 09/13/18. The facility was notified of the IJ on 08/16/19. The facility provided an acceptable Allegation of Compliance (AoC) on 08/20/19, which alleged removal of the Immediate Jeopardy on 08/20/19. The State Survey Agency verified the IJ was removed on 08/20/19, prior to exit on 08/23/19. The Scope and Severity was lowered to a D while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systematic changes. The findings include: Review of the facility's policy entitled Abuse Prohibition, revised 07/01/19, revealed the facility prohibited abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. The policy revealed the Center implemented an abuse prohibition program through the screening of potential new hires, training of employees (both new employees and ongoing training for all employees), and, prevention of occurrences. Additional abuse prohibition occurred through identification of possible incidents or allegations that needed investigation; investigation of incidents and allegations; protection of patients during investigations; and reporting of incidents, investigations, and the Center's response to the results of their investigations. The Center defined Abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury or mental anguish. The policy defined Sexual Abuse as a non-consensual sexual contact of any type with a resident and included but was not limited to sexual harassment, sexual coercion or sexual assault. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility did not provide a policy related to the resident assessment process for the capacity to consent to sexual relations. Review of the facility's policy entitled Abuse Prohibition policy revealed the Center Executive Director (ED), or designee, was responsible for operationalizing policies and procedures prohibiting abuse, neglect, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property included identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of patient property was more likely to occur. 1. Observation, on 08/06/19 at 10:09 AM, revealed Resident #5 walking independently in the outdoor courtyard with no facility staff present. Observation of Resident #5, on 08/10/19 at 3:54 PM, revealed he/she walked through the television room, attempted to enter the men's restroom, and then exited the area in the direction of the dining room. Observation, on 08/15/19 11:48 AM, revealed Resident #5 exited the building to the courtyard and sat with another resident under the gazebo. Further observation, on 08/15/19 at 12:13 PM, revealed the resident re-entered the building and sat down in the television room. Review of the clinical record revealed the facility admitted Resident #5 on 07/01/17 with diagnoses to include Major Depressive Disorder, Dementia without Behavioral Disturbance, Hypertension, and, on 10/05/18, the facility added an additional diagnosis of Impulse Disorder. Review of the Psychiatric Periodic Evaluation (PPE), dated 08/20/18, revealed the facility requested a follow-up visit to assess Resident #5's recent behavior with a peer. Resident #5 referred to the peer as his/her girlfriend and allegedly grabbed him/her on at least one occasion. Review of Resident #5's Care Plan for Mood/Behaviors, initiated 08/28/18, revealed the resident was impulsive at times and fixated toward female peers. Further review revealed the resident had sexual desires towards a female peer and a history of masturbation in public areas. Interventions included directing the resident to a private area, redirecting from female peers as needed and psychiatric consult as needed. Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #5 with a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) and determined the resident was interviewable. Review of the Advanced Practice Registered Nurse (APRN) progress note, dated 09/13/18, revealed Resident #5 exposed his/her genitals to another resident in the main dining room and asked the resident to perform a sexual act. Resident #5 stated he/she was just friends with the other resident. Review of Resident #5's nursing progress notes revealed on 09/28/18, the resident masturbated in the main dining room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 08/07/19 at 10:00 AM, with Resident #5 revealed the resident exposed his/her genitals to another resident in the main dining room. According to the resident, there were no staff present in the dining room at the time of the incident. Further review of APRN notes, dated 10/05/18, revealed Resident #5 engaged in oral sex with another resident in the main dining room. The note revealed the APRN informed Resident #5 sexual behaviors were not allowed, as the other resident was unable to give consent. Review of the PPE, dated 10/05/18, revealed an assessment of Resident #5 listed the patient's limitations as cognitively impaired. The mental status examination portion of the PPE revealed Resident #5 was aware that a person could not be able to give consent and therefore could not be a willing participant in sexual behavior and the patient's judgment in the matter seems to be somewhat impaired. Further review of the mental status examination revealed the physician noted it appeared as though the Resident #5 had been moving towards the peer for some time. Further review of the PPE, dated 10/05/18, revealed Resident #5 was increasingly acting out sexually, had contact with a female peer, and had approached other peers. The evaluation revealed the resident was aware the female peer could not give consent and therefore could not be a willing participant in sexual behavior. Review of Resident #5's nursing progress notes revealed the following entries on 11/22/18, the resident exhibited inappropriate behavior with another resident in the main dining room. Interview with Dietary Aide (DA) #1, on 08/15/19 at 12:07 PM, revealed that as she walked up to the facility, she observed Resident #5 in the main dining room. DA #1 stated she observed Resident #5's exposed genitals, and Resident #5 was standing next to Resident #26 who was seated at a table in the main dining room. She stated Resident #5's hands were on his/her genitals and moving back and forth. The DA revealed she tapped on the window of the dining room door, yelled Resident #5's name, and he/she ran out of the dining room. The DA revealed she received training on the facility's abuse policy; however, she did not report the incident because this type of incident had happened before and she thought the facility was aware. She revealed it was important to report alleged abuse to ensure residents were protected. Review of the Order Summary Report revealed a physician order, dated 01/03/19, to monitor behaviors two (2) times a day and, if a behavior was present, document the type, interventions, and outcomes in the nurses notes (NN). However, the facility was not able to provide a Behavior Monitoring Tool for Resident #5. Further review of Resident #5's nursing progress notes revealed, on 05/07/19, the resident reportedly requested another resident to perform a sexual act and, on 06/10/19, the resident exhibited inappropriate behavior in the television room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #18, on 08/16/19 at 11:13 AM, revealed Resident #99 and several other residents reported Resident #5 exposed his/her genitals and approached Resident #26 in the television room. The LPN stated Resident #3 and Resident #99 were present in the television room when the incident occurred. He revealed he immediately notified the CNE by phone to report the incident because of Resident #5's history of sexual behaviors. According to LPN #18, the CNE directed him to document the incident and notify the family. The nurse stated he documented the incident in Resident #5's progress notes; however, the documentation did not specify the type of behavior because he did not observe the resident expose his/her genitals. Continued interview with LPN #18, on 08/16/19 at 11:25 AM, revealed he was not aware of any special supervision requirements for Resident #5. Further review of the PPE, dated 06/18/19, revealed Resident #5 exposed him/herself several times and included a new order to start an Estradiol Patch (a female hormone replacement medication) zero point zero two five (0.025) milligrams (mg) weekly. Review of Resident #5's nursing progress notes revealed on 06/20/19, the resident exposed his/her genitals in the outdoor courtyard. Interview, on 08/06/19 at 2:56 PM with Resident #99, who the facility assessed with a BIMS score of thirteen (13) out of fifteen (15) and determined he/she was interviewable, revealed he/she witnessed Resident #5 take out his/her privates as he/she came back inside from the courtyard, around 7:00 PM several months back during the Spring. The resident stated he/she did not want to see this, let Resident #5 know it and pushed Resident #5 away. Resident #5 responded by stating, I don't know what the f--k you are talking about. Resident #99 further stated, I thought I did the right thing by telling Resident #5 to leave Resident #26 alone. Resident #99 further stated he/she told the nurse about the exposure. Interview with LPN #8, on 08/11/19 at 2:32 PM, revealed she was aware of Resident #5's sexual behavior and recalled an incident when a family member notified her the resident exposed his/her genitals in the courtyard. She stated she immediately went to the courtyard, which was packed with people, escorted the resident to the Administrative office, and reported the incident to the CNE. According to LPN #8, the CNE instructed her to return the resident to his/her room. She revealed nurses were responsible for documenting all behaviors; however, she did not document the incident because she thought the resident's assigned nurse would do it. LPN #8 could not recall any new interventions or increased supervision following the incident in the courtyard and stated staff were just directed to keep an eye on the resident. Interview, on 08/10/19 at 3:40 PM with Resident #3, who the facility assessed with a total BIMS score of thirteen (13) out of fifteen (15) and determined he/she was interviewable, revealed he/she redirected Resident #5 from the [NAME] hall because the resident was not supposed to be around Resident #26. Resident #3 revealed he/she witnessed Resident #5 take his/her genitals out and approach Resident #26 in the library a couple of months ago. He/she stated Resident #5 stood facing Resident #26, approximately a foot away and waved it back and forth. Resident #3 stated another female resident in the vicinity intervened and Resident #5 ran from the library. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further interview with Resident #3, revealed Resident #26 told him/her about an incident when Resident #5 allegedly asked him/her to perform oral sex. The resident revealed Resident #26 indicated he/she was scared and for the last three (3) to four (4) months stayed at the [NAME] nurse station. According to Resident #3, the sexual behaviors directed at Resident #26 started last year. Interview with Certified Nursing Assistant (CNA) #21, on 08/15/19 at 1:41 PM, revealed Resident #5 was not allowed on the [NAME] hall or in the dining room unless staff were present. She stated Resident #5 was caught in a sex act in the dining room and it was important to keep an eye on him/her to prevent any further incidents. Interview with CNA #10, on 08/09/19 at 4:43 PM, revealed Resident #5 walked everywhere in the facility, including the outdoor courtyard. The CNA further revealed resident care needs and behaviors were noted in the care tracker; however, she was not sure if Resident #5 had a history of behaviors. According to CNA #10, it would be important to know if a resident had a history of behaviors in order to provide care and keep other residents safe. Interview with CNA #7, on 08/10/19 at 5:39 AM, revealed she referred to the electronic care tracker to determine resident care needs. CNA #7 revealed she was not aware of Resident #5's sexual behavior(s). Interview with CNA #19, on 08/11/19 at 11:36 AM, revealed she was not aware of any issues related to Resident #5 or sexual behaviors. Interview with CNA #20, on 08/15/19 at 10:01 AM, revealed Resident #5 moved around constantly and staff were supposed to keep an eye on him; however, she was not aware of any increased supervision needs for the resident. Interview with CNA #12, on 08/13/19 at 2:50 PM, revealed she was told to keep an eye on Resident #5 because he/she made comments to Resident #26. She revealed she was not aware of any behaviors for Resident #5. Review of Resident #5's electronic Kardex during the interview revealed the resident liked to visit with peers and often watched television with them in their room. Further review revealed Resident #5 should be directed to a private area; however, there was no behavior(s) specified. Interview with LPN #4, on 08/09/19 at 3:57 PM, revealed Resident #5 had a history of behaviors; however, she was not sure what type. LPN #4 revealed she checked on the resident throughout the day, but the resident was not always in the room because he/she wandered around the facility. Interview with LPN #9, on 08/10/19 at 6:55 AM, revealed Resident #5 walked the hallways; however, she stated she was not instructed to supervise Resident #5 when the resident ambulated in the hallway or in resident rooms. Interview with LPN #17, on 08/15/19 at 10:31 AM, revealed Resident #5 tended to walk up and down the halls throughout the day. She further revealed other residents redirected him/her in the halls and staff redirected the resident when he/she came out of the room in the middle of the night. She stated nurses were responsible for documentation of behaviors to include the type of behavior, interventions implemented, and notifications made. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further interview with LPN #17 revealed requests for sexual acts, exposure of genitals, and masturbation in a common area would be considered sexual behaviors. The nurse further revealed any sexual activity between residents should be reported to the DON to determine if both parties were cognitively aware. According to LPN #17, staff could potentially prevent incidents of sexual behaviors with adequate supervision of the resident. Interview with the Psychiatrist, on 08/13/19 at 11:38 AM, revealed he evaluated Resident #5 and there was some concern with the resident trying to initiate sexual contact with a female peer. The physician revealed if inappropriate touching ever occurred, pharmacological intervention or hospitalization would be considered to protect a peer. He revealed other interventions would include adaptive clothing, increased monitoring, or moving the resident to a different part of the building. The physician revealed he expected the facility would monitor Resident #5 and keep him/her away from the peer to ensure his/her safety. Interview with the Social Services Director (SSD), on 08/13/19 at 5:04 PM, revealed she was aware of an incident involving Resident #5 exposing his/her genitals in the courtyard. She stated the CNE intervened and redirected the resident back inside the building. According to the SSD, a resident exposing their genitals in the presence of other residents was inappropriate. The SSD revealed the physician prescribed hormone therapy to manage Resident #5's behaviors; however, she was not aware of other implemented interventions. Interview with the Assistant Director of Nursing, on 08/23/19 at 3:29 PM, revealed she was aware of Resident #5 sexually acting out behaviors. She stated once the facility had knowledge the resident sexually acted out, the staff should record the resident's behavior, revise the plan of care, and notify the responsible party. She stated a consult with the psychiatry should be requested. She stated was not sure if other residents were affected but knew they witnessed Resident #5's sexually inappropriate behaviors. 2. Review of the clinical record for Resident #26 revealed the facility admitted the resident on 11/17/17 with diagnoses including Mild Intellectual Disabilities, Legal Blindness, Malignant Neoplasm of Endometrium, and Colostomy Status. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #26 with a Brief Interview for Mental Status (BIMS) exam score of ten (10) out of fifteen (15) and determined the resident was interviewable. Review of the CNE progress note, dated 05/07/19, revealed Resident #26 went to the nurses' station to report a male resident asked him/her to perform sexual acts while in the main dining area. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Phone interview with Resident #26's guardian, on 08/13/19 at 2:17, revealed the resident's mental condition was hard to figure out sometimes. He stated the facility called to inform him/her resident had not been sleeping, was crying, and/or hormonal due to recent surgery on 05/17/19. He stated the facility wanted to sedate the resident and he told them he did not want the resident knocked out. The Guardian stated Resident #26 stated he/she was scared and wanted to go home. In addition, the Guardian reported the resident called everyone his/her friend but he was not aware of a boyfriend. In addition, sometime in the past the facility had called to report Resident #26 had touched another resident a couple of times and would monitor for these behaviors in the future. However, the facility did not report to him that Resident #26 had performed oral sex on a resident or had another resident's genitals in his/her face. Review of nursing progress notes, dated 06/16/19, revealed Resident #26 no longer wanted to live at the facility and did not feel safe because something happen, however, would not elaborate. Behavioral changes noted by the facility stated Resident #26 refused to go to bed and preferred to sit at the nursing station. Review of Resident #26's Psychological Diagnostic Interview report, dated 07/15/19, revealed a history of disinhibited/sexually inappropriate behaviors occurred in November 2018. The interview occurred due to a request for the stabilization of Resident #26's depressed mood. The report stated Resident #26 indicated during the interview an increased dissatisfaction at the facility, and the resident displayed mood fluctuation that included tearfulness and irritability. Further review of psychotherapy progress notes, dated 07/30/19, revealed the plan was for continued monitoring of insomnia behaviors and referral to psychiatry for an evaluation. Review of the CNE progress note, dated 07/26/19, revealed Resident #26 exhibited childlike behaviors such as talking in a childlike voice and calling another female resident mommy. Resident #26 revealed she did not want to walk down the [NAME] Hall alone and wanted mommy to go with her. Review of a Psychiatry evaluation, dated 07/31/19, revealed the provider performed an initial mental health assessment to address Resident #26's anxiety, lack of sleep and difficulty re-directing negative behaviors. The Psychiatrist diagnosed resident with Adjustment Disorder with Mixed Anxiety, Depressed Mood, and Insomnia, and recommended the medication Trazodone to start 08/03/19 for sleep. Review of Physician progress note, dated 08/08/19, revealed Resident #26 prescribed melatonin 5mg for insomnia. Interview with Resident #26, on 08/06/19 at 10:04 AM, revealed Resident #5 came into his/her room, however, could not remember when and touched his/her brief. Interview with Resident #26, on 08/07/19 at 1:16 PM, revealed Resident #5 put his penis in his/her mouth two (2) times and it hurt and did not feel good. Review of the nursing documentation, dated 08/11/19 at 2:27 PM, revealed Resident #26 had been combative at times, redirection attempts were successful except when attempting to put resident to bed. In addition, the nursing documentations stated Resident #26 had not been physically combative in the past and would not give reason why she/he did not want to go to bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with APRN, on 08/15/19 at 9:12 AM, revealed Resident #26 was Intellectually Disabled and recently had a surgical procedure so labs were drawn to determine if hormone levels were abnormal and the lab results were normal. She stated she interviewed the resident regarding the oral sex incident that occurred between Resident #5 and Resident #26. The APRN stated she used simple questions during the interview due to resident's cognitive level. Resident #26 revealed Resident #5 had asked him/her to perform oral sex so she did because he/she was his/her friend. Resident #26 revealed she/he wanted to touch his/her genitals and put in his/her mouth. The APRN reported she was unsure if someone of Resident #26's cognitive level could consent to sex or oral sex. Interview with the Psychiatric Nurse Practitioner (NP), on 08/16/19 at 10:57 AM, revealed Resident #26 had a referral and was seen for anxiety and not sleeping. Psychiatric NP stated she believed Resident #26 did not have the intellectual ability to consent to consensual sex and/or oral sex now, or in the past. Further interview with the SSD, on 08/13/19 at 5:04 PM, revealed Resident #5 and Resident #26 had a relationship months and months ago, and Resident #26 referred to Resident #5 as his/her friend and the two (2) ate together in the dining room. She revealed the facility considered their sexual relationship consensual; however, she was not aware if a physician assessed either resident to ensure they were competent to consent. Interview with the CNE, on 08/13/19 at 6:23 PM, revealed the facility did not have a policy that directed staff in the assessment process to determine if residents had the capacity to consent to sexual relations. In addition, the CNE stated the facility did not have documented evidence of an assessment for the capacity to consent to sexual relations for Resident #5 or #26. She stated Resident #26 and #5 sexually acted out in the dining room area but was not sure of the date. In addition, the CNE stated Resident #5 had a history of exposing his/her genitals in common areas of the facility. The CNE confirmed Resident #26 had seen and touched Resident #5's penis. She stated it was normal human nature to have sexual feelings; however, where he/she chose to exhibit them was not always the best place. The CNE stated the facility felt like the sexual encounter was consensual after speaking with both residents and reviewing their last Brief Interview for Mental Status scores. She stated sexual abuse occurred when someone harmed another sexually; and just because a resident had known mental disabilities did not mean they could not make a decision to consent to sexual relations. Interview with the Center Executive Director (CED), on 08/13/19 at 9:38 AM, revealed the facility had a process it worked through to determine if an incident was abuse and she had final say. The ED stated there were so many rules and regulations to follow it was difficult to watch out for the rights of the residents. Further interview with the Center Executive Director (CED), on 08/23/19 at 4:26 PM, revealed she was aware of some, but not all, of Resident #5's history of behaviors and stated she could not recall if the facility assessed or interviewed all of the residents who observed the sexual behaviors. The CED further revealed the facility did not formally investigate the incidents. According to the CED, the facility considered the behaviors inappropriate or offensive and not an act of intentional abuse. The facility implemented the following actions to remove Immediate Jeopardy: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The Center Executive Director (CED) and the Center Nurse Executive (CNE) notified the Medical Director, on 08/17/19 at 6:29 PM, of the Jeopardy and an ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to develop an action plan. 2. The CNE and the CED initiated an investigation regarding Resident #456, on 08/10/19. 