STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. Building B. Wing	02/28/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment. Necessary Maintenance and Housekeeping was not provided in order to maintain a sanitary, orderly, and comfortable interior. Observation during tour of the building on 02/24/2025 revealed the following: There was a foul odor that smelled of stale urine noted throughout the 1C Unit hallway. The bathroom for room [ROOM NUMBER] had the appearance of dried urine on the floor and the room smelled liked strong stale urine. Additionally, the baseboard surrounding the sink in room [ROOM NUMBER] was pulled away from the sink and pulled away from the section of wall adjacent to the sink. The bathroom for room [ROOM NUMBER] had paint peeling off the wall around the plumbing, ceiling tile was sagging and there was a large water stain on the ceiling tile. The bathroom for room [ROOM NUMBER] smelled like old stale urine, the toilet was missing a seat, and the ceiling tile above the toilet was sagging and stained. room [ROOM NUMBER] had peeling paint on the sink cabinet door and the door was partially off the hinges. The bathroom for room [ROOM NUMBER] had no toilet paper holder attached to the wall, and there was no string on the call light in the bathroom. The 1C shower room had a brown substance that appeared to be fecal matter on the toilet seat and on a lawn chair in the room. Additional observation revealed there were black spots which appeared to be mold and a larger area of brownish discoloration on the ceiling tile in the shower. Also, observation on 02/24/2025 and 02/27/2025, revealed the cabinet in the dining/activity room on the 1C unit was missing baseboard leaving the damaged section of wall exposed. The findings include: Review of the facility policy titled, Safe and Homelike Environment, dated 12/12/2023, revealed the facility would provide housekeeping and maintenance services as necessary to maintain a sanitary, orderly, and comfortable environment. Further review revealed orderly was defined as an uncluttered physical environment that was neat and well-kept. Observation on 02/24/2025 at 2:20 PM, revealed a foul odor noted throughout 1C Unit hallway. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/24/2025 at 2:27 PM, revealed the bathroom for room [ROOM NUMBER] had the appearance of dried urine on the floor and the room smelled liked strong stale urine. Further observation revealed the baseboard surrounding the sink in room [ROOM NUMBER] was pulled away from the sink and pulled away from the section of wall adjacent to the sink. Observation on 02/24/2025 at 2:46 PM, revealed the bathroom for room [ROOM NUMBER] had paint peeling off the wall around the plumbing. Further observation revealed the ceiling tile was sagging and there was a large water stain on the ceiling tile. Observation on 02/24/2025 at 2:53 PM, revealed the bathroom for room [ROOM NUMBER] smelled like old stale urine. Further observation revealed the toilet was missing a seat. Continued observation revealed the ceiling tile above the toilet was sagging and stained. Observation on 02/24/2025 at 2:59 PM, revealed room [ROOM NUMBER] peeling paint on the sink cabinet door and the door was partially off the hinges. Further observation in the bathroom revealed the toilet paper holder was not attached to the wall, and the toilet paper roll was stored on the back of the commode without a container. Continued observation revealed there was no string on the call light in the bathroom. Observation on 02/24/2025 on 3:04 PM, revealed the 1C shower room had a brown substance that appeared to be fecal matter on the toilet seat and on a lawn chair in the middle of the room. Further observation revealed there were black spots which appeared to be mold and a larger area of brownish discoloration on the ceiling tile in the shower. Observation on 02/24/2025 at 5:10 PM, and 02/27/2025 at 3:45 PM, revealed the cabinet in the dining/activity room on the 1C unit was missing baseboard leaving the damaged section of wall exposed. In an interview, on 02/27/2025 at 3:48 PM, State Registered Nurse Aide (SRNA)16 stated she had been working at the facility for almost six months and the baseboard in the dining/activity room on the 1C unit had been missing as long as she had been there. Further, she stated the other areas of disrepair, including stained ceiling tiles had also been in that condition since she started. Per interview, SRNA16 stated maintenance staff was not in the building on her shift. She stated putting in work orders was the responsibility of first shift and management staff, since they were in the building at the time maintenance was also present. She further stated, maintenance services could be better, but if no one complained about repairs needed, nothing would get fixed. In an interview, on 02/27/2025 at 4:23 PM, Licensed Practical Nurse (LPN)4 stated if staff noticed areas of disrepair, they were to put work orders in the maintenance system. She further stated she noticed some cabinets needed to be replaced and she thought maintenance was aware of this. In continued interview, LPN4 stated she saw maintenance replace some tiles a month or two ago, but not since then. In an interview, on 02/27/2025 at 4:29 PM, the IC Unit Manager stated members of management completed daily rounds on rooms and were to check for repairs needed; however, she did not know who was responsible for rooms 101-112. Per interview, she stated she would put in work orders for the ceiling tiles, and baseboards needing repair, and the missing toilet paper holder which she observed during the unit tour with the State Survey Agency Representative prior to the interview. In further interview, the 1C Unit Manager stated maintenance issues needed to be addressed to provide a comfortable, homelike environment for the residents. She further stated one of the residents who used the bathroom (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for room [ROOM NUMBER] toileted independently, but might have been missing the commode, which meant housekeeping needed to clean the bathroom more frequently, including a deep clean. In an interview, on 02/28/2025 at 9:00 AM, the Maintenance Director stated his role was to ensure upkeep of the building. He further stated he completed preventative maintenance as well as checked for work orders in the maintenance system for any repairs needed. Per interview, members of the management team were each assigned a group of rooms to round on every day and they were expected to put work orders in for any areas of concern they identified. In continued interview, he stated he received work orders for ceiling tile repair on 1C this morning and had been working on replacing stained and sagging tiles. The Maintenance Director it was important to ensure building upkeep in order to provide a safe, homelike environment for the residents. In an interview on 02/28/2025 at 9:50 AM, the Admissions Coordinator stated she was assigned daily rounds on the section of rooms that included rooms [ROOM NUMBER]. She further stated those daily rounds included checking bathrooms and sinks for maintenance and housekeeping issues. In continued interview, she stated she noticed the ceiling tiles and put in a work order this morning. Per interview, she had not noticed them before today because she might have gotten distracted by other issues while rounding. Additionally, the Admissions Coordinator stated the 1C Unit was in need of environmental upgrades because it was not a comfortable, homelike environment for the residents. Per interview, she stated addressing maintenance issues was important for safety concerns and because no one would want to live in a poorly maintained facility. In an interview, on 02/28/2025 at 1:00 PM, the Director of Nursing (DON) stated she was part of the management team that performed rounds on resident rooms. She stated it was her expectation each manager enter identified issues into the maintenance system and also bring up any environmental concerns in morning meeting. In continued interview, the DON stated she was not aware of the ceiling tiles, baseboards, and other items in disrepair on 1C. Additionally, the DON stated the facility was responsible for providing a safe, homelike environment for the residents. In an interview, on 02/28/2025 at 2:43 PM, the Executive Director (ED) stated he expected members of the management team to conduct rounds on their assigned rooms on a daily basis and give reports of their findings to him each day. Per interview, the ED stated he entered any findings related to building upkeep into the maintenance system and followed up on any issues. The ED stated he doubted the baseboards and other identified items on 1C had been in disrepair for months. In additional interview, the ED stated building maintenance was a constant challenge, and he expected repairs to be completed as soon as any issues were identified.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on personnel files, facility policies, Kentucky regulation KRS 216.789 (1), and KRS 216.718 (4), the facility failed to ensure it did not employ or otherwise engage individuals with a disqualifying criminal conviction or finding in the State Nurse Aide Abuse Registry for three of 10 employee files reviewed. Review of the Cook's background check, Statewide Criminal Repository, revealed a Felony Burglary, 3rd degree with a Guilty disposition on 06/02/2016. Additionally, there was no documented evidence Nurse Aide (NA) Abuse Registry checks were completed for the Cook, Business Office Manager, or Administrative Assistant, prior to employment. The findings include: 1. Review of the facility policy titled, Abuse Prevention Program, revised 03/2021, revealed the facility conducted employee background checks per state and federal regulations, and will not knowingly employ or otherwise engage any individual who has been convicted of abuse, neglect, or misappropriation. The facility abuse prevention program provides policies and procedures that govern conducting background checks to avoid hiring persons who have been found guilty of abusing, neglecting, or mistreating individuals. Review of the facility policy titled, Background Check Disqualifying Criteria, undated, revealed as part of the hiring procedures it is the facility's policy to conduct criminal