3. The CNE assessed Resident #456, on 08/10/19, and determined the resident's care needs were met. 4. On 08/10/19, the CNE provided re-education to the Licensed Nurse assigned to Resident #456 to insure appropriate staff assignment. 5. The Center Nurse Practitioner (NP) re-assessed Resident #26, on 08/12/19, with no abnormal findings. 6. The CNE filed an initial report of abuse, on 08/12/19, regarding Resident #26. 7. The CNE placed Resident #5 under one to one (1:1) supervision on 08/15/19, and filed an initial report with the Office of Inspector General. Residents #5 and #26 will remain under 1:1 supervision until psychiatric assessment for ability to consent to sexual acts. 8. The CNE filed an initial report of abuse, on 08/15/19, regarding Resident #5. 9. The CED and the Social Services Director (SSD) reviewed all grievances/concerns received from 09/13/18 to 08/17/19, with no additional findings, to insure all allegations of abuse/neglect, including sexual acts were reported to the Office of Inspector General (OIG), investigated by the facility, and residents protected during the investigation. 10. The CNE, the SSD, the Unit Managers, and the CED interviewed all residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater (eighty (80) of one hundred, seven (107) residents) to insure no allegations of abuse/neglect to include sexual acts. No additional concerns were reported. 11. Licensed nurses conducted body audits of all other residents (twenty-seven (27) of one hundred, seven (107) residents) to insure no evidence of physical trauma with no issues identified. 12. Beginning 08/06/19, Center staff, including agency staff, received education on reporting allegations of abuse and neglect; all allegations of abuse are investigated thoroughly and timely; protection of residents during an abuse investigation; the process for staff who believe their voiced concern was not addressed. A post-test with a one hundred percent (100%) passing grade was required. One hundred two (102) of one hundred twenty-one staff, including agency staff received the education as of 08/19/19. 13. Staff unavailable during this timeframe, including agency staff, were re-educated prior to returning to work. 14. Newly hired staff received the education, including post-test, during orientation by the CED, the Nurse Practice Educator (NPE), or the CNE. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. The Regional [NAME] President of Operations (RVP) educated the CED, CNE, and the SSD, on 08/17/19, regarding the facility abuse prohibition policy, including reporting to the OIG, completing a thorough investigation, and protection of a resident during an investigation. This education was validated with a post-test requiring a 100% passing grade. 16. The CED and/or the CNE reviewed grievances/concerns with the CNE, UMs, SSD, NPE and the Clinical Reimbursement Managers and or Registered Nurse Weekend Supervisor conducted interview with five (5) random residents per hall and five (5) random staff daily for two (2) weeks, including weekends. These interviews insured allegations of abuse or failure to provide care were reported, investigated, and residents protected. 17. The CNE or CED reported findings of audits of grievances/concerns and interviews monthly for six (6) months to the QAPI Committee until the issue was resolved or as determined by the QAPI Committee. The State Survey Agency validated the removal of Immediate Jeopardy as follows: 1. Interview with the Center Nurse Executive (CNE) on 08/22/19 at 2:35 PM revealed she participated in an ad Hoc Quality Assurance Performance Improvement (QAPI) meeting with the Center Executive Director (CED) and the Medical Director on 08/17/19 at 6:29 PM for discussion of the Jeopardy and they developed an action plan. Interview with the Medical Director, on 08/22/19 at 3:53 PM, revealed she participated in an ad Hoc QAPI meeting on 08/17/19 at 6:29 PM and discussed the Jeopardy and development of an action plan. Interview with the CED, on 08/23/19 at 3:55 PM, revealed she participated in an ad Hoc QAPI meeting on 08/17/19 with the CNE and the Medical Director at which time they discussed the Jeopardy and developed an action plan. 2. Interview with the CNE, on 08/22/19 at 2:35 PM, revealed on 08/10/19, she and the CED initiated an investigation regarding Resident #456. Interview with the CED, on 08/23/19 at 3:55 PM, revealed she and the CNE initiated an investigation regarding Resident #456 on 08/10/19. 3. Interview with the CNE, on 08/22/19 at 2:35 PM, revealed she performed and assessment of Resident #456 and determined the resident's care needs were met. 4. Interview with the CNE, on 08/22/19 at 2:35 PM, revealed she provided education to the Licensed Nurse assigned to Resident #456 regarding appropriate staff assignment. 5. Interview with the Center Nurse Practitioner (NP), on 08/23/19 at 3:29 PM, revealed she re-assessed Resident #26 with no abnormal findings. Review of the clinical record revealed an assessment dated [DATE] of Resident #26 indicating no abnormal findings. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Interview with the CNE, on 08/22/19 t 2:35 PM, revealed she completed an initial report of abuse regarding Resident #26 on 08/12/19. Review of facility records revealed a copy of an initial report of abuse, dated 08/12/19, regarding Resident #26. 7. Interview with the CNE, on 08/22/19 at 2:35 PM, revealed she placed Resident #5 under one to one (1:1) supervision on 08/15/19, and filed an initial report of abuse and Residents #5 and #26 will remain under 1:1 supervision until completion of a psychiatric assessment for the ability to consent to sexual acts. Review of facility records revealed documentation of 1:1 supervision completed for Residents #5 and [TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34116 Based on interview, record review, and facility policy review it was determined the facility failed to have an effective system to ensure staff reported allegations of sexual abuse when they occurred and to ensure these allegations were reported to State agencies for one (1) of two (2) of a total sample of fifty-six (56) residents, Resident #26. Record review revealed Resident #5 requested and engaged in sexual acts with Resident #26, including exposure of his/her genitals and masturbation in common areas. Interview with staff revealed these sexual acts were not always reported because the facility was aware and it occurred often. In addition, the facility failed to report the incidents to the required State agencies. The facility's failure to report potential resident abuse has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 08/13/19 and was determined to exist on 09/13/18. The facility was notified of the IJ on 08/16/19. The facility provided an Acceptable Allegation of Compliance (AOC) on 08/20/19, which alleged removal of the Immediate Jeopardy on 08/20/19. The State Survey Agency verified the IJ was removed on 08/20/19, prior to exit on 08/23/19. The Scope and Severity was lowered to a D while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systematic changes. The findings include: Review of the policy Abuse Prohibition, revised 07/01/19, revealed the purpose of the policy was to ensure the Center staff were doing all that was within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property. The policy revealed staff would identify events - such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse - and determine the direction of the investigation. Anyone who witnessed an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property was to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. The notified supervisor would report the suspected abuse immediately to the Center Executive Director (CED) or designee and other officials in accordance with state law. All reports of suspected abuse must also be reported to the patient's family and attending physician. Further review of the policy revealed upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee would perform the following: enter allegations in to the Risk Management System (RMS); report allegations involving abuse (physical, verbal, sexual, mental) not later than two (2) hours after the allegation was made. The policy revealed the CED or designee would notify local law enforcement, Licensing Boards and Registries, and other agencies as required. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 08/07/19 at 10:00 AM, with Resident #5, who the facility assessed with a Brief Interview for Mental Status (BIMS) score of 10 out of 15 and determined the resident was interviewable, revealed the resident exposed his/her genitals to another resident in the main dining room. Review of the Advanced Practice Registered Nurse (APRN) progress note, dated 09/13/18, revealed Resident #5 exposed his/her genitals and asked another resident to perform a sexual act. Further review of the PPEs, dated 10/05/18, revealed Resident #5 was increasingly sexually acting out, made sexual contact with a female peer, and had approached other peers. Further review of APRN notes, dated 10/05/18, revealed Resident #5 engaged in oral sex with another resident. Review of the nursing progress notes revealed Resident #5 masturbated in the dining room on 09/28/18, exhibited inappropriate behavior with another resident in the dining room on 11/22/18; reportedly requested another resident to perform a sexual act on 05/07/19; exhibited inappropriate behavior in the television room on 06/10/19; and exposed his/her genitals in the outdoor courtyard on 06/20/19. Further review of the Psychiatric Periodic Evaluation (PPE), dated 06/18/19, revealed Resident #5 had exposed him/herself several times. Interview, on 08/07/19 at 1:16 PM, with Resident #26, who the facility assessed with a BIMS score of ten (10) out of fifteen (15) and determined the resident was interviewable, revealed his/her friend, Resident #5 put his/her genitals in his/her month two (2) times. Resident #26 stated, It hurt and it did not feel good. Review of the Center Nurse Executive (CNE) progress note, dated 05/07/19, revealed Resident #26 reported Resident #5 asked him/her to perform oral sex in the main dining area. Interview with Dietary Aide (DA) #1, on 08/15/19 at 12:07 PM, revealed she observed Resident #5 with his/her genitals exposed standing next to Resident #26 in the dining room. The DA further revealed she did not report the incident and stated she thought the facility was aware of the behavior because it had happened before. She revealed it was important to report suspected abuse to ensure residents were protected. Interview with Licensed Practical Nurse (LPN) #17, on 08/15/19 at 10:31 AM, revealed requests for sexual acts, exposure of genitals, and masturbation in a common area would be considered sexual behaviors. The nurse further revealed any sexual activity between residents should be reported to the CNE to determine if both parties were cognitively aware. Interview with LPN #8, on 08/11/19 at 2:32 PM, revealed a family member reported Resident #5 exposed his/her genitals in the courtyard. According to LPN #8, she escorted the resident to the administrative office and reported the incident to the CNE. LPN #8 revealed it was important to report suspected abuse to protect residents. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #18, on 08/16/19 at 11:13 AM, revealed a resident reported Resident #5 exposed his genitals and approached Resident #26 in the television room. The LPN stated he notified the DON of the allegation. Interview with the Center Nurse Executive (CNE), on 08/13/19 at 6:23 PM, revealed in the past Resident #5 and Resident 26 spoke sexual innuendo to each other and stated she was aware of only one sexual act between the residents. According to the CNE, the facility did not report the incident to state agencies because it was considered a consensual relationship. Interview with the Center Executive Director (CED), on 08/13/19 at 9:38 PM, revealed she was responsible to oversee the operation of the total Center. She revealed reporting was not her sole responsibility and stated she, the CNE, and the Interdisciplinary Team discussed the criteria for reporting with each incident. According to the CED, ultimately, either she or the CNE made the decision to report and she would override the decision if she disagreed. Further interview with the CED on 08/23/19 at 4:26 PM, revealed she was aware of some, but not all, of Resident #5's behaviors and stated the facility considered them inappropriate but not an act of sexual abuse. 40366

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on interview, record review, and facility policy review it was determined the facility failed to have an effective system to investigate allegations of sexual abuse and to protect residents from further potential abuse for one (1) of two (2) of a total sample of fifty-six (56), Resident #26. Resident #5 performed a sexual act with Resident #26, made requests for oral sex, exposed his/her genitals, and masturbated in the presence of Resident #26 and other residents; however, the facility failed to investigate the allegations to prevent potential abuse and ensure resident safety. The facility's failure to investigate an allegation of potential abuse has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 08/13/19 and was determined to exist on 09/13/18. The facility was notified of the IJ on 08/16/19. The facility provided an Acceptable Allegation of Compliance (AOC) on 08/20/19, which alleged removal of the Immediate Jeopardy on 08/20/19. The State Survey Agency verified the IJ was removed on 08/20/19, prior to exit on 08/23/19. The Scope and Severity was lowered to a D while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systematic changes. The findings include: Review of the policy Abuse Prohibition, revised 07/01/19, revealed the Center would implement an abuse prohibition program through screening of new hires; training of employees (both new employees and ongoing training for all employees); prevention of occurrences; identification of possible incidents or allegations which need investigation; investigation of incidents and allegations; protection of patients during investigations; and reporting of incidents, investigations, and Center response to the results of their investigations. Further review of the policy revealed upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Center Executive Director (CED) or designee would perform the following: initiate an investigation within 24 hours of an allegation of abuse that focused on whether abuse or neglect occurred and to what extent; clinical examination for signs of injuries, if indicated; causative factors; and interventions to prevent further injury. The policy revealed the investigation would be thoroughly documented in the Risk Management System (RMS) ensuring documentation of witnessed interviews was included. The policy further revealed the Center would protect patients from further harm during an investigation; provide the patient with a safe environment by identifying persons with whom he/she feels safe and conditions that would feel safe; and assign a representative from Social Services or designee to monitor the patient's feelings concerning the incident, as well as the patient's involvement in the investigation. Review of the clinical record revealed the facility admitted Resident #5 on 07/01/17 with diagnoses to include Major Depressive Disorder, Dementia without Behavioral Disturbance, Hypertension and, on 10/05/18, the facility added an additional diagnosis of Impulse Disorder. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #5 with a Brief Interview for Mental Status score of ten (10) out of fifteen (15) and determined the resident was interviewable. Interview, on 08/07/19 at 10:00 AM, with Resident #5 who the facility assessed with a Brief Interview for Mental Status (BIMS) score of ten (10 out of fifteen (15) and determined the resident was interviewable, revealed the resident exposed his/her genitals to another resident in the main dining room. Review of the Advanced Practice Registered Nurse (APRN) progress note, dated 09/13/18, revealed Resident #5 exposed his/her genitals and asked a resident to perform a sexual act. Further review of the Psychiatric Periodic Evaluations (PPEs), dated 10/05/18, revealed Resident #5 was increasingly sexually acting out, had contact with a female peer, and had approached other peers. The evaluation revealed the resident was aware the female peer could not give consent and therefore could not be a willing participant in sexual behavior. Further review of Advanced Practice Registered Nurse (APRN) notes, dated 10/05/18, revealed Resident #5 engaged in oral sex with another resident. The ARNP informed Resident #5 sexual behaviors were not allowed as the other resident was unable to give consent. Review of Resident #5's nursing progress notes revealed the following behaviors: on 09/28/18 the resident masturbated in the main dining room; on 11/22/18 the resident exhibited inappropriate behavior with another resident in the main dining room; on 05/07/19 the resident reportedly requested another resident to perform a sexual act; on 06/10/19 the resident exhibited inappropriate behavior in the tv room; and on 06/20/19 the resident exposed his/her genitals in the outdoor courtyard. Further review of the PPEs, dated 06/18/19, revealed Resident #5 had exposed him/herself several times. Review of nursing progress notes for Resident #26, dated 06/16/19, revealed Resident #26 reported feeling unsafe and no longer wanted to live at the facility. Resident conveyed something had happened but did not elaborate, later refused to go to bed, and preferred to sit at nurse's station. Interview with Licensed Practical Nurse (LPN) #8, on 08/11/19 at 2:32 PM, revealed a family member notified her Resident #5 was exposing his/her genitals in the courtyard. The LPN stated she escorted the resident to the Administrative office and reported the incident to the Center Nurse Executive (CNE). Further interview with LPN #8 revealed she did not provide a written statement and did not know if the facility investigated the incident. LPN #8 revealed it was important to investigate alleged abuse to ensure residents were protected. Interview with LPN #18, on 08/16/19 at 11:13 AM, revealed several residents reported Resident #5 exposed his genitals and approached Resident #26 in the tv room. LPN #18 revealed he reported the incident to the CNE; however, he was not asked to provide a written statement and was not aware if the facility investigated the incident. The nurse stated Resident #26 had an intellectual disability and he was concerned with his/her ability to consent. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #17, on 08/15/19 at 10:31 AM, revealed any sexual activity between residents should be reported to the CNE to determine if both parties were cognitively aware. Interview with the Social Services Director (SSD), on 08/13/19 at 5:04 PM, revealed an allegation of abuse should be reported immediately to the CNE and CED to begin an investigation. She further revealed the facility interviewed residents and staff as part of the investigation process and stated the most important thing was to ensure resident safety. Further interview with the SSD revealed the facility considered Resident #5 and Resident #26's sexual relationship consensual; however, Resident #26 was not assessed by a professional to ensure he/she was competent to consent. Interview with the CNE, on 08/13/19 at 6:23 PM, revealed the facility did not conduct a formal investigation(s) of Resident #5's sexual behaviors or sexual encounters with Resident #26 and stated the relationship was consensual. According to the CNE, Resident #26 could consent to the relationship at the time of the encounter(s); however, he/she was appointed a legal guardian. Interview with the Center Executive Director (CED), on 08/23/19 at 4:26 PM, revealed she was aware of some, but not all, of Resident #5's sexual behaviors. She revealed the facility did not formally investigate the incidents involving Resident #5's sexual behaviors or his/her sexual interactions with Resident #26. The CED stated the issues were considered more behavioral and not an act of sexual abuse.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 28733 Based on interview, record review, and policy review it was determined the facility failed to ensure Minimum Data Set (MDS) information was transmitted timely for one (1) of fifty-six (56) sampled residents (Residents #1) where data submission exceeded one hundred-twenty (120) days. The findings include: Request of the facility's policy related to the Automated Data Processing Requirements revealed the facility did not have a specific policy. Interview with MDS Nurse #1, on 08/15/19 at 10:15 AM, revealed the facility followed the CMS (Centers for Medicare and Medicaid) requirements for transmission, as the facility did not have a policy. Review of Resident #1's clinical record revealed the facility admitted the resident on 03/06/19 with diagnoses that included Diabetes Mellitus, Hyperlipidemia, and Hypertension. He/she had a planned discharge on 03/22/19. Review of the Batch report revealed the assessment for Resident #1, dated 03/22/19, was transmitted with an accepted date of 08/08/19, or one hundred thirty-nine (139) days after the assessment date. Interview with MDS Coordinator #2, on 08/15/19 at 10:09 AM, revealed she started working in the department in March, 2019. She stated she was not familiar with any processes on how to look for missing MDS transmissions. She did not know how or where to look for any missing MDS submissions. Interview with MDS Coordinator #1, on 08/15/19 at 10:15 AM, revealed she was responsible for data submissions. She stated she preferred to submit data daily, and at minimal, twice weekly. MDS Coordinator #1 stated she looked in the computer system to make sure all submissions were submitted. She stated all Omnibus Budget Reconciliation Act (OBRA), and Prospective Payment System (PPS) assessments were submitted unless for private insurance and private pay individuals whose assessments were not submitted. Further interview revealed she depended on her software program to audit and flag when the next type of submission was needed or updated and her computer system provided a flag with a next due date, and which resident was due next. She stated she reported directly to the Center Executive Director (CED). She stated the form utilized included two (2) check boxes, one (1) to submit data and one (1) box for do not submit data and she inadvertently checked the do not submit box instead of the submit box. MDS Coordinator #1 stated by not checking the correct submit box the data was not submitted. She stated that Residents #1 was checked wrong and the data was not submitted, therefore the discharge was not submitted to CMS. She stated Resident #1 was discharged without anticipated return. Further interview revealed she had fourteen (14) days to submit the data after completion and she had no other audit system in place to track discharges. She stated Resident #1's data submission exceeded one hundred-twenty (120) days. Interview with the CED, on 08/23/19 at 4:26 PM revealed she had not identified previous concerns related to timely submission of MDS data.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 28733 Based on observation, interview, record review, and facility policy review it was determined the facility failed to develop the baseline care plan for one (1) of fifty-six (56) sampled residents (Resident #456). Resident #456 did not have a base line care plan initiated within forty-eight (48) hours, per facility policy. The findings include Review of the facility's policy, Person-Centered Care Plan, revised 07/01/19, revealed the center developed and implemented a baseline person-centered care plan within forty-eight (48) hours for each patient (resident), which included the instructions needed to provide effective and person-centered care that met professional standards of quality care. Further policy review revealed the practice standards for the baseline care plan must be developed within forty-eight (48) hours, and include the minimum healthcare information necessary to properly care for a patient including, but not limited to initial goals based on admission orders, physician orders, dietary orders, social services, and Pre-Admission Screening and Resident Review (PASRR) recommendation, if applicable. Policy review revealed a comprehensive care plan may be developed in place of a baseline care plan if developed within forty-eight (48) hours, and met the requirements for a comprehensive care plan. Review of the clinical record revealed the facility admitted Resident #456 on 08/07/19 with diagnoses that included Recurrent Seizures with a History of Seizures, Peripheral Artery Disease (PAD), Acute Encephalopathy, Hypertension, Pulmonary Infiltrate, Cardiomyopathy, Acute Systolic Congestive Heart Failure, Aortic Stenosis, Aortic and Mitral Regurgitation. Further review revealed the facility developed the baseline care plan seventy-two (72) hours after admission, on 08/10/19. Review of Resident #456's baseline care plan, dated 08/10/19, revealed his/her care plan for loss of interest and appetite, and at nutritional risk focus, revealed the goal and interventions were created on 08/10/19. His/her baseline care plan focus, goals, and interventions for risk of complications related to Antibiotic Use for Urinary Tract Infection (UTI), Psychotropic Drugs Use, Seizure Activity, Risk for Skin Breakdown was initiated and created on 08/10/19. Interview with Minimal Data Set (MDS) Coordinator #1, on 08/15/19 at 12:10 PM, revealed the care plan provided an overall detailed picture of the resident's needs with goals. Further interview revealed staff added interventions to accomplish the goals identified. She stated she was not aware Resident #456's initial care plan needed to be completed in forty eight (48) hours, nor that Resident #456's initial care plan was not completed timely. The MDS Coordinator stated it was her responsibility to add the interventions on all focus areas identified and the goals; and, that the care plan was not completed timely. She further stated the interventions were to be put into place so the resident could accomplish his/her goals. She stated the MDS department reported directly to the Center Executive Director, and not to the nursing department. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Center Executive Director (CED), on 08/23/19 at 4:26 PM, revealed the care plans were personalized person centered and described the resident and their history, as well as what was going on with them. The CED stated the facility reviewed care plans every day. She stated when a baseline care was not initiated for three (3) days, there was a potential for the resident not to get all the care needs met In addition, if a plan was not developed the total care needs of the resident would not be provided by staff and the lack of a care plan potentially could impact resident care.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35750 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to implement the care plan for two (2) of three (3) sampled residents out of a total sample of fifty-six (56) residents (Resident #25, #46). Resident #46 was care planned for alteration in comfort related to his/her fracture of the radius and muscle spasms. However, nursing staff did not know about the resident's fracture and certified nursing assistant (CNA) #3 repositioned the resident in his/her bed by pulling on the resident's fractured wrist. In addition, staff did not assist Resident #25 with a change of clothing. The findings include: Review of the facility's policy Pain Management revised 03/01/18, revealed residents were evaluated as part of the nursing assessment process for the presence of pain upon admission/readmission, quarterly, with change in condition or change in pain status, and as required by the state thereafter. Pain management consistent with professional standards of practice, the comprehensive person-centered care plan, and the patient's goals and preferences is provided to residents who require such services. The purpose of the policy was described to maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain. Review of the facility's policy Person-Centered Care Plan, revised 07/01/19, revealed the facility focused on the resident as the locus of control and supported the resident in making his/her own choices to have control over his/her daily life. The purpose of the policy was to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and to eliminate or mitigate triggers that may cause re-dramatization of residents, as well as to promote positive communication between residents, resident representatives, and team to obtain the resident's input into the plan of care and ensure effective communication and optimize clinical outcomes. 1. Interview, on 08/06/19 at 3:31 PM, with Resident #46 revealed the resident had a fracture on his/her left wrist. Resident #46 stated he/she had a pain level of seven (7) out of ten (10). Observation, on 08/07/19 at 10:17 AM, of Resident #46 revealed he/she was on his/her cellular phone and wiped tears away. The resident stated, I have a pain level of ten (10) out of ten (10) and got the Tylenol about ten (10) minutes ago. Before the CNA pulled me over using my broken wrist, it was not as bad. The resident stated when the CNA pulled him/her over to change him/her, he/she screamed out in pain. The resident stated the CNA may not have known about his/her broken wrist. Observation and interview, on 08/07/19 at 10:40 AM, of Resident #46 revealed the resident was crying, and touched his/her wrist and stated it hurt, and in pain. Interview with Resident #46 on, 08/08/19 at 11:58 AM revealed he/she experienced a pain level of three (3) out of ten (10) and he/she had not received his/her Tylenol, but he/she had gotten the other morning medications. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the clinical record for Resident #46 revealed the facility admitted the resident on 05/13/19 with diagnoses including Epilepsy, Obesity, Anxiety Disorder, Major Depressive Disorder, Atrial Fibrillation and Nondisplaced Fracture of Neck of Left Radius, Seaquale. Review of Resident #46's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) and determined the resident was interviewable. Continued review of the MDS revealed the facility assessed Resident #46's bed mobility as extensive assistance by two (2) staff. The facility determined Resident #46 had frequent moderate pain and determined through a pain assessment interview that Resident #46's pain affected the resident's function. Review of Resident #46's Comprehensive Care Plan, dated 06/19/19, revealed the resident required assistance with his/her performance of Activities of Daily Living (ADLs) related to decreased functional mobility, morbid obesity and bed mobility and was at risk for alteration in comfort related to a fracture of the radius and muscle spasms. Interventions care planned included to observe for shortness of breath, fatigue and/or change of condition. Also to administer muscle relaxants as needed for spasms, and advise the resident to request pain medication before pain became severe. In addition, nursing staff was to assist Resident #46 to a positron of comfort utilizing pillows and appropriate positioning devices. Review of Resident #46's Nurse Aide Care Plan, on 08/07/19 at 2:43 PM, with Certified Nursing Assistant (CNA) #3 on the mini Kiosk, revealed the facility had no information about the resident's broken wrist or his/her pain issue, and no interventions related to observing for pain, and/or being cautious with the resident's fractured left wrist, to alert CNA's to the fracture. Review of Resident #46's Initial Nursing Assessment, dated 05/13/19, revealed the facility assessed the resident to have experienced pain in his/her left wrist that was sharp, aching produced soreness and was worse on movement and pain got worse with movement and position. Review of Resident #46's Physician Progress Note dated 08/08/19 revealed the Advanced Practice Nurse indicated the resident had left wrist pain and was prescribed Norco 5-325 milligram (mg), by mouth, every eight (8) hours as needed (PRN) related to left wrist pain and to continue Tylenol 650 mg, by mouth, every four (4) hours PRN. Review of Resident #46's Medication Administration Record (MAR) from 08/01/19 through 08/07/19 revealed a zero (0) pain level for the August 7th day shift. However, the resident reported a pain level of ten (10) out of ten (10) on the pain scale to the State Surveyor after CNA #3 had repositioned him/her pulling on the resident's wrist. Interview, on 08/07/19 at 2:43 PM, with CNA #3 revealed she was not told in report Resident #46 had a fractured wrist or had pain in his/her hand. She stated all staff should know the resident had a broken hand/wrist. However, as CNA #3 reviewed the Kiosk related to ADL care and pain, she was unable to find any documentation related to monitoring for pain or any caution on touching the fractured wrist. CNA #3 stated the aide's care plan should have the issue documented in the Kiosk since all CNA's could access it. The CNA stated she expected to receive the information during shift report; however, she had not been told by the CNA on the previous shift. (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 the [NAME] Hall Unit Manager, on 08/13/19 at 11:55 AM, revealed the facility did not provide a report sheet with the residents' names or care areas to CNA's. She stated the facility had an electronic Kiosk. Interview, on 08/13/19 at 11:32 AM, with CNA #22 revealed she wrote her assigned residents' care needs down on a blank piece of paper since this was only her second (2nd) day at the facility. She stated she did this because she wanted to know if the residents were incontinent and to know how to transfer/reposition residents assigned to her, and the facility did not provide a report sheet. Interview, on 08/16/19 at 10:29 AM, with Licensed Practical Nurse (LPN) #14 revealed she was the nurse for Resident #46 on 08/07/19. The resident told her the CNA had accidentally grabbed his/her arm as they had turned him/her over before the resident could tell the CNA. After the incident, the resident reported more pain than usual to her. The LPN stated she thought CNA's were aware of the resident's wrist fracture. LPN #14 stated the resident was a reliable reporter and if he/she had reported a pain level of ten (10) out of ten (10) she believed the resident who usually had a pain level of four (4) or five (5) out of ten (10). She further stated pulling the resident on the broken wrist could make the break worse. However, she had not told the CNA's about Resident #46's broken wrist or pain issue but thought it was on the Aide Care Plan. LPN #14 stated the facility had mostly agency staff in the building and it was hard to maintain continuity of care for the residents. She stated the aides rotated a lot and there was often all new staff, which affected the residents. LPN #14 stated the aide should not have grabbed the wrist to reposition Resident #46 and it was a lack of communication between nursing staff. Interview, on 08/16/19 at 10:58 AM, with the Minimum Data Set (MDS) Coordinator revealed she was aware Resident #46 was frequently in pain, which resulted in difficulty sleeping at night for the resident. She stated the resident's pain was moderate to severe and it was the responsibility of nursing staff to be aware of the pain issue and nurse's responsibility to educate CNA's about the resident's pain and fractured wrist. Interview, on 08/13/19 at 3:31 PM, with the Center Nurse Executive (CNE) revealed the staff could look at the Kiosk which was updated with the resident's information to find out if a resident had a pain issue or fracture; a second way for CNA's to receive the information was during report. The CNE stated since the CNA did not know about the fractured wrist of Resident #46 it could have caused more harm to the resident. The CNE reviewed the NP's progress note and stated she had communicated the treatment plan with Resident #46 and his/her nurse. The NP added a diagnosis of Left Wrist Pain. She stated she expected nurses to assess resident pain, administer pain medication as ordered and contact the provider for further orders if not effective. Interview with the Center Executive Director (CED), on 08/23/19 at 4:26 PM revealed resident specific care plans described the resident and the care staff provided. She stated the facility had not identified issues with staff's failure to implement care plan interventions, but stated failing to follow a care plan affected the care staff provided to the residents. 34116 2. Observation, on 08/10/19 at 3:30 AM, revealed Resident #25 fully dressed with a round, darkened area from the crotch of his/her pants extending down the inner thighs to the knees. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the clinical record revealed the facility admitted Resident #25 on 02/18/15 with diagnoses to include Heart Failure, Diabetes Mellitus Type 2, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Retention of Urine, and Chronic Kidney Disease. Review of the Annual Minimum Data Set (MDS), dated [DATE], revealed Resident #25 required the assistance of one (1) person for toileting and dressing. Further review of the clinical record revealed a Physician's Order, dated 05/26/18, for Lasix (diuretic) 40 mg (milligrams) daily for edema. Review of the resident's Care Plan revealed Resident #25 sometimes refused incontinent care, refused to change clothes, and refused assistance when going to bed. The care plan included an intervention to allow staff to assist with care. Further review of the Care Plan revealed the resident required assistance for ADL (activity of daily living) care related to limited mobility and kidney disease. Interventions included evaluating him/her for pain prior to activity. Interview with CNA #7, on 08/10/19 at 3:50 AM, revealed Resident #25 sometimes refused care and she usually left the resident alone until he/she calmed down. Interview with CNA #5, on 08/10/19 at 3:52 AM, revealed interventions for refusal of care could include talking to the resident or offering a snack. Further interview with CNA #7, on 08/10/19 at 5:39 AM, revealed Resident #25's care plan for ADL's and incontinent care was not implemented. Interview with Licensed Practical Nurse (LPN) #8, on 08/11/19 at 2:32 PM, revealed Resident #25 was prescribed a diuretic and should be checked frequently for incontinence. Interview with LPN #19, on 08/16/19 at 9:10 AM, revealed the purpose of the care plan was to communicate the resident's care needs. LPN #19 stated the assigned nurse and the Unit Manager (UM) were responsible for ensuring the care plan was implemented as needed. Interview with LPN #17, on 08/15/19 at 10:31 AM, revealed care plan interventions should be monitored to ensure they were effective. Interview with the Unit Manager (UM) for the North hall, on 08/23/19 at 1:42 PM, revealed the interdisciplinary team (IDT) reviewed care plans daily to ensure interventions were in place and residents received all care needed. However, they had not identified any issues with Resident #25's care provided. Interview with the ADON (Assistant Director of Nursing), on 08/23/19 at 3:29 PM, revealed the staff should implement the interventions on the plan of care to ensure resident care needs were met. The ADON stated the facility had not identified any issues with Resident #25's care provided. Interview with the Center Executive Director, on 08/23/19 at 4:26 PM, revealed the facility had not identified any trends related to ADL care or implementation of care plans.

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35750 Based on interview, record review, and facility policy review it was determined the facility failed to ensure resident care plans were revised to meet care needs for one (1) of one (1) sampled residents out of a total of fifty-six (56) total residents (Residents #106). Resident #106's Care Plan was not updated with interventions related to the resident's new diagnosis of Pneumonia with Antibiotic therapy or any interventions related to this diagnosis. In addition, licensed nursing staff failed to monitor the resident for edema related to his/her diagnosis of Congestive Heart Failure; the resident died at the facility. Review of Resident #106's clinical record revealed no updates for the intervention given by the Advanced Practice Registered Nurse (ARPN), to elevate the resident's left lower extremity (LLE) and left upper extremity (LUE) was elevated at least four (4) times a day above the resident's heart and that his/her care plan was updated with the ordered interventions. The findings include: 1. Review of the facility's policy Person Centered Care Plan, revised [DATE], revealed the focus of the care plan was the resident's locus of control and supported the resident in his/her own choices and having control over his/her daily life. Further review revealed the resident had the right to participate in the development and implementation of the person-centered care plan; could request meetings and revisions to the person-centered care plan, was informed in advance of changes and was able to see his/her care plan and the right to sign after significant changes to his/her care plan. The care plan was prepared by the Interdisciplinary Team which included the physician, a registered nurse and an aide with the responsibility for the resident. Care plans were communicated to the appropriate staff, the resident; his/her decision maker/family. Care plans were reviewed and revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments and as needed to reflect the response to care and changing needs and goals and the revisions were document on the care plan evaluation note. 1. Resident #106's clinical record review revealed the facility admitted the resident on [DATE], with diagnoses including Lymphedema not Elsewhere Classified, Chronic Kidney Disease Stage 3, Essential Hypertension, Personal History of Venous Thrombosis, Acute on Chronic Combined Systolic (congestive) and Diastolic (congestive) Heart Failure, Localized Edema and Pneumonia. Resident #106's Quarterly Minimum Data Set (MDS) review, dated [DATE], revealed the facility assessed the resident with Brief Interview for Mental Status score (BIMS) of ,d+[DATE], and determined the resident would have been interviewable and able to make his/her needs known with clear speech and was understood. The facility determined the resident's admission weight was 433 pounds. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #106's Comprehensive Care Plan review revealed, the resident's focus areas included the risk for respiratory complications related to Sleep Apnea and Congestive Heart Failure (CHF). The goal was written as the resident would be free of atelectasis as evidenced by increased breath sounds until the next Target Date which was [DATE]. Interventions included to obtain laboratory tests as ordered and report them to the physician (a complete or partial collapse of the entire lung or area) as indicated, to encourage the resident to express his/her feelings of fear and anxiety and to provide verbal and non-verbal support to the resident, and to provide oxygen at 2 liters per minute (LPM) per nasal cannula (NC) to use when the resident was in bed; he/she was able to remove the oxygen as needed. The facility determined the resident was also at risk for skin break down. On [DATE], the facility added edema to lower extremities to the care plan with interventions of observing for signs/symptoms of skin breakdown, to encourage the resident to elevate his/her legs as much as possible and to follow orders by the physician. However, the review revealed the facility had not updated the care plan related to the resident's recent diagnosis of Pneumonia and the Antibiotic therapy ordered by the Advanced Practice Registered Nurse (APRN), nor had nursing staff updated the care plan with additional interventions related to the resident's respiratory system. Resident #106's Progress Note, dated [DATE] at 5:46 PM, by Licensed Practical Nurse (LPN) #19 documented the resident's vital signs and communicated the Change in Condition to the Nurse Practitioner. The NP gave orders for Levaquin 750 grams (gm), per mouth (PO), for seven (7) days and Probiotic PO, twice a day (BID) for ten (10) days. Resident #106's APRN evaluation documentation review, dated [DATE], revealed she ordered Lasix twenty (20) milligram (mg), by mouth (PO), every morning (q AM) times four (4) days, in addition to the Lasix forty (40) mg already ordered. She also ordered Resident #106's daily weight to be obtained at the same time each day for five (5) days and then weekly weight to be taken on each Tuesday. Further orders included a STAT (now) chest x-ray, CBC/CMP/BNP (lab tests) for the next morning. Further review revealed nursing staff was to elevate the resident's LUE and LLE above the level of the heart for thirty (30) minutes at least four (4) times daily related to the resident's edema. The APRN wrote all other medications were to be continued and nursing staff was to follow up with the laboratory results. She ordered nursing staff to monitor Resident #106 closely and documented she had communicated her treatment plan and orders with the resident and his/her nurse on [DATE] at 10:55 PM. Review of Laboratory Results, dated [DATE], revealed Resident #106's B-type Natriuretic Peptide (B-type natriuretic peptide (BNP), a hormone produced by the heart and levels go up when heart failure develops or gets worse, and levels goes down when heart failure is stable. BNP levels are higher in patients with heart failure than people who have normal heart function) results showed a critical High level of 3226.5 picograms per milliliter (pg/ml), normal range ,d+[DATE] pg/ml. Resident #106's Medication Administration Record (MAR) review for [DATE] revealed nurses had not transcribed the order by APRN, dated [DATE], to elevate the resident's left lower extremity (LLE) and the left upper extremity (LUE) at least four (4) times a day above the heart level related to his/her edema. However, licensed nursing staff continued to follow an old order dated, [DATE], to elevate the LUE on a pillow, three (3) times a day. There was no documented evidence licensed nursing staff monitored the resident's LLE edema, or elevated the left leg above the resident's heart as ordered by the NP on [DATE]. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #106's MAR review for [DATE] revealed the resident's daily weight was supposed to be obtained by nursing staff from [DATE] through [DATE]. However, the actual weight was documented only one (1) time by nursing staff on the Daily Skilled Note on, [DATE] at 1:02 PM, as 345.5 pounds by LPN #19. However, there was no documented evidence the resident's weight was obtained by nursing on, [DATE] or [DATE], as ordered by the NP although it was checked off on the MAR. Interview with Registered Nurse (RN) #3, on [DATE] at 2:43 PM, revealed he was familiar with Resident #106, and had provided care for the resident during some shifts at the facility. The RN stated the resident died before he came on shift. RN #3 stated the resident had been sick that past week, with Pneumonia. Continued interview with RN #3, on [DATE] at 3:47 PM, revealed he started his shift on [DATE] at 6:30 PM and probably was the only RN in the building. He was told Resident #106 was dead and was asked to pronounce Resident #106's death. He visualized the resident between 6:30 PM and 7:00 PM, and stated the resident had no heart rate (HR); however, the RN could not remember if he took the resident's blood pressure (BP), but he stated he looked at the resident's eyes. He stated, I merely did a note that he died as it was part of his duties as the RN in the building. He further stated, if there were any medications left on the MAR he documented the person was either no longer at the facility, or deceased . RN #3 stated he expected the nurses to complete a change of condition assessment when the resident had gotten sick and was on Antibiotic therapy, He stated nursing should record a follow up in the medical record, related to resident findings such as temperature obtained, breath sounds heard and the oxygen saturation levels. Interview with Licensed Practical Nurse (LPN) #6, on [DATE] at 12:25 PM, revealed she was on duty when Resident #106 died in the facility. She stated the resident was fine, had no problems, nothing out of the norm. LPN #6 further stated if a resident had Pneumonia the resident's lungs should have been assessed. During further interview, LPN #6 stated she could not remember if the resident had Pneumonia, was on Antibiotic therapy or, if she assessed Resident #106 for edema. She stated the resident died somewhere at the beginning of night shift maybe around 7:00 PM. LPN #6 stated when she found the resident unresponsive she performed a Sternum rub; however, the resident did not respond. The LPN stated Resident #106 required a Respiratory Assessment and was to be checked for swelling/edema due to orders and new diagnosis of pneumonia. The nurse stated it was impossible for us nurses to check everything, it was challenging and to perform actual assessments on everybody was not possible. She stated on most weekends the facility was understaffed, had many call-ins which made it hard on nurses. 41851 2. Review of the facility's policy, Falls Management, revision date [DATE], revealed those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury and actual occurrence of falls. Review of Resident #96's clinical record revealed the facility readmitted the resident on [DATE], with diagnoses including Hematoma to Left Forehead with Small Laceration. (continued on next page)

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	185290	A. Building B. Wing	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed Resident #96 required extensive assistance of one (1) with bed mobility and transfers. The facility assessed Resident #96 to have a Brief Interview for Mental Status score of three (3) of fifteen (15) and determined the resident was not interviewable. Review of the Care Plan for Resident# 96 dated [DATE], revealed the resident was at risk for falls related to decreased mobility and unsteady balance and diagnosis of seizure disorder, poor safety awareness. Interventions included a bed/chair alarm, and for staff to provide verbal cues for safety and sequencing when needed. Review of a facility investigation, Risk Management System Event Summary Report dated [DATE], revealed Resident #96 sustained an unwitnessed fall, and was found on the floor in the resident's room at 4:05 AM with a chief complaint of headache. Interview with the Assistant Director of Nursing (ADON)/Staff Development Coordinator (SDC) on [DATE] at 3:29 PM, revealed care plans should be updated as needed so the staff will know how to care for the residents. Interview, on [DATE] at 4:15 PM, with the Center Executive Director revealed any issues with falls go through Quality Assurance and Performance Improvement Plan Review (QAPI). She stated, We know our frequent falls and with each fall an intervention should be care planned at that time. If there are no interventions for falls the resident would have the potential to fall again.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on interview, record review, and facility policy review it was determined the facility failed to have an effective system to initiate CPR (Cardiopulmonary resuscitation) for two (2) of thirteen (13) sampled residents, Residents #6 and #8. On [DATE], facility staff found Resident #6 unresponsive. The physician's orders revealed Resident #6 was full code status; however, staff failed to initiate cardiopulmonary resuscitation and pronounced the resident expired. In addition, observation on [DATE], revealed an overhead page was called for a code blue to Resident #8's room. Staff was observed to bring a cart containing emergency life saving equipment to the resident's room. However, the cart did not contain an ambu bag to deliver life saving rescue breathing, nor a stethoscope to listen for heart rate and breath sounds. Once the ambu bag was obtained the nursing staff failed to attached oxygen supply to the bag until surveyor intervention, which delayed the life saving measures of rescue breathing. The resident was transferred to an acute care hospital and expired. The facility's failure to provide basic life support has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE] and was determined to exist on [DATE]. The facility was notified of the IJ on [DATE]. The facility provided an Acceptable Allegation of Compliance (AOC) on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. The State Survey Agency verified the IJ was removed on [DATE], prior to exit on [DATE]. The Scope and Severity was lowered to a D while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systematic changes. The findings include: Review of the policy Cardiac and/or Respiratory Arrest, revised [DATE], revealed Regency Center supported the right of every patient to accept or decline cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. The policy revealed the Center would perform CPR on all patients, except in certain limited circumstances, unless there was a written physician's order, agreed to by the patient or health care decision maker, not to resuscitate (DNR), in accordance with state regulation/law. If a patient does not have a DNR order, CPR/AED certified staff would initiate CPR/AED and emergency medical services (EMS) will be activated. Review of the Cardiac and/or Respiratory Arrest Procedure, revised [DATE], revealed upon discovery of a patient in cardiopulmonary arrest (e.g., no apparent pulse, blood pressure, or respiration), staff would immediately call for assistance; alert the licensed nurse and CPR/automated external defibrillator (AED) certified staff; and prepare the patient for CPR/AED while determining the presence of a Do Not Resuscitate order (DNR). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the procedure revealed for witnessed arrest if there was no visual identification of DNR status or no DNR order on the patient's medical record: CPR/AED certified staff would initiate CPR/AED application; call 911 and notify the primary physician; and designate an individual to record events on the CPR/AED Flow Sheet. The procedure revealed CPR should continue until one of the following occurred: It was discovered that the patient had a DNR order; Restoration of effective, spontaneous circulation; care was transferred to a team providing advanced life support (emergency medical services (EMS)); the rescuer was unable to continue because of exhaustion, the presence of dangerous environmental hazards, or because continuation of the resuscitative efforts placed others in jeopardy; or if state regulation allowed licensed nurse to pronounce/certify death, reliable and valid criteria indicating irreversible death were met, criteria of obvious death were identified, or criteria for termination of resuscitation were met. When EMS personnel arrive, they assume responsibility and treatment would be directed by EMS personnel. Notify the family/health care decision maker of the patient's status. The Cardiac and/or Respiratory Arrest Procedure revealed for Unwitnessed Arrest for Patients without a DNR the Registered Nurse (RN) or Licensed Practical Nurse (LPN) would evaluate the patient for obvious clinical signs of irreversible death unless not permitted by state regulation. If at least ONE obvious clinical sign of irreversible death is present, do not initiate CPR. Obvious clinical signs of irreversible death include: Lividity or pooling of blood in dependent body parts (livor mortis); Hardening of muscles or rigidity (rigor mortis); Injuries incompatible with life. If there are no obvious clinical signs of irreversible death, follow section 2 above to initiate CPR/AED. Review of the closed clinical record revealed the facility readmitted Resident #6 on [DATE] with diagnoses to include Pneumonia, Acute Respiratory Failure (ARF), Acute on chronic diastolic (Congestive) Heart Failure (CHF), and Fluid overload. Further review of the clinical record revealed a Physician Order, dated [DATE], for full code status. Review of the Nursing Progress Notes, dated [DATE] at 3:30 PM, revealed Registered Nurse (RN) #4 documented she went in to Resident #6's room at 1:40 PM to administer medication and found the resident unresponsive to verbal and physical stimuli. Vitals were attempted and the body was found cool to touch. Vitals were unable to register and there were no respirations and no pulse. At that point, the resident ceased to breath and a second nurse verified. Further review of the Nursing Progress Notes, dated [DATE] at 3:23 PM, revealed RN #5 documented she was called to the room for help. The resident was unresponsive, cool to touch, and white in color. The pulse oximeter was unable to be read on Resident #6's finger and he/she had no respirations, pulse, and the pupils were unresponsive to light. The nurse documented the resident had ceased to breathe and therefore was pronounced dead at 2:00 PM; however, CPR was not initiated per the resident's wishes for full code status. Interview with Certified Nursing Assistant (CNA) #23, on [DATE] at 2:45 PM, revealed she provided incontinent care for Resident #6 around lunchtime and stated the resident was responsive during care. She further revealed Registered Nurse (RN) #4 discovered the resident unresponsive later in the afternoon during medication pass. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #4, on [DATE] at 2:38 PM, revealed she discovered Resident #6 unresponsive in bed around 1:00 PM. She stated she assessed the resident and was unable to detect a pulse or respirations. The RN revealed she left the bedside to check the resident's code status, saw he/she was a Full Code, and asked another nurse to call a Code Blue because she did not know how to overhead page. Further interview with RN #4 revealed CPR should be performed for a Full Code until EMS arrived or there was a pulse, heartbeat, and respirations; however, she did not initiate CPR on Resident #6 because she was not sure of the code status and other staff were at the bedside by the time she checked. According to RN #4, the resident was cold to touch and showing signs of death by the time everything happened; however, clinical signs of irreversible death were not present as defined in the facility policy. Interview with Licensed Practical Nurse (LPN) #22, on [DATE] at 4:00 PM, revealed he responded to the Code Blue for Resident #6, along with the North Hall Unit Manager (UM), LPN #12, and RN #5. He stated he and RN #5 brought the emergency cart to the room; however, they did not initiate CPR because RN #5 pronounced the resident deceased . Further interview with LPN #22 revealed staff should perform CPR on residents who were a Full Code until EMS arrived or the resident was pronounced deceased ; however, Resident #6 was pronounced deceased before staff knew he/she was a Full Code. Interview with LPN #12, on [DATE] at 3:44 PM, revealed she and the North Hall UM responded to the Code Blue for Resident #6 and stated she could see the resident was already deceased because of the color and temperature of his/her skin. LPN #12 stated CPR had to be done for a Full Code whether the resident looked deceased or not; however, she did not initiate CPR. Interview with RN #5, on [DATE] at 2:08 PM, revealed she responded to the Code Blue for Resident #6. She stated when she entered the room RN #4 and the North Hall UM were at the bedside and instructed her to call 911; however, she did not observe either nurse performing CPR. RN #5 revealed the procedure for a Full Code included assessment for absence of pulse/respirations, initiating and continuing CPR until the resident started breathing on their own or until medical help arrived. The nurse revealed Resident #6 was a Full Code; however, she did not initiate CPR because she was not sure of what was going on. Further interview with RN #5 revealed the resident's skin was pale and looked like he/she was already gone. She revealed she observed for rise/fall of the chest, saw there was no reading on the pulse oximeter and stated she looked at the resident's face; however, she did not assess the pupils with a pen light. According to RN #5, she acted under the direction of the North Hall UM when she pronounced the resident deceased at 2:00 PM. Interview with the North Hall UM, on [DATE] at 2:22 PM, revealed she responded to Resident #6's room for a Code Blue and stated when she got to the room staff were trying to obtain vital signs; however, no one was performing CPR. According to the UM, the resident was deceased because he/she was discolored, ashen, the pupils were fixed, and there were no vital signs. The UM stated she informed RN #5 she could call the time of death because she was a Registered Nurse. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further interview with the UM revealed CPR should be started immediately if a resident was a Full Code and there was not every sign of death; however, Resident #6 had expired and it was in the facility's Cardiac and/or Respiratory Arrest Procedure that an RN could call death if there were no signs of life. The UM revealed clinical signs of irreversible death included discolored skin, fixed pupils, no heartbeat, pulse, or oxygen saturation. Interview with the Interim Center Nurse Executive (CNE), on [DATE] at 2:47 PM, revealed CPR should be started on an unresponsive resident with a Full Code status; however, CPR would not be initiated if there were obvious clinical signs of death. The CNE revealed she did not know if Resident #6 had irreversible signs of death and stated nursing documentation for Resident #6 indicated irreversible death because the resident's body was cold. Interview with Advanced Practice Registered Nurse (APRN) #2, on [DATE] at 3:24 PM, revealed staff should call a code and start CPR upon discovering an unresponsive resident who was a Full Code. According to the APRN, physical brain cell death began after approximately four to six minutes of no blood flow, which could not be estimated if a person was found unresponsive. Review of the Emergency Medical Services (EMS) Patient Care Record for Resident #6, dated [DATE], revealed EMS arrived on scene at 2:08 PM. According to the assessment note, dated [DATE] at 2:40 PM, the Fire Department arrived on scene a couple of minutes before EMS and was advised by a nurse that she called time of death at 2:00 PM and they were not needed. Further review revealed no CPR was being performed when EMS arrived and EMS advised the Fire Department to initiate CPR. The note revealed the resident was intubated at 2:19 PM with complications to include patient vomiting/aspiration. According to the record, EMS discontinued CPR at approximately 2:43 PM per Medical Control Order and the resident was pronounced expired. 