background checks on all applicants offered employment. The policy revealed the Office of Inspector General (OIG) has the authority to exclude individuals from federally funded health care programs and maintains a list of all currently excluded individuals called the List of Excluded Individuals/Entities (LEIE). The facility checks the LEIE on all potential hires to ensure new hires are not on the excluded list. If the applicant is on the list, the applicant is not eligible for hire. Any criminal history report in question or flagged report needs to be sent to the Executive Director and the facility's consulting group Human Resources (HR) for review and approval before orientation. Convictions for a felony robbery offense occurring less than seven years from the date of the criminal background check was considered disqualifying. Review of the Kentucky regulation KRS 216.789 (1), effective 07/14/2022, revealed no long-term care facility shall knowingly employ a person in a position which involves providing direct care services to a resident if that person has been convicted of a felony offense related to theft. Review of the Kentucky regulation KRS 216.718 (4), effective 06/29/2023, revealed direct care service means a service provided to a resident in a long-term care facility by direct care staff. Review of the facility map, revealed the kitchen was on the Ground floor right next to the dining room. Further, the Beauty Shop, smoking patio, and Therapy department were on the Ground floor. Review of the Cook's personnel file, revealed the [NAME] signed on 12/20/2024, he was given information or information was reviewed with him to include policies, and procedures related to Resident Rights and Resident Abuse. Review of the position description Dietary Cook signed by the [NAME] on 12/20/2024, revealed an essential responsibility and job function included Maintain effective communication with residents . (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Cook's background check, completed on 12/16/2024, revealed results were flagged for the Statewide Criminal Repository, the 7 year County Criminal History, and the Criminal History Nationwide . sections. The background check for the Statewide Criminal Repository revealed Felony Burglary, 3rd degree with a Guilty disposition on 06/02/2016. The 7 year County Criminal History stated to see results in the Statewide criminal repository. The Fraud and Abuse Control information System (FACIS) III section noted no pertinent information was found against the LEIE. In an interview, on 02/28/2025 at 11:27 AM and 02/28/2025 at 1:11 PM, the Director of Nursing Services (DON) stated she did not participate in Human Resources (HR) checks. She stated the [NAME] was hired in December 2024 or January 2025 and no longer worked at the facility. The DON further stated she thought the Cook's felony conviction would make him ineligible to work in the facility. In an interview, on 02/28/2025 at 2:43 PM, the Administrator stated the facility Human Resources (HR) Director was out of the facility for a personal issue, and he was currently covering the role of HR. He further stated the purpose of conducting the background checks was to make sure anyone working in the building did not have a background which was not conducive to providing resident care. The Administrator also stated according to the facility policy, the [NAME] was hired based on the seven year span. He stated the facility hired employees according to a case by case basis depending on what the applicant did. In continued interview, on 02/28/2025 at 2:43 PM, the Administrator stated the facility policy, Background Check Disqualifying Criteria, stated after seven years the applicant could be hired. (However, this policy referred to the LEIE). The Administrator also stated per facility policy, after seven years the facility could bring on board an applicant. When questioned if the facility policy superseded regulation, he stated he could speculate there could be a potential issue if an applicant was hired with a burglary guilty disposition. He also stated the facility wanted to have the best care for residents. 2. Further review of the facility policy titled, Abuse Prevention Program, revised 03/2021, revealed the facility conducts employee background checks per state and federal regulations and will not knowingly employ or otherwise engage anyone with a disciplinary action in effect against a professional license by a state or licensing body including the Nurse Aide Registry. Review of personnel files, revealed no documented evidence the facility conducted Kentucky Nurse Aide (NA) Abuse Registry checks prior to beginning employment with the facility for the Cook, Business Office Manager (BOM), and Administrative Assistant (AA). Per the personnel files, the [NAME] began employment on 12/20/2024, the BOM began employment on 01/09/2025, and the AA began employment on 01/22/2025. In an interview, on 02/28/2025 at 11:32 PM, the Director of Nursing (DON) and Regional [NAME] President (RVP) of Operations, both stated the facility did not complete NA Abuse Registry checks for non-clinical staff. In an interview, on 02/28/2025 at 1:11 PM, the DON stated she was not involved in conducting the NA Abuse Registry checks as they were to be completed by Human Resources (HR). She stated the purpose of the NA Abuse Registry check was to ensure in this type of environment the facility hired people qualified and safe to be around residents. She stated if the NA Abuse Registry checks were not completed, the facility could have someone not qualified or safe to be around the vulnerable population. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 02/28/2025 at 2:43 PM, the Administrator stated the NA Abuse Registry checks were to be completed in order to make sure whoever was in the building did not have a background that was not conducive to providing resident care. He stated the NA Abuse Registry checks were to be completed by HR, although he re-iterated she was out of the facility at this time and he was completing the HR duties. He further stated the NA Abuse Registry checks should be completed and records kept for their files.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. Based on interview, record review, and review of facility policy, the facility failed to send a copy of the notice of transfer to a representative of the Office of the State Long-Term Care Ombudsman for 3 of 3 sampled residents investigated for hospitalizations out of a total sample of 29 residents, Resident (R)23, R95, and R107. The findings include: Review of the facility policy titled, Transfer and Discharge, dated 12/12/2023, revealed the facility was to notify the long-term care ombudsman of transfers and maintain evidence the notice was sent to the Ombudsman. 1. Review of R95's admission Record revealed the facility admitted the resident on 07/14/2021 with diagnoses at time of survey including Alzheimer's disease, bariatric surgery status, and alcohol dependence in remission. Review of the facility Notice of Transfer or Discharge, dated 09/03/2024, revealed the resident was sent to the hospital after sustaining a fall at the facility. Further review revealed there was no documented evidence the form was sent to the Ombudsman. 2. Review of R107's admission Record revealed the facility admitted the resident on 03/25/2024 with diagnoses including chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease, unspecified, and interstitial pulmonary disease. Review of the Progress Note, dated 11/17/2024, revealed R107 had become unresponsive and was transferred to the local hospital and admitted for altered mental status. Review of the facility's Notice of Transfer or discharge: Notice of Bed Hold Days, dated 11/18/2024, revealed the facility documented R107 was transferred for altered mental status. Further review revealed the document failed to indicate the local ombudsman had been notified of the transfer. 3. Review of R23's admission Record revealed the facility admitted the resident on 11/22/2015 with diagnoses including Type II Diabetes Mellitus, Unspecified Dementia, Delusional Disorders, and Chronic Kidney Disease Stage III. Review of R23's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating no cognitive deficit. In an interview, with R23, on 02/26/2025 at 2:28 PM, R23 stated she has been out to the hospital on multiple occasions for different problems. Review of R23's Electronic Medical Record (EMR), under the Census section, revealed the resident was transferred out to the hospital on several occasions, including on 06/28/2024, 07/09/2024, 10/15/2024, 11/04/2024, and 12/03/2024. However, further review of the medical record, revealed no documented evidence the Ombudsman was notified of these transfers to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, with the Social Services Director, on 02/28/2025 at 2:15 PM, she stated she was not responsible for notifying the Ombudsman of residents' transfers out to the hospital. She stated Medical Records was responsible; however, the Medical Records person was not working today, and was unable to be reached by phone. In an interview, with the Regional Nurse Consultant, on 02/28/2025 at 2:40 PM, she stated the facility had not been notifying the Ombudsman of any hospital transfers from the facility. She further stated she could not find evidence of emails being sent to the Ombudsman related to transfers. In an interview, on 02/28/2025 at 3:22 PM, Ombudsman 2 stated he had not received any notifications since 05/2021, regarding residents from this facility being transferred to the hospital . In an interview, on 02/28/2025 at 1:00 PM, the Director of Nursing (DON) stated she was not able to provide documented evidence of notification of transfers to the ombudsman. In an interview, with the Executive Director, on 02/28/2025 at 3:10 PM, he stated either social services or medical records were responsible for notifying the ombudsman of resident transfers to the hospital. He stated this would be for both facility initiated or unplanned transfers.