28733 2. Review of the facility's policy titled, Emergency Cart, review dated [DATE] and revision dated [DATE] revealed the facility would maintain at least one (1) emergency cart per nursing care floor. Emergency carts would contain all supplies required to establish and sustain basic life support. Equipment from the emergency cart would be used only when emergency care was provided. Equipment taken from the emergency cart would be identified and replaced promptly. The emergency cart would be checked every twenty-four (24) hours, and after every use. The Emergency Cart Checklist purpose ensured all supplies critical to basic life support were readily available on the emergency cart. Review of Resident # 8's clinical record revealed the facility admitted the resident on [DATE] with the diagnoses of Chronic Obstructive Pulmonary Disease, Essential Hypertension, Heart Failure, Chronic Atrial Fibrillation, and Wedge Compression Fractures of the First, Second, and Third Vertebra. Continued review of the medical record revealed the resident had a full code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This surveyor heard a Code Blue overhead paged, on the [NAME] Hall to room [ROOM NUMBER], on [DATE] at 2:14 PM, and observed one staff came around from the nurse's station rushed down the corridor carrying an Ambu bag in a plastic bag. Upon arrival to room, a Code Blue was in progress. This surveyor continued to observe the staff person take the Ambu bag into Resident #8's room. Continued observation during the code, a staff member requested a stethoscope and another staff member left the resident's room and returned with a stethoscope. Further observation, revealed the staff initiating life saving measures did not apply oxygen tubing to the ambu bag to deliver oxygen to the resident during rescue breathing, until surveyor intervention. Interview with the RN #2, on [DATE] at 3:05 PM, revealed she was the scribe during the code and the staff had to return to the nurse's station to obtain an Ambu bag, and again to obtain a stethoscope to use during the code. She stated the Ambu bag and the stethoscope were both to be on the emergency cart at all times. She stated not having the essential equipment allowed for potential delays in care and services for the resident during a crisis and a resident potentially could not survive with a delay. Review of the Emergency Cart Checklist, revised [DATE], revealed checklist instructions required staff to mark, yes or no, if the cart was locked. If the cart remained locked, staff were to check external items and replace if anything was missing or expired, and then initial the checklist. Further review of the checklist directions revealed an unlocked cart required staff to check each item and to replace any missing or expired items, then to initial each item on the checklist, then lock the cart. Items listed on the checklist include an Ambu bag, oral airways, cylinder (oxygen), suction catheter/kit, blood pressure cuff, and stethoscope. Review of the [NAME] Unit Emergency Cart checklist, dated November, 2019 revealed the emergency cart was not checked and initialed, on [DATE] through [DATE], being four (4) of six (6) days of the month. In addition, the Ambu bag and the stethoscope was initialed by staff on the checklist, as present on the Emergency Cart Checklist on [DATE]. However, the Ambu bag and a stethoscope was not on the crash cart when the Emergency Cart taken to the resident's room during the Code Blue, on [DATE]. Observation, on [DATE] at 6:10 PM, of the North Hall Emergency Cart with LPN #12 revealed the cart was unlocked and there was no saline, stethoscope, or backboard stored on the cart. Further observation revealed a backboard stored in the UM's office. Review of the North Hall Emergency Cart Checklist, dated [DATE], revealed the nurse documented there were no missing or expired items on the cart. Interview with LPN #12, [DATE] at 3:44 PM, during observation of the cart revealed the 3rd shift nurse was responsible for checking and verifying the contents of the emergency cart. According to LPN #12, the Emergency Cart Checklist was not accurate because there was no saline or stethoscope available on the cart. She stated a resident could potentially be hurt or die if the necessary supplies were not available during an emergency. Interview with the North Hall UM, on [DATE] at 6:30 PM, revealed a stethoscope and saline should be stored on the crash cart for emergencies. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further interview with the North Hall UM, on [DATE] at 2:22 PM, revealed she checked the emergency cart daily to ensure all supplies on the checklist were stocked on the cart. The UM revealed the cart was not locked and she had identified issues with staff removing supplies. She further revealed she notified the previous Assistant Center Nurse Executive and Center Nurse Executive of the issue on multiple occasions; however, nothing was ever done to correct the problem. The UM revealed a resident could die if supplies were not available on the cart during an emergency. Review of the [NAME] Unit Emergency Cart checklist, dated [DATE] revealed an uncompleted emergency cart checklist. The staff did not check and initial for ten (10) of thirty-one (31) days, on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] were. Review of the facility's [NAME] Unit Emergency Cart checklist, dated [DATE] revealed the emergency cart was not checked for emergency items, and initialed, on [DATE], and [DATE], [DATE], [DATE], and [DATE]. Review of the facility's Emergency Cart checklist on the [NAME] Unit, dated [DATE] revealed line items for emergency use on the emergency cart was not checking and initialing by staff, on [DATE], [DATE], and [DATE]. Review of the facility's [NAME] Unit Emergency Cart checklist, dated [DATE] revealed the emergency cart was not checked for emergency items by checking off each line item, and initialed by staff, on [DATE] and on [DATE]. Review of the facility's [NAME] Unit Emergency Cart checklist, dated [DATE] revealed the emergency cart was not initialed; therefore, not checked for supplies, on [DATE] through [DATE] (15 days), [DATE], [DATE], [DATE], [DATE], and [DATE]. The Emergency Cart was not checked for nineteen (19) of thirty (30)-days during the month of [DATE]. Interview with RN #3, on [DATE] at 5:30 PM, revealed night shift was the designated shift for checking the emergency cart on the unit. He stated the facility had not assigned staff to routinely check the emergency cart. Therefore, it ended up being the person who thought about doing it. He stated the Emergency Cart had never been locked. He revealed the cart did not have locks to lock. He stated he spoke with the former Director of Nursing (DON) about locking the emergency carts to prevent supplies from being taken off the cart to ensure all necessary items would be available for code situations. He stated he has seen times when the emergency cart was missing items, such as the Ambu bag, and tubing for the suction machine. He stated the facility would not be able to provide effective CPR without the equipment. In addition, if the suction equipment, oxygen equipment, and items to complete assessments, such as stethoscope and Ambu bags were not be readily available, it could delay emergency treatment. He stated he only worked weekends, and was not aware of any ongoing audits for the emergency carts and had not been ask to complete any audits for the Emergency Cart. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #5, on [DATE] at 6:36 PM, revealed the night shift staff checked the emergency cart against the Emergency Cart Checklist. RN #5 stated staff checked to make sure the emergency cart had the needed supplies, such as the suction equipment, items for oxygen delivery such as an Ambu bags and airways. She stated the emergency carts contained the supplies used during an emergency and particularly during a code blue, when the resident has stopped or potential stop breathing or their heart had stopped. Any delay in initiating and providing breaths may compromise the outcome of a the residents status, if the resident was found not breathing or without a heart beat. RN #5 stated the stethoscope was placed on the cart, so during a code or crisis, nursing could assess residents breath sounds or heart sounds. She stated staff having to leave the code to obtain supplies, that should have been on the emergency cart, could delay services and potentially could lead to a negative outcome for the resident. Telephonic interview with LPN #18, on [DATE] at 1:44 PM, revealed night shift staff was supposed to check the emergency cart at the beginning of every shift and she worked night shift. She stated she checked the paper (Emergency Cart Checklist) when she worked. She replied when checking the sheet and initialing, she was stating everything was on the cart. If something was missing, she would go get it and replace the item on the emergency cart. She stated the Ambu bags were stored in the bottom drawer of the crash cart and in the medication room. She stated the importance of checking the cart was to be prepared when you needed the emergency equipment in the event of a code situation. The emergency cart lacking supplies, such as the Ambu bag would cause a delay in the person able to breath and could delay care resulting in a person dying or incurring a brain injury. She stated she had heard the Ambu bag was not on the cart. She stated she believed staff had not replaced the Ambu bag on the cart after another patient had expired, on [DATE]. She stated whoever had a code was responsible for replacing items used during the code. In addition, she stated sometimes staff removed items from the cart for resident use. She stated, it sounded like staff failed to check the cart if the Ambu bag was missing from the cart. Interview with LPN #1, on [DATE] at 3:45 PM, revealed when she brought the crash cart to Resident #8's code blue on [DATE]. She stated the Ambu bag was not on the cart, but should have been. She stated if emergency supplies were not on the cart it could lead to a potential delay in rescue breathing or the death of a resident. Interview with Interim Center Nurse Executive (CNE), on [DATE] at 2:47 PM, revealed she was in an interim position, and would be here for thirty (30) days or less. She revealed she was still learning the facility's policy. She stated she responded to the code blue on [DATE]. She stated the staff brought the emergency cart to the room; however, the Ambu bag and stethoscope was not on the Emergency Cart. However, she was not aware of their process and she was still learning the current facility's emergency response process. She stated the facility also had an interim unit manager, and she was not aware of any issues with the emergency carts. She stated the facility was not doing any audits on the emergency carts at this time. Interview with the Center Executive Director (CED), on [DATE] at 9:45 AM, revealed they had not identified any issues with the Emergency Carts. She stated she was not aware of any audits done with the Emergency Cart Checklist. However, the CNE was responsible for the clinical components of nursing needs. She stated the items on the emergency cart checklist were supposed to be on the cart. The lack of supplies may have a negative outcome for a resident during a code status. The facility implemented the following actions to remove the Immediate Jeopardy: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #6 and Resident #8 no longer reside in the facility. All residents of the facility have the potential to be affected. No additional residents have experienced cardiac/respiratory arrest. 2. The Center Nurse Executive (CNE), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), and/or Clinical Quality Specialist (CQS) completed reeducation with all licensed nurses and agency nurses on the facility policy and procedures regarding: Cardiac/Respiratory Arrest, Cardiopulmonary Resuscitation (CPR) Flow Sheet, Death Pronouncement for Kentucky Nurses, Emergency Cart Checklist and Advanced Directives to be completed by [DATE]. A post-test was administered at the time of the reeducation that required a passing score of 100% that will be graded by the CNE, ADNS, UM and/or CQS to validate understanding. Licensed Nursing and Agency Licensed Nursing Staff no available during this time frame would be provided reeducation including a posttest by the CNE, UM, CRC, MDS, RN Supervisor and/or CQS upon day of return to work. New licensed nursing hires would be provided education and posttest during orientation by the CNE, ADNS or UM. 3. The CNE, ADNS, UM, CRC, MDS Nurse, RN Supervisor and/or CQS would conduct five (5) licensed nurse interviews for two (2) weeks then three (3) times a week for two (2) weeks, then weekly for eight (8) weeks then monthly times one (1) month then ongoing thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to ensure care plans were implemented with any corrective action upon discovery including weekends and holidays to determine staff are aware of the process of Cardiac/Respiratory Arrest, Cardiopulmonary Resuscitation Flowsheet, Death Pronouncement for Kentucky Nurses, Emergency Cart Checklist, and Advanced Directives. 4. Beginning [DATE] a chart audit would be conducted upon all deaths that occur in the facility by the Interdisciplinary Team (IDT) which includes the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing, Medical Director, Social Service Director, Dietitian, Minimum Data Set (MDS) Coordinator, and Clinical Reimbursement Coordinator to ensure that the resident's Advanced Directives were followed. 5. The results of the interviews and audit would be reviewed daily to reflect that the CPR flowsheet was used during/after CPR was initiated including documentation of Emergency Response System (EMS) arrival, death was pronounced according to the policy and procedures for Kentucky Nurses, and the Emergency cart check list was completed daily, all items are available and restocked after use by the CED or CNE with corrective action upon discovery. 6. The CED, CNE and/or ADNS would submit the results of the audit findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly time six (6) months which consists of the Center Executive Director, Center Nurse Executive, Assistant Director of Nursing, Medical Director, Social Service Director, Dietician, Health Information Manager, MDS Coordinator, Clinical Reimbursement Coordinator, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Nursing Aides for any additional follow up and/or in-servicing until the concern is resolved and ongoing thereafter as determined by the QAPI Committee. The SSA validated the facility implemented the following actions: 1. Record review revealed Resident #6 and Resident #8 no longer reside in the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Record review revealed the facility completed re-education with all licensed nurses and agency nurses on the facility policy and procedures regarding: Cardiac/Respiratory Arrest, Cardiopulmonary Resuscitation (CPR) Flowsheet, and Death Pronouncement for Kentucky Nurses, Emergency Cart Checklist, Person Centered Care Plans, and Advanced Directives. Continued observation revealed all licensed staff had been tested on respiratory assessment, change of resident condition, updating the plan of care, CPR, Emergency Cart Checklist, pronouncement of death and advanced directives. All exams had a 100% passing score. Training was completed [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. All licensed staff received training by [DATE] as verified by employee roster. Observation on [DATE] at 2:30 PM, of the code cart and code cart checklist from the North and [NAME] Nursing Units revealed the code checklist in place and all items accounted for in the Code Carts. Interview on [DATE] at 9:45 AM, with the Assistant Director of Nursing, revealed the resident's code status was on the care plan or the paper chart. She stated the Advanced Directive delegated what the resident wants done whether it be full CPR or a Do Not Resuscitate. Interview with RN #6, on [DATE] at 9:00 AM, revealed an Advanced Directive directed the staff to what the resident wanted at the end of their life. She stated the Administration quizzed her almost daily on Advanced Directives. Interview with RN #7, on [DATE] at 9:10 AM, revealed an Advanced Directive informs staff of resident wishes for the end of life. She stated the Administration had quizzed her on Advanced Directives. Interview with Licensed Practical Nurse (LPN) #7, on [DATE] at 10:15 AM, revealed Advanced Directives were a residents medical wishes upon death. She stated whenever a resident became unresponsive, the nurse should immediately check the code status and start CPR if the resident was a code. Interview with RN #8, on [DATE] at 10:30 AM, revealed a resident's code status could be located in the chart, Electronic Medical Record, Kardex or care plan. She stated she had been re-educated on the signs and symptoms of death, how and when to perform a respiratory assessment and complete the CPR Flowsheet. She stated an Advanced Directive lets staff know the residents wishes as their do not resuscitate status. She stated if a resident became unresponsive, stay with the resident, call for help, and the code status. She stated staff should also notify the physician and the responsible party. Interview with Certified Nursing Assistant (CNA) #28, on [DATE] at 11:25 AM, revealed anytime a resident was unresponsive she would immediately call for the nurse. Interview with Minimum Data Set (MDS) Coordinator #3, on [DATE] at 1:00 PM, revealed she had received training from the CNE regarding Cardiac/Respiratory Arrest, Cardiopulmonary Resuscitation (CPR) Flow Sheet, Death Pronouncement for Kentucky Nurses, Emergency Cart Checklist and Advanced Directives. She stated she had provided training to staff on respiratory assessments and how to perform one. She stated the licensed personnel had to test on respiratory assessment. She stated she also assisted with the assessments of all the residents in the facility. She revealed she had assisted staff in reeducation on change in condition, MD and family notification and how to fill out the Code Checklist. She stated staff were also instructed on the use of a resident's Advance Directive. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the North Hall Unit Manager, on [DATE] at 1:20 PM, revealed a resident's code status can be found on the front of their chart, on the MAR, Point Click Care Electronic Medical Record, or the plan of care. She stated an Advanced Directive defines a resident's choice and instructions at the end of life, and needed to be followed. She stated the licensed staff had been re-educated to assess, call for help, notify the doctor as well as begin CPR whenever a resident was deemed to be a full code. She stated the CNE had been quizzing her on Advance Directives and Cardiac Arrest. Interview with the DON, on [DATE] at 1:45 PM, revealed all licensed staff had been re-educated on Advanced Directives, and following a resident's code status as documented on the plan of care. She stated the staff were trained on signs of irreversible death, and each nurse received this training on a one (1) to one (1) basis followed by a posttest. She stated the posttest was graded immediately so staff could have immediate feedback on their answers. She stated the facility was interviewing five (5) nurses on cardiac/respiratory arrest, the CPR Flowsheet, Death Pronouncement, the Code Cart Checklist, and Advanced Directives. 3. Record review revealed five (5) licensed nurses were interviewed on [DATE], [DATE], [DATE], [DATE], and [DATE] with the following questions: What are Advanced Directives, What is the purpose of the CPR Flowsheet, Who can pronounce death in Kentucky, Who is responsible to update [TRUNCATED]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and facility policy review it was determined the facility failed to supervise and monitor residents to ensure an accident free environment for six (6) of twelve (12) residents of a total sample of fifty-six (56) residents, Resident #6, #62, #77, #78, #100, and #102. Staff failed to supervise Resident #77 to ensure his/her safety. On 07/21/19, the resident exited the building to an outdoor courtyard without staff knowledge and fell from his/her wheelchair. The facility transferred the resident to the emergency room (ER) where he/she was diagnosed with a closed head injury. Observations revealed residents with lighters in their possession without staff knowledge, Resident #6, #62, #77, #78, #100, and #102. The findings include: Review of facility policy Smoking, revised 07/24/18, revealed the admissions designee would explain the Center's smoking policy to the patients and their families, and inform them that patients would be assessed to determine if supervision was required. Smoking supplies (including, but not limited to, tobacco, matches, lighters, lighter fluid, etc.) would be labeled with the patient's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station. The policy revealed patients would not be allowed to maintain their own lighter, lighter fluid, or matches. Review of the policy Falls Management, revised 03/15/16, revealed patients would be assessed for falls risk as part of the nursing assessment process and those determined to be at risk would receive appropriate interventions to reduce risk and minimize injury. Patients who experienced a fall would receive appropriate care and investigation of the cause. Practice standards for falls management included development of an individualized plan of care and review/revision of the care plan regularly. Review of the policy Accidents/Incidents, revised 11/28/16, revealed Genesis HealthCare (GHC) staff would use the Risk Management System (RMS) to report, review, and investigate all accidents/incidents which occurred, or allegedly occurred, on Center property and involved, or allegedly involved, a patient who was receiving services. An accident was defined as any unexpected or unintentional incident which may result in injury or illness to a resident/patient. This does not include adverse outcomes that were a direct consequence of treatment or care that was provided in accordance with current standards of practice (e.g., drug side effects or reaction). The policy further revealed the Center Executive Director (CED), Center Nurse Executive (CNE), or designee would review all accidents/incidents to determine if required documentation was completed and interventions to prevent further accidents/incidents had been identified and implemented. The policy revealed root cause analysis would be completed within 30 days of the occurrence. Review of the facility's designated 'Smoking Times' revealed residents were permitted to smoke outside on the back patio at 6:30 AM, 9:30 AM, 12:50 PM, 4:00 PM, 7:00 PM, and 9:30 PM. Observation, on 08/06/19 at 1:05 PM, revealed Resident #6 was outside the facility unsupervised at the front of the building near the kitchen entrance. Further observation revealed the resident removed a lighter from his/her pocket, lit and smoked a cigarette. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation, on 08/06/19 at 3:52 PM, revealed Resident #78 dropped a cigarette lighter, on the floor next to the resident's dresser in his/her room. Observation, on 08/07/19 at 8:55 AM, revealed Resident #62 stored his/her cigarettes in a case hanging from the walker and a lighter in his/her pocket. Observation, on 08/10/19 at 3:35 AM, revealed Resident #6 and Resident #100 entered the building from the courtyard. Interview with Resident #6 during observation revealed he/she knew the access code to the courtyard door. Interview with Resident #100 revealed the facility used to allow residents to smoke unsupervised but recently changed the smoking procedure. Observation, on 08/10/19 at 12:07 PM, revealed Resident #102 stored a lighter in his/her pants pocket. Interview during observation revealed the resident knew the master code to the exit doors and stated it was common knowledge among the residents. Resident #102 further revealed he/she went outside in the middle of the night to smoke in the courtyard. Observation, on 08/10/19 at 11:45 AM, revealed Resident #77 seated in a wheelchair in the resident's room with a black lighter in his/her hand. Interview during observation revealed the resident knew the access code to the courtyard door and usually went outside around 5:30 AM to smoke because there was usually no one out there. According to Resident #77, all the residents knew the access code to the courtyard door. Review of the clinical record revealed the facility admitted Resident #77 on 04/14/17 with diagnoses to include Acquired Absence of Right Leg above the Knee, End Stage Renal Disease, Congestive Heart Failure, Paroxysmal Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease (COPD). Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) total score of fifteen (15) out of (15) and determined he/she was interviewable. Review of the Progress Notes, dated 07/21/19 at 1:22 AM, revealed Resident #77 fell out of the wheelchair in the outside courtyard and landed on the concrete. The resident was alert and oriented to person/place/time with some slight confusion and bleeding from the right side of his/her forehead. The note further revealed the nurse activated 911. Review of the Emergency Department (ED) Physician Notes, dated 07/21/19, revealed Resident #77 discharge diagnoses included a closed head injury and facial abrasion. Review of the Advanced Practice Registered Nurse (APRN) Follow Up Progress Note, dated 07/22/19, revealed the resident reported losing his/her balance when adjusting in the wheelchair which caused him/her to fall forward out of the wheelchair. Review of the RMS Event Summary Report, dated 07/21/19, revealed Resident #77 fell asleep in courtyard while smoking outside the designated time. Further review of the investigation summary revealed the facility determined the root cause of the fall was the resident smoked outside of designated times. Corrective actions included re-education related to the smoking policy and not going outside after designated smoking times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Certified Nursing Assistant (CNA) #1, on 08/06/19 at 3:52 PM, revealed residents were not to keep lighters on their person, and the CNA was not able to explain how the resident came to have a lighter. Interview with Certified Nursing Assistant (CNA) #7, on 08/10/19 at 5:39 AM, revealed she last observed Resident #77 in the television (TV) room around 1:15 AM. She further revealed a resident yelled for her around 3:00 AM to report Resident #77's fall. She stated she discovered Resident #77 lying on the concrete in the courtyard bleeding from the head. CNA #7 revealed she was not aware the resident was outside and stated residents should not go outside alone to smoke because they could get burned or hurt. Interview with CNA #3, on 08/06/19 at 1:25 PM, revealed there was a designated smoking area in the back courtyard and stated the facility assigned staff to supervise residents during scheduled smoking times. She stated smoking materials, including lighters, were collected and locked in a box located in the front office. According to the CNA, it was important to supervise residents smoking to prevent potential burns and ensure their safety. Interview with CNA #19, on 08/11/19 at 11:36 AM, revealed residents were not permitted to go outside after 11:00 PM, or smoke at the front of the building, because they could get hurt of lost if there was no staff to supervise them. She further revealed residents were not permitted to store their own lighters because they could accidentally catch themselves or something else on fire. According to CNA #19, the oxygen stored in the building could cause an explosion. Interview with Licensed Practical Nurse (LPN) #19, on 08/16/19 at 9:10 AM, revealed she was assigned to Resident #77 on the night of the fall and stated she was not aware he/she was outside. LPN #19 revealed Resident #77 fell and busted his/her head because I could not monitor the resident that night. The nurse further revealed Resident #96 also fell that night and stated she was assigned to care for thirty-six (36) residents, including two (2) tracheostomies, on the evening of Resident #77's fall. Further interview with LPN #19 revealed residents knew the access code to the door and there was a problem with residents going outside unsupervised late at night. According to LPN #19, she notified administration regarding the issue; however, the Administrator told her it would not do any good to change the code because residents knew the master code. Interview with LPN #9, on 08/10/19 at 6:55 AM, revealed she assumed some residents were permitted to smoke outside unsupervised; however, she was not sure of the facility's smoking policy. LPN #9 revealed residents usually went outside around 10:00 PM to smoke and stated she observed residents enter the code to the doors. The LPN further revealed there was no way staff supervised Resident #6 because he/she was outside around 2:30 or 3:00 AM. According to LPN #9, sometimes there was a raccoon that came out at night in the courtyard and hissed at you. Interview with the North Hall Unit Manager (UM), on 08/16/19 at 10:29 AM, revealed the courtyard was closed at night; however, residents knew the code to the door. She stated Resident #77 was outside when he/she was not supposed to be, fell asleep, fell out of the wheelchair, and sustained an abrasion to his/her scalp and knee. The UM further revealed staff were responsible for performing rounds during the shift to ensure residents were supervised. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further interview with the North Hall UM revealed the area in front of the facility was non-smoking; however, residents were permitted to smoke if staff supervised them. The UM revealed residents were not permitted to store their personal lighters and were required to turn them in to staff after designated smoking breaks. She stated she rounded every day and observed for smoking items; however, there was no formal audit process in place. Interview with the Assistant Director of Nursing (ADON), on 08/23/19 at 3:29 PM, revealed CNA's and nurses were responsible for supervision of residents at all times. She further revealed residents at high risk for falls should not be outside alone because of the risk for fall and/or injury. Interview with the Center Nurse Executive (CNE), on 08/22/19 at 2:51 PM, revealed the root cause of Resident #77's fall was forgetting to lock the wheelchair brakes. She further revealed staff were responsible for monitoring residents during the shifts; however, she could not recall if the facility interviewed staff related to the circumstances of Resident #77's fall. Interview with the Center Executive Director (CED), on 08/23/19 at 4:26 PM, revealed the facility identified concerns related to access codes to doors and smoking procedures. The CED revealed the facility developed a formal Quality Assurance Process Improvement plan related to the smoking procedure, including resident smoking outside of designated hours, smoking outside at the front of the building, and storage of personal lighters. The CED further revealed she walked around the facility to monitor for compliance to the policy. Further interview with the CED revealed she was aware of issues related to residents knowledge of door codes. She stated the facility changed the door codes within the last 6-8 months; however, the master code was just reset during the survey. 41851

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35750 Based on interview, record review, and facility policy review it was determined the facility failed to ensure nursing staff performed Respiratory Assessments for one (1) of three (3) sampled residents of a total sample of fifty-six (56) residents (Resident #106). Interview and record review revealed nursing failed to monitor and assess for respiratory decline that included auscultation of lung sounds, evidence of sleep apnea, edema in extremities, and/or weight fluctuations related to Resident #106's diagnoses of Congestive Heart Failure and new onset of pneumonia. Interview with Licensed Practical Nurse (LPN) #6 on, [DATE] at 12:25 PM, revealed on [DATE] she was assigned to care for Resident #106 and was unaware of the resident's recent diagnosis and treatment for pneumonia. She stated she administered the resident's medication around 10:30 AM on [DATE]; and if the resident had a pneumonia diagnosis then she should have assessed the resident's lungs at that time but she did not. In addition, she could not remember if she assessed Resident #106 for edema either. LPN #6 stated after the 10:30 AM assessment, she did not re-assess the resident again until later when she found him/her deceased , during her evening shift around 7:00 PM. LPN #6 stated she performed a Sternum rub; however, the resident did not respond. The findings include: Review of the facility's policy Respiratory Management revealed residents were assessed for the need of respiratory services which was part of the nursing assessment process. If respiratory care was needed, the licensed nurse who had been trained on the procedure and had demonstrated competency performed the assessment. The purpose of the policy was to provide appropriate respiratory services. Review of the job description for the Charge Nurse - Licensed Practical Nurses revealed he/she worked under the direction of the Nursing Supervisor, Unit Manager, or Center Nurse Executive. The Charge Nurse ensured delivery of efficient and effective nursing care while achieving positive clinical outcomes; and resident/family satisfaction and operated within the scope of his/her practice defined by the State Nurse Practice Act and delegated aspect of resident care to licensed and unlicensed staff consistent with their scope of practice and collaborated with the nursing team and other disciplines, residents and families. Review of Resident #106's clinical record revealed he/she had been admitted to the facility on , [DATE], with diagnoses including Lymphedema not Elsewhere Classified, Chronic Kidney Disease Stage 3, Acute on Chronic Combined Systolic (congestive) and Diastolic (congestive) Heart Failure, Essential Hypertension, Localized Edema and Pneumonia. Review of Resident #106's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) and the resident scored a fifteen (15) out of fifteen (15), which meant the resident was interviewable. The facility's assessment determined the resident's admission weight was four hundred thirty-three (433) pounds. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #106's Progress Note, dated [DATE] at 5:46 PM, by LPN #19, revealed the Nurse Practitioner ordered Levaquin seven hundred fifty (750) grams (gm), per mouth (PO), for seven (7) days and Probiotic PO, twice a day (BID) for ten (10) days related to the new diagnosis of Pneumonia. Review of Resident #106's Comprehensive Care Plan implemented on, [DATE], revealed the resident was at risk for respiratory complications related to Sleep Apnea and Congestive Heart Failure (CHF) with a goal for the resident to be free of Atelectasis as evidenced by increased breath sounds. Interventions included to obtain laboratory results as ordered by the physician, oxygen at two (2) Liters per minute via Nasal Cannula (NC) when in bed, removed as needed (PRN) and to encourage the resident to express feelings of fear and anxiety. On [DATE], edema to the lower extremities was added to the care plan by the facility. Interventions included observing for signs/symptoms of skin breakdown and to encourage the resident to elevate his/her legs as much as possible as ordered by physician. However, there was no care plan related to the resident's recent diagnosis of Pneumonia and the ordered Antibiotic therapy. Further review of Resident #106's Progress Note, dated [DATE] at 10:35 AM, revealed LPN #19 documented the resident was on continuous oxygen via NC and Antibiotics for Pneumonia. Later, at 6:35 PM, LPN #18 documented the resident was in no acute distress and continued on his/her treatment for Pneumonia. However, there was no documented evidence the nurse had listened to the resident's lung sounds and/or completed a full assessment of the resident's Respiratory System. Review of Resident #106's Advanced Practice Registered Nurse (APRN) evaluation dated, [DATE], revealed the resident's breath sounds were very diminished throughout all lobes. She documented the resident had two (2) plus (+) pitting edema to the left lower extremity (LLE) and two (2) plus (2+) edema to the left upper extremity (LUE) and showed general weakness. In addition, the APRN ordered Lasix twenty (20) milligram (mg), PO, every morning (q AM) times four (4) days; in addition, to the Lasix forty (40) mg already ordered. She also ordered staff to weigh Resident #106 daily at the same time each day, for five (5) days and then weekly each Tuesday related to the diagnosis of CHF. Further review revealed the APRN ordered a STAT(immediately) chest x-ray, a Complete Blood Count/Complete Metabolic Panel and a B-type Natriuretic Peptide (BNP) for the next morning. In addition, she ordered nursing staff to elevate the resident's LUE and LLE above the level of the heart for thirty (30) minutes at least four (4) times daily related to the resident's edema. The APRN wrote for nursing to continue administering all medications as ordered and to follow up with the laboratory results. She ordered nursing staff to monitor Resident #106 closely and documented she communicated her treatment plan and orders with the resident and his/her nurse on [DATE] at 10:55 PM. Review of Laboratory Results, dated [DATE], revealed Resident #106's B-type Natriuretic Peptide (B-type natriuretic peptide (BNP), a hormone produced by the heart, levels go up when heart failure develops or gets worse, and levels goes down when heart failure is stable. BNP levels are higher in patients with heart failure than people who have normal heart function) results showed a critical High level of 3226.5 picograms per milliliter (pg/ml), normal range ,d+[DATE] pg/ml. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional review of Resident #106's APRN evaluations dated, [DATE] at 2:21 PM, revealed the APRN reviewed the chest x-ray that showed mild cardiomegaly (an enlargement of the resident's heart) with clear lung sounds. She documented nursing staff was to continue orders and follow the laboratory results and monitor the resident closely. However, she stated if the resident's respiratory status declined the resident was at risk for hospitalization but he/she was stable at the time of the NP's evaluation. She documented she had communicated her plan for Resident #106 with the resident, the nurse, the Center Nurse Executive (CNE) and the Medical Director. However, review of the resident's clinical record revealed staff had not performed Respiratory Assessments and had not monitored the resident's edema and/or elevated the LLE and LUE as ordered at least four (4) times a day above the resident's heart. Review of Resident #106's MAR for [DATE], revealed the nurses had not transcribed the order by APRN, dated [DATE], which was to elevate the resident's LLE and the LUE at least four (4) times a day above the heart level related to his/her edema. Instead licensed nursing staff continued to follow an old order dated, [DATE], to elevate the LUE on a pillow, three (3) times a day. There was no documented evidence licensed nursing staff monitored the resident's LLE edema, or elevated the left leg above the resident's heart as ordered. Review of Resident #106's Nursing Documentation, dated [DATE] through [DATE], revealed the note served as a Daily Skilled Note with the resident's vital signs (VS) recorded. The note stated the VS were within normal limits (WNL) for the resident with a heart rate (HR) 80 beats per minute (BPM), his/her BP as , d+[DATE] mm hg, the respiratory rate (RR) as eighteen (18) breath per minute (BPM) and the resident's oxygen saturation (O2 Sat) as 98 %. The resident received two (2) liters (L/MIN) of oxygen per minute via nasal cannula (NC). Nursing documented on [DATE] at 1:02 PM, the resident weighed three hundred forty-five point five (345.5) pounds (lbs) which presented a ninety point four (90.4) lb difference from the resident's previous weight of four hundred thirty-six point four (436.4) lbs, which was obtained on [DATE] at 9:17 AM. However, upon admission the facility determined the resident's weight was four hundred thirty three (433 lbs) pounds (lbs) at sixty-eight (68) inches tall. Review of Resident #106's MAR for [DATE] revealed the resident's daily weights were supposed to obtained from [DATE] through [DATE]. However, the actual weight was only documented one (1) time by nursing staff on the Daily Skilled Note on, [DATE] at 1:02 PM, as 345.5 pounds by LPN #19. Further review revealed there was no documented evidence the resident's weight was obtained by nursing on, [DATE], or on, [DATE], as ordered by the APRN although it was checked off on the MAR. (continued on next page)

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	185290	A. Building B. Wing	08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #6 on, [DATE] at 12:25 PM, revealed she was on duty when Resident #106 died in the facility and had worked a sixteen (16) hour shift. She stated the resident was fine, had no problems, nothing out of the norm. She stated she had brought the resident his/her nighttime medication and knew the resident was ill at the time; however, she was unsure if the resident required oxygen therapy. She stated as part of her duty she checked on residents about every two (2) hours to know how her assigned residents were doing and she administered medications. The LPN stated on, [DATE], on her shifts nothing occurred that was out of the ordinary. She stated the Progress Note completed by her dated; [DATE] at 10:35 AM, revealed Resident #106 was in no pain or acute distress. The nurse documented the resident's VS as: heart rate (HR) 80 beats per minute (BPM), his/her BP as ,d+[DATE] mm hg, the respiratory rate (RR) as eighteen (18) breath per minute (BPM) and the resident's oxygen saturation (O2 Sat) as 98 %. LPN #6 further stated if a resident had Pneumonia, she should have assessed the resident's lungs. However, when she opened the skilled note, dated [DATE], the program took her to the end of the assessment portion and did not bring up the Respiratory Assessment. LPN #6 stated she could not remember if the resident had Pneumonia, was on Antibiotic therapy, or, if she assessed Resident #106 for edema. She stated the resident died sometime during the night shift. She stated she found the resident with his/her eyes closed, mouth open as he/she always did. LPN #6 stated the resident was still warm when she found him/her. She performed a Sternum rub; however, the resident did not respond. LPN #6 stated she then passed the medication cart off to RN #3 upon finding Resident #106 deceased . About an hour before she found Resident #106 deceased she had spoken to the resident's roommate. However when she walked into the room later with the resident's medications the resident did not answer her. She stated, this had never happened to her in her career and it shocked her. During continued interview with LPN #6, she stated during the day shift on [DATE] she cared for twenty-three (23) residents; however, on this day, she worked a double shift and during second shift an additional ten (10) residents were added to her assignment. The LPN stated Resident #106 required a Respiratory Assessment and his/her extremities required assessments for swelling/edema. The LPN stated she recalled the resident had a water pitcher but was unsure if he/she was on fluid restrictions. The nurse stated it was impossible for us nurses to check everything, it was challenging and to perform actual assessments on everybody was not always possible. She stated on most weekends the facility was understaffed and had many call-ins, which made it hard on the nurses. Interview with RN #3, on [DATE] at 02:43 PM, revealed he was familiar with Resident #106, and had provided care for the resident during some shifts at the facility. The RN stated the resident had died before he came on shift and had been sick that past week, due to a new diagnosis of Pneumonia. He stated the resident was on Antibiotic therapy. The RN further stated he was told two (2) nursing aides found the resident unresponsive and informed the nurse about it who then went to assess the resident. Continued interview with RN #3 on, [DATE] at 03:47 PM, revealed, he started his shift on [DATE] at 6:30 PM, and LPN #6 told him Resident #106 was dead. The RN stated he had not seen the resident alive; and the nurse on duty asked that he pronounce Resident #106's death. He visualized the resident between 6:30 PM and 7:00 PM, and stated the resident had no heart rate (HR); however, the RN could not remember if he took the resident's blood pressure (BP), but he stated he looked at the resident's eyes. He stated, I merely did a note that he died . He further stated if there was anything left on the MAR he documented the person was either no longer at the facility, or diseased, and documented all that had transpired. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN #3 stated he had walked in on the scene. and that LPN #6 was the nurse on duty and Resident #106 had expired before he had arrived at the facility. He could not recall if the undertaker had come in; however, he had signed the Provisional Report of Death and documented the hour of death at 10:20 PM. Review of the Provisional Report of Death dated, [DATE] at 10:20 PM, revealed the resident was under universal precautions and the Kentucky Organ Donor Affiliated ([NAME]) had been notified by the Registered Nurse (RN) #3 of the resident's death and the body was released to the funeral home. Interview with the North Hall Unit Manager (UM), on [DATE] at 4:11 PM, revealed the facility admitted Resident #106 with a diagnosis of Congestive Heart Failure (CHF). She stated the resident was there for rehabilitation and strengthening due to his/her CHF. The UM stated she expected nursing staff to assess Resident #106s respiratory status at least daily and more frequent if there were noted issues, such as new onset of pneumonia. The assessment should include lung sound respiratory rate assessment as well as looking at nail beds for discoloration. She stated nursing management tracked the resident's changes in condition through the twenty-four hour report and discussed findings in the morning meeting. However, she did not remember any abnormal findings regarding nursing care provided to Resident #106's prior to his/her death in the facility. She stated if nursing did not assess residents' respiratory status by listening to the breath sounds harm could come to the resident. Interview with the Assistant Director of Nursing, on [DATE] 3:29 PM, revealed she was not directly aware of Resident #106's death but stated she expected nursing to assess and reassess any change in a resident's condition, including decline and death. She stated nursing should document timely and completely to reflect the resident's condition. In addition, nursing should relay that information to other care providers for further direction to prevent potential resident harm. Interview with the Center Executive Director, on [DATE] at 4:26 PM, revealed she was not aware of any concerns related Resident #106's change in condition or any other resident decline.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 35750 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure interventions were in place to manage pain for one (1) of three (3) sampled residents (Resident #46) out of a total resident sample of fifty-six (56) residents. Interview and observation of Resident #46, on 08/07/19 at 10:17 AM, revealed the resident on his/her cellular phone and wiped tears away. The resident stated, I have a pain level of ten out of ten (10/10) and got the Tylenol about ten (10) minutes ago. Resident #46 stated, Before the CNA {certified nursing assistant} pulled me over using my broken wrist, the pain was not as bad. The resident stated the CNA pulled him/her over during incontinent care causing him/her to scream out in pain. Interview with CNA #3, on 08/07/19 at 2:43 PM, revealed she was not told in report Resident #46's had a fractured wrist or had pain in his/her hand. The CNA stated she was not instructed to avoid the use of the resident's wrist and she expected to receive this information during shift report and she felt bad she had grabbed the resident's wrist during repositioning. The findings include: Review of the facility's policy titled Pain Management revised, 03/01/18, revealed residents were evaluated as part of the nursing assessment process for the presence of pain upon admission/readmission, quarterly, with change in condition or change in pain status, and as required by the state thereafter. Pain management that was consistent with professional standards of practice, the comprehensive person-centered care plan, and the patient's goals and preferences is provided to residents who required such services. The purpose of the policy was described to maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain. Pain was documented on the Medication Administration Record (MAR). Additionally, the Center's staff were to report any observation or communication of pain to the nurse responsible for the resident. Observation and interview, 08/07/19 at 10:17 AM, revealed while on his/her cellular phone the resident wiped away tears and stated, I have a pain level ten out of ten (10/10) and got the Tylenol about ten (10) minutes ago. Before the aide pulled me over using my broken wrist, it was not as bad. When she pulled me over to change me I screamed out. He/she stated, The nurses' aides might not know my wrist is broken. Observation and interview of Resident #46 on, 08/07/19 at 10:40 AM, revealed the resident cried, touched his/her wrist and stated,It hurts, I am despondent and in pain. Interview with Resident #46 on, 08/07/19 at 2:33 PM, revealed he/she received Tylenol and an ice pack about 20 minutes ago. He/she stated the nurse told him/her to alternate the position of the ice from the elbow to the hand where the swelling was located. He/she stated, Right now, my pain level is a eight out of ten (8/10). The resident stated, in the morning I heard a pop and I knew it was not good when the aide pulled me over and I yelled out in pain this morning. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #46 on, 08/08/19 at 11:58 AM revealed he/she experienced a pain level of 3/10. Resident #46 stated, No, have not gotten my Tylenol yet but my I got my other morning medicines. He/she stated, I asked my nurse aide to request the pain medication a few minutes ago. The resident stated, Nobody pulled my hand today I was repositioned better today. Review of Resident #46's medical record revealed the facility admitted the resident on, 05/13/19 with diagnoses including Epilepsy, Atrial Fibrillation, Nondisplaced Fracture of Neck of Left Radius, Seaquale, Obesity, Anxiety Disorder, and Major Depressive Disorder. Review of Resident #46's Quarterly Minimum Data Set (MDS) dated , 06/19/19, revealed the facility assessed Resident #46 with a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) determining the resident was interviewable. Continued review of the MDS revealed the facility assessed Resident #46's bed mobility as extensive assistance by two (2) staff and determined a pain assessment interview should be conducted because Resident #46's pain affected the resident's function. The facility determined Resident #46 had frequent moderate pain. Review of Resident #46's Comprehensive Care Plan dated 06/19/19, revealed the resident required assistance with the performance of ADL's (activities of daily living) related to decreased functional mobility, morbid obesity and bed mobility and was at risk for alteration in comfort related to fracture of radius and muscle spasms. Interventions included to observe for SOA (shortness of air), fatigue and/or change of condition and adjust ADL tasks, administer muscle relaxants as needed for spasms, advise to request pain medication before pain becomes severe and assist to a positon of comfort utilizing pillows and appropriate positioning devices. Review of Resident #46's Nurse Aide Care Plan, on 08/07/19 at 2:43 PM, with CNA #3 on the electronic mini Kiosk, revealed there was no information about the resident's broken hand or his/her pain issue, or any interventions related to observing for pain and not pulling on the resident's fractured left wrist documented on the electronic device. Review of Nurse's Notes for Resident #46 revealed on, 08/07/19 at 1:03 AM, the resident was noted to rest in bed without signs of acute distress and his/her pain level was two of ten (2/10) and weighed three hundred thirty-five point nine (335.9) pounds (lbs). Review of Resident #46's Physician Progress Note dated 08/08/19, revealed Resident #46's Advanced Practice Registered Nurse (APRN) indicated the resident had left wrist pain and prescribed Norco five, three hundred twenty-five (5-325) milligram (mg), by mouth (PO), every eight (8) hours as needed (prn) related to left wrist pain and to continue Tylenol 650 mg, PO, every four (4) hours prn. Review of the Initial Nursing Assessment for Resident #46, dated 05/13/19, revealed the facility assessed the resident to have experienced pain in his/her left wrist that was sharp, aching produced soreness and the pain got worse with movement and position. Review of Resident #46's radiology report with a date of service of 07/24/19 revealed the resident had distal radial and ulna fractures with malalignment and mild soft tissue swelling. Review of Resident #46's radiology report with a date of service of 07/13/19 revealed the resident had a stable impaction fracture involving the distal Radius and Ulna with mild displacement. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #46's Medication Administration Record (MAR) for August 1st through 7th, 2019 revealed a zero (0) pain level for August 7th day shift. However, the resident reported a pain level of ten out of ten (10/10) on the pain scale to the State Survey Agency after CNA #3 had repositioned him/her pulling on the resident's wrist. Interview with CNA #3, on 08/07/19 at 02:43 PM, revealed she was not told in report Resident #46's had a fractured wrist or had pain in his/her hand, but the resident had told her about it. However, as CNA #3 reviewed the Kiosk related to ADL care and pain, jointly with this writer, she was unable to find any information related to caution on not touching the fractured wrist or monitoring for pain. CNA #3 stated this information should be recorded there because if it was in the Kiosk it was accessible to all nurse aides and everybody should know Resident #46 had a broken wrist. The CNA stated she expected to receive this information during shift report and she felt bad she grabbed the resident's wrist during repositioning. She stated this created a whole lot of issues for Resident #46 and she felt bad it had happened. Interview with the [NAME] Hall Unit Manager, on 08/13/19 at 11:55 AM, revealed the facility did not provide a report sheet with the residents' names or care areas to CNA's. She stated the facility had an electronic Kiosk in which the CNA's could locate resident care areas. Interview with CNA #22 on, 08/13/19 at 11:32 AM, revealed she wrote her assigned residents' care needs on a blank piece of paper since it was only her second (2nd) day at the facility. She stated she did this because she wanted to make sure she knew how to care for her assigned residents. CNA #22 stated she knew how to use the Kiosk and looked things up, such as the type of assistance with transfers and she documented on the Kiosk. However, she made her own report sheet because she wanted to have the correct information on the residents and the facility did not provide a report sheet. Interview with Licensed Practical Nurse (LPN) #14, on 08/06/19 at 10:29 AM, revealed she was the nurse for Resident #46 on 08/07/19. She stated she had been told by the resident, that the CNA had accidentally grabbed his/her arm as they turned him/her over before he/she could tell the CNA. She stated the resident reported more pain than usual to her. LPN #14 stated she supplied the resident with an ice pack and gave him/her a dose of Tylenol. The LPN stated to her knowledge, the aides were aware of the resident's wrist fracture. However, the aides should have used a draw sheet to roll the resident over and should not have grabbed any limbs. LPN #14 stated the resident was a reliable reporter and if he/she had reported a pain level of ten out of ten (10/10) she believed the resident, who usually had a pain level of four or five out of ten (4/10 or 5/10). She further stated pulling the resident on the broken wrist could make the break worse. She stated it was very hard to control such a high pain level. However, she had not told the CNA's about the resident's broken wrist. LPN #14 stated she thought it was on their care plan. She stated she had assumed the aides knew about the resident's wrist fracture. LPN #14 stated the facility had mostly agency staff in the building and it was hard to maintain continuity of care for the residents. She stated the aides rotated a lot and there was often all new staff, which affected the residents. LPN #14 stated the aide should not have grabbed the resident's wrist to reposition him/her and she knew there was a lack of communication between nursing staff. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with the Minimum Data Set (MDS) Coordinator, on 08/16/19 at 10:58 AM, revealed she knew Resident #46 was frequently in pain which made it hard for the resident to sleep at night. She stated the resident's pain was moderate to severe and nursing staff was supposed to be aware of the pain issue. She stated it was their responsibility to educate the nurse aides about the resident's pain. Continued interview revealed it was the nurse aide's responsibility to let the nurse know if a resident experienced pain. The MDS Coordinator stated she hoped CNA's would not grab a resident on a fractured limb; however, if this had occurred, it could cause more pain and further injury. She further stated a resident with a pain level of ten out of ten (10/10) on the pain scale could become cautious, scared and very uncomfortable which was not good care. The MDS Coordinator stated residents should be repositioned with a draw sheet and help if they were able to; however, she stated it did not sound like the facility had followed policies and procedures. She stated Resident #46 should have been repositioned by two (2) staff members with a draw sheet. Interview with the APRN, on 08/13/19 at 12:00 PM, revealed currently Resident #46 was non-weight bearing and should not be helping with his/her left arm for repositioning since the x-ray had established the resident's wrist fracture had not healed. The APRN stated she expected nursing staff to use the resident's shoulders for moves with two (2) staff and do so only if the resident could tolerate it. However, the APRN stated, there should not have be any movements to the resident's wrist. Nursing staff was to make sure the resident would not put any weight on his/her wrist, zero (0) weight and the CNA should not have pulled the fractured wrist to reposition the resident. The APRN stated pulling the resident by the injured wrist could have created more pain and cause harm to Resident #46. Further interview with the APRN revealed if the resident cried and experienced a pain level of 10/10 on the pain scale she hoped nursing staff reported this to the Medical Director. She stated the resident was alert and oriented and a reliable reporter and she believed the resident experienced the pain he/she reported. The APRN stated nursing staff has access to orders and should have known about Resident #46's wrist fracture. She stated the nurses should have communicated the fracture to the CNA's and the CNA's should get a proper shift report, and have been aware of the resident's fracture. The NP stated the facility had many agency staff, which made a difference since agency staff was not as familiar with the facility's residents as permanent nursing staff. She stated there was a need for effective communication. The APRN stated that at times agency nursing staff and permanent nursing staff did not communicate openly. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with the Center Nurse Executive (CNE) ,on 08/13/19 at 3:31 PM, revealed she had a reportable occurrence to the Office of Inspector General during the annual survey. She stated the APRN who was at the facility had informed her a CNA provided care to the resident by pulling Resident #46 over by his/her fractured wrist. The CNE stated she asked the resident about the incident and the resident stated he/she had not reported it, and stated the girl nurse aide, did not mean to do it. She further stated the resident told her it happened last week and it had been an agency nurse aide; however, the resident was unsure of the aide's name. Further interview revealed the CNE told the resident she wanted to fix the process and not punish the nurse aide. The resident requested to post a sing above his/her bed to alert nursing staff to the fractured left wrist. The CNE stated staff could look at the Kiosk which was updated with the information on residents to know if a resident had a pain issue or fracture and a second way for CNA's to receive the information was in report. However, interview with CNA #3 on, 08/07/19 at 2:43 PM, revealed she was not told in report Resident #46's had a fractured wrist nor was the information available in the Kiosk. Further interview with the CNE revealed since the CNA did not know about the fractured wrist of Resident #46 it could have caused more harm to the resident. The CNE stated she never knew of a resident's pain level of 10/10 on the pain scale at the facility whom nursing had not taken care off. She questioned if Resident #46 told nursing staff about his/her pain and expected nurses to assess the pain and contact the provider for further orders. The CNE stated the NP had adjusted Resident #46's pain medication. However, the APRN changed the pain medication on 08/08/19 by discontinuing Mobic seven point five (7.5) mg, per mouth (PO), daily; she implemented Norco 5-325mg, PO, every eight (8) hours, as needed (PRN) for seven (7) days related to wrist pain and continue Tylenol 650 mg, PO, every 4 hours, PRN. The APRN's progress note stated she had communicated the treatment plan with Resident #46 and his/her nurse. The NP added a diagnosis of Left Wrist Pain. Interview with the Center Executive Director (CED), on 08/23/19 at 4:26 PM, revealed the facility had not identified issues with resident pain not being managed.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28733 Based on observation, interview, record review, facility policy review, and review of the job description for the Center Executive Director, it was determined the facility failed to be effectively administered in a manner that enabled effective use of resources to attain and maintain the highest practicable physical, mental, and psycho-social wellbeing for two (2) of thirteen (13) sampled residents, Resident's #6 and #8. Review of a closed clinical record revealed the facility readmitted Resident #6 on [DATE], after a hospitalization for Pneumonia with sepsis and fluid overload. Review of the resident's nursing assessments revealed they were incomplete or non-existent. Record review and interview revealed nursing staff found the resident unresponsive in the bed on [DATE], and failed to initiate cardiopulmonary resuscitation (CPR) to honor Resident #6's advance directive for a Full Code. Furthermore, record review revealed the facility admitted Resident #8 on [DATE] with the diagnoses of Heart Failure, Chronic Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Essential Hypertension. Continued review revealed the facility failed to assess, Resident #8's respiratory and cardiovascular status consistently and report changes in condition to the physician. In addition, the facility did not assess or notify the physician of Resident #8's seven (7) pound weight gain over a two-day period or the abnormal blood test results obtained on [DATE]. Resident #8 reported he/she did not feel well on [DATE], prior to lunch and nursing did not assess his/her respiratory or cardiovascular status, and did not inform the physician of the resident's complaint. After lunchtime, staff found the resident unresponsive on the floor, initiated CPR, then transferred the resident to the hospital where he/she expired. The facility's failure to be administered in an effective manner to ensure resident's were provided consistent respiratory and cardiovascular assessments per the plan of care, that residents advance directives were followed when found unresponsive, and staff notified residents physicians a change of condition occurred, has caused, or is likely to cause, serious injury, harm, impairment, or death. Immediate Jeopardy was identified on [DATE], and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The facility provided an acceptable Credible Allegation of Compliance on [DATE], alleging the removal of Immediate Jeopardy on [DATE]. The State Survey Agency verified Immediate Jeopardy was removed on [DATE] as alleged, prior to exit on [DATE]. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. 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 - Few	Review of the Job Description for the Center Executive Director (CED), effective [DATE], revealed the CED would create an environment where staff members were highly engaged and focused on providing the highest level of clinical care and compassion to patients, residents, and families. The CED would administer and coordinate all activities of the facility to assure the highest degree of quality of care was consistently provided to residents, subject to the rules and regulations promulgated by government agencies to ensure residents received the proper services. Review of the policy Cardiac and/or Respiratory Arrest, revised [DATE], revealed Regency Center supported the right of every patient to accept or decline cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. The policy revealed the Center would perform CPR on all patients, except in certain limited circumstances, unless there was a written physician's order, agreed to by the patient or health care decision maker, not to resuscitate (DNR), in accordance with state regulation/law. If a patient does not have a DNR order, CPR/AED certified staff would initiate CPR/AED and emergency medical services (EMS) will be activated. Review of the Cardiac and/or Respiratory Arrest Procedure, revised [DATE], revealed upon discovery of a patient in cardiopulmonary arrest (e.g., no apparent pulse, blood pressure, or respiration), staff would immediately call for assistance; alert the licensed nurse and CPR/automated external defibrillator (AED) certified staff; and prepare the patient for CPR/AED while determining the presence of a Do Not Resuscitate order (DNR). Further review of the procedure revealed for witnessed arrest if there was no visual identification of DNR status or no DNR order on the patient's medical record: CPR/AED certified staff would initiate CPR/AED application; call 911 and notify the primary physician; and designate an individual to record events on the CPR/AED Flow Sheet. The procedure revealed CPR should continue until one of the following occurred: It was discovered that the patient had a DNR order; Restoration of effective, spontaneous circulation; care was transferred to a team providing advanced life support (emergency medical services (EMS)); the rescuer was unable to continue because of exhaustion, the presence of dangerous environmental hazards, or because continuation of the resuscitative efforts placed others in jeopardy; or if state regulation allowed licensed nurse to pronounce/certify death, reliable and valid criteria indicating irreversible death were met, criteria of obvious death were identified, or criteria for termination of resuscitation were met. When EMS personnel arrive, they assume responsibility and treatment would be directed by EMS personnel. Notify the family/health care decision maker of the patient's status. The Cardiac and/or Respiratory Arrest Procedure revealed for Unwitnessed Arrest for Patients without a DNR the Registered Nurse (RN) or Licensed Practical Nurse (LPN) would evaluate the patient for obvious clinical signs of irreversible death unless not permitted by state regulation. If at least ONE obvious clinical sign of irreversible death is present, do not initiate CPR. Obvious clinical signs of irreversible death include: Lividity or pooling of blood in dependent body parts (livor mortis); Hardening of muscles or rigidity (rigor mortis); Injuries incompatible with life. If there are no obvious clinical signs of irreversible death, follow section 2 above to initiate CPR/AED. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy Person-Centered Care Plan, revised [DATE], revealed the purpose of the care plan was to attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. Person-centered care meant to focus on the patient as the locus of control and support the patient in making his/her own choices and having control over his/her daily life. The policy revealed a comprehensive, individualized care plan would be developed within seven (7) days after completion of the comprehensive assessment for each patient that included measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that were identified in the comprehensive assessments. The center must develop and implement a baseline person-centered care plan within forty-eight (48) hours for each patient which included the instructions needed to provide effective and person-centered care meeting professional standards of quality care. Review of the facility's policy titled, Change in Condition: Notification of, revised [DATE] revealed a center must immediately inform the patient, consult with the patients's physician, and notify, consistent with his/her authority, the patient's Health Care Decision Maker (HCDM) where there was a significant change in the patient's physical, mental, or psychosocial status (that was, a deterioration in health, mental, or psychosocial status in either life-threatening conditions, or clinical complications); or a need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment) Interview on [DATE] at 9:45 AM, with the Center Executive Director (CED), revealed she was ultimately responsible for the services provided in the facility. She stated the facility had not identified any issues with care and services provided related to physician notification, weights, nursing assessments or staff following advanced directives. She stated the Center Nurse Executive was directly responsible for the provision of nursing care.