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and review of facility policy, the facility failed to implement the Comprehensive Care Plan (CCP) for 1 of 29 residents reviewed for care planning, Resident (R)141. On 01/15/2025, a care plan intervention for a perimeter mattress was added to R141's CCP due to the resident sustaining a fall from bed on the same date. Although the resident sustained another fall from bed on 01/19/2025, the intervention for the perimeter mattress was not implemented until 02/28/2025, during survey. The findings include: Review of the facility policy, titled, Comprehensive Care Plans, dated 11/01/2024, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident that included an assessment of the resident's needs. Further review revealed qualified care team members responsible for carrying out interventions would be notified of their responsibilities for the initial care plan, as well as when changes were made. Review of R141's admission Record revealed the facility admitted the resident on 01/15/2025 with diagnoses to include vascular dementia with agitation, osteoporosis, and a history of falls. Review of the Health Status Note, dated 01/15/2025, signed by Licensed Practical Nurse (LPN)8, revealed she found R141 lying on the floor by her bed. Additional review revealed the resident denied pain and LPN8's assessment found no sign of injury. Review of R141's CCP, dated 01/15/2025, revealed the facility identified the resident as at risk for falls and listed interventions including keeping the bed in low position, keeping the resident's call light in reach, and utilizing a perimeter mattress. All interventions were dated 01/15/2025. Review of the IDT [Interdisciplinary Team] Note, dated 01/16/2025, revealed the facility determined after R141 fell out of bed, they would install a perimeter mattress to prevent further falls. Review of the Health Status Note, dated 01/19/2025, signed by Registered Nurse (RN) 5, revealed she found R141 lying on the floor beside her bed, on top of pillows and blankets. Additional interview revealed R141 denied pain and RN5's assessment did not reveal signs of injury. Review of the IDT Note, dated 01/20/2025, revealed R141 fell out of bed on 01/19/2025 and was wearing appropriate footwear, but the resident was unable to state what she was doing at the time of the fall. Additional review revealed no documented evidence the facility verified previous care planned interventions, to include the perimeter mattress were in place at the time of the resident's fall. Review of R141's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of four out of 15, which indicated severe cognitive impairment. Additional review revealed the facility assessed the resident as having two falls without injury during the look back period. Observation on 02/24/2025 at 3:16 PM; 02/27/2025 at 3:17 PM; and 02/28/2025 at 10:21 AM, revealed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R141 had a regular mattress with no perimeter for fall prevention noted. During interview on 02/28/25 at 10:47 AM, Licensed Practical Nurse (LPN)4 stated she did not know if R141 had ever had a perimeter mattress. She further stated she was assigned to the resident, but since she did not put the resident to bed, she would not know what kind of mattress the resident had. In continued interview, LPN4 stated following the care plan was important in order for residents to have everything they need for safe care. During observation and interview, on 02/28/2025 at 10:21 AM, the 1C Unit Manager stated R141 should have a perimeter mattress because it was on her care plan. The 1C Unit Manager then checked and felt the edge of R141's bed, and stated she could not tell if there was a perimeter mattress on the resident's bed. In an additional interview on 02/28/2025 at 10:38 AM, the 1C Unit Manager stated staff just changed R141's mattress to a perimeter mattress. She stated the resident did not have a perimeter mattress before today. During an interview, on 02/28/2025 at 1:00 PM, the Director of Nursing (DON) stated she did not have a comment on why R141 did not have a perimeter mattress in place after falling out of the bed twice. In additional interview, the DON stated the unit manager for each unit was responsible for ensuring care planned interventions were in place. The DON stated, following the care plan was important to prevent accidents and injuries. During an interview, on 02/28/2025 at 2:43 PM, the Executive Director (ED) stated he expected the nursing department to follow up on residents after a fall to ensure care planned interventions were in place.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 sampled residents reviewed for falls, out of a total sample of 29 residents, Resident (R)141. R141 sustained a fall on 01/15/2025 and was found lying on the floor by her bed. The Interdisciplinary Team (IDT) decided a perimeter mattress should be placed on the bed to prevent further falls, on 01/16/2025. However, the perimeter mattress was not placed on the bed, and the resident sustained another fall on 01/19/2025, when she was again found on the floor lying beside her bed. The perimeter mattress was not placed on the bed until 02/28/2025, during the Survey. The findings include: Review of the facility policy, titled, Incidents, Accidents, and Supervision, dated 12/12/2023, revealed the facility was to conduct investigations into incidents, including falls, to identify a root cause and implement