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28733 Based on observation, interview, record review, review of the facility's policy, and the Center's Executive Director (CED) job description it was determined the facility failed have an effective system to address system failures related to providing Respiratory and Emergency Services through regularly scheduled Quality Assurance Performance Improvement (QAPI) meetings. The QAPI Committee, failed to identify discrepancies related to staff delivery of Respiratory Care Services; nor with the provision of Emergency Services in order to meet residents advance directive wishes, and did not implement a formal plan of action to address. Based on interview, record review, and facility policy review it was determined the facility failed to provide resident's with consistent respiratory/cardiovascular services for two (2) of thirteen (13) sampled residents. Record reviews for Resident's #6 and #8 revealed incomplete or non-existent respiratory and cardiovascular nursing assessments during several days of their facility stay. Both Resident #6 and #8 experienced a decline that lead to cardiac and respiratory arrest while at the facility. Staff did not initiate life saving measures for Resident #6, per his/her wishes for a full code status and was pronounced dead at 2:00 PM on [DATE]. Resident #8 had a seven pound weight gain in two days. The nurse practitioner order blood test, however, the test results were abnormal, and staff did not notify the practitioner. Resident #8 had a respiratory status change in condition; however the physician was not notified. Resident #8 voiced he/she did not feel well on the morning of [DATE]; however nursing did not assess respiratory or cardiovascular systems. Later that afternoon the resident was found unresponsive on the floor by staff. Life saving measures were started, however, not all necessary items were immediately available to provide care. The resident expired at the hospital after emergency transfer.The facility's QAPI process did not identify issues with care for a corrective action plan to be developed. The facility's failure to address systems failures and implement correction plans for these issues has caused, or is likely to cause, serious injury, harm, impairment, or death. Immediate Jeopardy was identified on [DATE], and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The facility provided an acceptable Credible Allegation of Compliance on [DATE], alleging the removal of Immediate Jeopardy on [DATE]. The State Survey Agency verified Immediate Jeopardy was removed on [DATE] as alleged, prior to exit on [DATE]. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the Job Description for the Center's Executive Director (CED), effective [DATE], revealed the CED would assure the QAPI Process was understood and utilized by all members of the Center Leadership Team to continually improve all aspects of Center performance. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy for Quality Assurance Performance Improvement (QAPI) Process, dated [DATE], revealed the Center was committed to incorporating the principles of Quality Assurance and Performance Improvement (QAPI) into all aspects of the Center work processes, service lines, and departments. All staff and stakeholders were involved in QAPI to improve the quality of life and quality of care for the patients' experience. Further review of the policy, revealed the QAPI program was ongoing, integrated, data driven, and comprehensive, addressing all aspects of care, quality of life, and patient centered rights and choice. The Center Executive Director (CED) led the center's QAPI processes and involved departments, staff and stakeholders-balancing a culture of safety, quality, and patient centeredness. The QAPI processes and improvements were based on evidence drawing from multiple sources, prioritizing improvement opportunities, and bench marking results against developed targets. Improvement Activities and Performance Improvement Projects were the structure and means through which identified problem areas were addressed. The learning, through applied QAPI plans, was continuous, systematic and organized. Continued review of the policy revealed the QAPI Committee met at least ten (10) times annually to monitor quality within the Center, identify issues, and develop and implement appropriate plans of action to correct identified quality issues. Attendees included the CED, the Chief Nurse Executive (CNE), the Medical Director, the Infection Preventionist, a representative from each department, including one (1) Certified Nursing Assistant (CNA), and divisional support leaders, as appropriate, to provide further insight and resource management. Interview with Interim Center Nurse Executive (CNE), on [DATE] at 2:47 PM, revealed she was in an interim position, and would be at the facility, for thirty-one (31) days or less. She stated she was not aware of any issues related to audits of care provided. She stated the facility was not doing any audits for residents that coded or expired in the facility to determine if care and services were provided per policy. She also stated at this time the facility was not auditing emergency carts to ensure they were stocked with emergency care items. Further interview with CNE, on [DATE] at 3:06 PM revealed she was still learning the facility process for change of condition notification and was still learning the process related to the nurses reporting change of condition to the physician. She stated she was unable to speak to the in-services provided to the nurses on reporting change of condition. She stated she was unable to speak to the process because she has only been here for thirty-one (31) days, and does not handle the education. She stated her only role was to oversee the day to day operations on a temporary basis. Interview with the Center Executive Director (CED), on [DATE] at 9:45 AM, revealed audits were being conducted however, she had not identified any issues with residents care. The CED stated the facility had not found issues with or audited for physician notification compliance. She stated the facility did not find any issues during the audits related to respiratory care services requiring corrective action or change in plans. However, the CNE was responsible for the clinical components of nursing needs. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further interview with the Center Executive Director (CED) on [DATE] at 3:40 P.M. revealed she was ultimately responsible for the center. She revealed the Quality Assurance Performance Improvement (QAPI) Committee met monthly and as needed. She stated the attendees were the Medical Director, the Chief Nursing Executive (CNE), Unit Managers, one (1) licensed nurse, one (1) Certified Nursing Assistant (CNA), Social Services Director, Activities, Minimum Data Set (MDS) Nurse, Dietician, Advanced Registered Nurse Practitioner (ARNP), Dietary Manager, Housekeeping Manager and Therapy. She stated the committee reviewed monthly reports that pulled from QAPI data, which gave them a percentage on where the facility was on various issues. She stated the QAPI also pulled trends from grievances and self-identification through process review and in the discussion of outcomes. She stated facility plans were generated through the QAPI process. She stated she felt the facility had provided staff with education they needed to do their jobs more effectively. She stated the QAPI plan was to continue to audit to assure staff understanding of the facility policies and procedures as written. Telephonic interview with the Medical Director, on [DATE] at 4:00 PM, revealed she was aware Resident #6 and Resident #8 had expired. She stated she had not discussed in QAPI, the issues related to residents identified with full code status and initiation of basic life support. In addition, she was not in attendance for the [DATE] QAPI meeting; because she was on a flight related to an out of town meeting. She was aware this was a meeting pertaining to the deficiencies cited during the Recertification survey; however could not speak to facility audits or findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34116 Based on observation, interview, record review, and facility policy review it was determined the facility failed to maintain infection standards for two (2) of fifty-six (56) sampled residents (Residents #6 and #69). Staff failed to maintain proper infection control standards during tracheostomy care and dressing changes. In addition, observations revealed staff failed to sanitize hands during medication pass. The findings include: 1. Review of the facility's policy Infection Prevention and Control Program (IPCP) Description, revised 03/11/19, revealed the IPCP was developed to provide staff with a coordinated organizational structure, technical procedures, comprehensive work practices, and guidelines to reduce the risk of transmission of infection or communicable diseases. The goals of the program were to provide a safe, sanitary and comfortable environment; decrease the risk of infection to patients and staff; monitor for occurrence of infection and communicable disease and implement appropriate control measures; identify and correct problems relating to infection prevention and control practices; and facilitate compliance with state and federal regulations relating to infection prevention and control. The policy revealed responsibilities of the Infection Preventionist included facilitating the implementation of the Genesis Infection Control Policies and Procedures, reviewing and implementing updates/revisions as issued; and monitoring procedures for proper infection prevention and control technique, as indicated and appropriate. Review of the facility's Tracheotomy Suctioning Procedure, revised 12/01/18, revealed the following steps: (not all steps in procedure are listed here) Cleanse hands and establish the need for suctioning by evaluating the patient for breath sounds, respiratory rate, and pulse oximetry. Put on personal protective equipment (PPE) including gloves, raise the head of the bed and position alert patient in a semi-Fowler's position. Open sterile saline or water, turn on suction machine and adjust vacuum, remove gloves and cleanse hands. Fill rinse cup with sterile saline or water. With sterile hand, rinse catheter in sterile water and repeat procedure until breath sounds clear and no more mucus returns. Rinse connecting tubing, remove PPE, and cleanse hands. Review of the clinical record revealed the facility admitted Resident #69 on 04/01/19 with diagnoses that included Persistent Vegetative State, Anoxic Brain Damage, Acute and Chronic Respiratory Failure, Tracheostomy Status, and Chronic Obstructive Pulmonary Disease (COPD). Further review of the clinical record revealed Physician Orders, dated 04/01/19, to perform tracheostomy suctioning as needed pre and post treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of tracheostomy care, on 08/06/19 at 10:45 AM, revealed Resident #69 lying in bed with a tracheostomy collar secured in place. Further observation revealed Licensed Practical Nurse (LPN) #2 performed hand hygiene, opened a tracheostomy suction kit, and donned sterile gloves. She used her gloved hands and opened the drawer of the bedside table, searched and closed the drawer, picked up a graduated container, and filled it with tap water at the resident's sink. The nurse failed to change the soiled gloves, and continued to remove a sterile suction catheter from its package, attached it to suction, removed the inner cannula of the resident's tracheostomy, inserted the suction catheter, and suctioned the airway. LPN #2 cleared the secretions from the suction catheter using tap water and continued to suction Resident #29's airway two (2) additional times using the tap water. The nurse removed the soiled gloves and washed her hands. LPN #2 donned clean gloves, picked up the inner cannula, touched the sterile tubing of the cannula with the non-sterile glove, and reinserted the contaminated cannula in to Resident #29's tracheostomy. Interview with LPN #2 during tracheostomy care revealed it was okay to use tap water for suctioning; however, she should have changed gloves after she touched the bedside table and faucet. She stated the soiled gloves could cross contaminate the tracheostomy and potentially cause an infection. Interview with LPN #4, on 08/09/19 at 3:57 PM, revealed it was important to use sterile supplies and maintain sterile technique during tracheostomy care to prevent potential pneumonia or airway infection. Interview with the UM (Unit Manager) for the North Hall, on 08/23/19 at 1:42 PM, revealed sterile gloves and water should be used for tracheostomy suctioning to prevent cross contamination. Interview with the Center Nurse Executive (CNE), on 08/22/19 at 2:51 PM, revealed she was not aware of any concerns with infection control or tracheostomy care. She further revealed sterile water should be used for tracheostomy suctioning and stated it was important to maintain sterile technique to prevent an airway infection. According to the CNE, the facility evaluated nursing skill competencies annually and, as needed. Interview with the Center Executive Director (CED) on 08/23/19 at 4:26 PM, revealed the facility had not identified any concerns related to infection control or tracheostomy care. 38739 2. Review of the CDC's (Centers for Disease Control) guidelines revealed hand hygiene was necessary after glove removal because hands could become contaminated through small defects in gloves from the outer surface of gloves used during removal. CDC guidelines stated hand hygiene should be performed immediately after gloves were removed. The CDC recommends changing gloves when going from dirty to clean area. Review of the facility's policy Hand Hygiene, revised 11/28/16, revealed hand hygiene was to be performed before providing patient care, before conducting an aseptic procedure, and after contact with a patient's environment. Hands were to be washed with warm water, applying soap and rubbing hands vigorously outside the stream of water, covering all surfaces, rinsing hands, and drying them thoroughly with a disposable towel. Also, use a towel to turn off the faucet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy Wound Dressings: Aseptic, revised 11/30/15, revealed prior to the wound care, the care giver was to clean the over-bed table, place a clean barrier on the over-bed table, place wound care supplies on the barrier, and cleanse hands and don clean gloves before beginning the wound care treatment. If a break in aseptic technique occurred, the procedure should be stopped, gloves removed, hands cleaned, and apply clean gloves. If treating multiple wounds and the wounds were in close proximity, treat the less contaminated wound first, and if in separate locations, treat each as a separate procedure. During the wound care process, if gloves become contaminated, remove gloves, cleanse hands, and apply clean gloves. Review of Resident #88's clinical record revealed the facility admitted the resident on 09/03/19 with the diagnoses of Vascular Dementia, Hypertension and Ascites. Observation, on 08/09/19 12:08 PM, revealed LPN #6 placed wound supplies onto Resident #88's bedside table. The table was observed to contain crumbs, a dried substance over the middle to the table and other particulate matter to the tabletop. LPN #6 placed the wound supplies and treatment creams onto the table without cleaning the table top or placement of a barrier. LPN #6 proceeded to place clean gloves to her hands and moved the resident's linen and handled the resident's inner right thigh with her gloved hands. Observation revealed an open wound to Resident #88's right inner thigh. The wound was dried to the left inner thigh and was pulled apart to expose the area by LPN #6. LPN #6 stated the resident's wound was not previously covered with a dry dressing and therefore was stuck to the resident's left leg. The LPN stated bleeding began when she removed the dressing which was adhered to the wound bed. LPN #6 described the leg wound as three (3) inches in length and one (1) inch wide and was open and bled. During continued interview, LPN #6 stated the resident's wound was a Stage two (2) ulcer. She stated the tissue was red with mild slough but the wound edges were healthy. LPN #6 stated she did not observe undermining of the wound. The LPN washed her hands, donned new gloves and handled the wound cleaner bottle with her gloved left hand and proceeded to spray into the wound and wiped off the excess with her right hand with a dry gauze and gloved hand. Previous observations with LPN #6 at the treatment cart revealed the wound cleaner bottle was not wiped off before she entered the resident's room. LPN #6 proceeded to obtain the medicated cream with her right hand, scooped the cream into the same gloves used to clean the wound and the packages which laid on the uncleaned uncovered table and proceeded to wipe the cream into and around the wound. Further observation revealed LPN #6 then threw away the rest of the dirty supplies into the resident's garbage, washed her hands and left the room. The LPN stated the wound needed a cover and she would get a doctor's order and would place cover to the wound after the order was obtained. Continued observation revealed LPN #6 left the room with the cleansing spray bottle, placed it into the treatment cart without wiping the bottle, did not clean the resident's over the bed table, and the LPN did not remove the bloody wound supplies from the room which were placed into the resident's garbage. Interview with the Center Nurse Executive (CNE), on 08/22/19 at 2:50 PM revealed she had not identified issues with staff and hand hygiene during dressing changes. The CNE stated maintaining infection control practices during treatment was important to prevent the spread of infection. Interview with the Center Executive Director, on 08/23/19 at 4:26 PM, revealed the facility expected staff to follow infection control standards to prevent infection control concerns. 41851 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of facility's policy Infection Prevention and Control, revised 03/11/19 revealed a comprehensive process that addressed the prevention, identification, reporting, investigation, and controlling of infections and communicable diseases for patients, staff, and others. Review of the facility's policy Hand Hygiene, revised 11/28/16, revealed hand hygiene was to be performed before providing patient care, before conducting an aseptic procedure, and after contact with a patient's environment. Observation of medication pass, on 08/08/19 at 9:22 AM, revealed License Practical Nurse (LPN) #4 failed to perform hand hygiene in between passing medication to residents. Observation of medication pass to Residents #71, #49, #51 revealed the LPN failed to sanitize her hands in between medication pass. Interview with LPN #5 on 08/08/19 at 8:36 AM, revealed he/she should have sanitized his/her hands in between medication pass. LPN #5 stated he should have sanitized his hands in between medication passes to residents. LPN #5 stated that not having good hand hygiene could pass on pathogens to other residents and the outcome to the resident could be harm. Interview with the Center Nurse Executive (CNE), on 08/22/19 at 2:50 PM revealed she had not identified issues with staff and hand hygiene during medication passes. The CNE stated maintaining infection control practices during treatment, including hand hygiene, was important to prevent the spread of infection. Interview with the Center Executive Director, on 08/23/19 at 4:26 PM, revealed the facility expected staff to follow infection control standards to prevent infection control concerns.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 34116 35750 Based on interview and record review it was determined the facility failed to ensure its staff and agency staff were trained at a minimum on what activities constituted abuse, neglect and exploitation, dementia management and management of persons with intellectual disabilities and resident abuse prevention. The findings include: Review of the facility's policy, Abuse Prohibition revised 07/01/19, revealed the facility prohibited abuse, mistreatment, neglect, misappropriation of resident property and exploitation for all residents. The policy stated the center complied with the Elder Justice Act (EJA) and employees were designated mandatory reporters and obligated to report any suspicion of a crime against a resident without fearing any retaliation. The policy defined abuse, in specific sexual abuse, as a non-consensual sexual contact of any type with a resident, which included, but was not limited to sexual harassment, sexual coercion or sexual assault. Mental abuse included, but was not limited to humiliation, harassment, threats of punishment or deprivation. Mental abuse occurred through either verbal or nonverbal conduct which caused, or had the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation or degradation. Further review of the policy revealed the facility implemented the abuse prohibition program by screening potential hires, training of employees, and provided ongoing training for all employees, prevented occurrences, identified possible incidents or allegations which needed investigations, investigated such incidents, protected residents during investigations and reported incidents, investigations and the Center's responses and results of investigations. The policy further stated if the suspected abuse was resident-to-resident, the resident who had attacked/threatened another was removed from the setting or situation and an investigation was completed. The center provided adequate supervision when a resident-to-resident threat was suspected, was responsible for identifying residents who had a history of disruptive, intrusive interactions, exhibited other behaviors and notified the family and the physician who was to follow up, e.g, with a psychiatric evaluation. The policy stated the Center sought options such as room changes, which was based on the situation; and the facility sought alternative placement for the resident who exhibited the abusive behavior if warranted. Interview with Certified Nursing Assistant (CNA) #6 on, 08/10/19 at 8:04 AM, revealed she had not received abuse training; however, after an incident happened at the facility she got a paper, an assessment, which she filled out and gave it back. CNA #6 stated she did not even know who the Center Nurse Executive (CNE) was until today. She stated she received no proper orientation to the facility or a proper walk through. Interview with Licensed Practical Nurse (LPN) #8, on 08/11/19 at 2:32 PM, revealed she worked the [NAME] Unit but floated back and forth. She further stated after a potential abuse incident the facility leadership came around with papers to read and sign. (continued on next page)

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #3, on 08/14/19 at 2:43 PM, revealed he worked about four (4) shifts a month at the facility and it was a challenge with so many agency staff. He stated there was a problem with communication among nursing staff. He stated some agency staff did not know where to find things; nurses had to keep their eyes open and he stated, the facility could do a better job with educating nurse aides on policy and procedures. Interview with the Center Executive Director (CED), on 08/13/19 at 9:38 AM, revealed she believed having so many rules made it difficult for an operator as herself to watch out for the residents and follow the rules to protect the residents. She stated she had a responsibility to the residents; however, as a human being she could not catch everything, such as abuse. It was part of her duties to oversee the operations of this center and she stated abuse was a hot topic and there was constant education.