corrective actions and interventions. Review of R141's admission Record revealed the facility admitted the resident on 01/15/2025 with diagnoses including vascular dementia with agitation, osteoporosis, and a history of falls. Review of the facility Health Status Note, dated 01/15/2025, revealed Licensed Practical Nurse (LPN)8 documented she found R141 lying on the floor by her bed. Further review revealed the resident denied pain and LPN8's assessment found no sign of injury. Review of R141's Comprehensive Care Plan (CCP), dated 01/15/2025, revealed the facility identified the resident as at risk for falls and listed interventions including keeping the bed in low position, utilizing a perimeter mattress, and keeping the resident's call light in reach. All interventions were dated 01/15/2025. Review of the facility IDT [Interdisciplinary Team] Note, dated 01/16/2025, revealed the facility determined after R141 fell out of bed, they would install a perimeter mattress for fall prevention. Further review revealed no documented evidence the facility verified previous care planned interventions were in place at the time of the resident's fall. Review of the facility Health Status Note, dated 01/19/2025, revealed Registered Nurse (RN) 5 documented she found R141 lying on the floor beside her bed, on top of pillows and blankets. Further interview revealed R141 denied pain and RN5's assessment did not reveal signs of injury. Review of the facility IDT Note, dated 01/20/2025, revealed the facility noted R141 fell out of bed on 01/19/2025 and was wearing appropriate footwear, but the resident was unable to state what she was doing at the time of the fall. Further review revealed no documented evidence the facility verified previous care planned interventions, to include the perimeter mattress were in place at the time of the resident's fall. Review of R141's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (continued on next page)

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	185039	A. Building B. Wing	02/28/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(BIMS) score of four out of 15, indicating the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as having two falls with no injury during the look back period. Continued review revealed the facility assessed the resident as requiring maximum assist for transfers and as dependent on staff to push her wheelchair. Observation on 02/24/2025 at 3:16 PM, revealed R141 had a regular mattress with no perimeter for fall prevention noted. In an interview, on 02/24/2025 at 3:16 PM, R141 stated she remembered falling out of bed and sometimes did not want to ask staff to help her to get up because she was afraid she would fall again. Observation on 02/27/2025 at 3:17 PM, and on 02/28/2025 at 10:21 AM, revealed R141 had a regular mattress with no perimeter for fall prevention noted. In an interview, on 02/28/2025 at 10:47 AM, with LPN4, who was assigned to R141, she stated she did not know if R141 had ever had a perimeter mattress. She further stated she did not put the resident to bed, so she would not know what kind of mattress the resident had. During observation and interview, on 02/28/2025 at 10:21 AM, the IC Unit Manager felt of R141's mattress for a perimeter and stated she could not tell by feeling or looking at the mattress if it had a perimeter. In an additional interview on 02/28/2025 at 10:38 AM, the 1C Unit Manager stated they had just changed R141's mattress because it was not a perimeter mattress, but now it was. The 1C Unit Manager walked away and would not engage in further interview. In an interview, on 02/28/2025 at 1:00 PM, the Director of Nursing (DON) stated the process for investigating a resident's fall began with the assigned nurse completing an assessment to check for injuries. The nurse was then to assess the circumstances surrounding the fall, as well as notify the responsible party, the physician, and the DON of the resident's fall. She further stated the clinical team including Nurse Managers, Therapy, and the Nurse Practitioner would determine a root cause and determine an appropriate intervention to prevent further falls. In continued interview, the DON stated it was the Unit Manager's responsibility to ensure care plan interventions were implemented. The DON did not have a comment as to the reason the facility failed to provide a perimeter mattress as care planned for R141, after she fell out of the bed twice. In an interview, on 02/28/2025 at 2:43 PM, the Executive Director (ED) stated the facility process for investigating a fall was to discuss them in morning meetings and break down causal factors in clinical meeting to determine appropriate fall interventions. When questioned about the resident not having a perimeter mattress in place as per the CCP, he stated he did not have that information. He further stated the facility's goal was to keep perimeter mattresses in stock, so if a resident needed one, they could install it quickly.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, record review, and review of facility policy, the facility failed to assist residents in obtaining routine dental care for 2 of 7 sampled residents reviewed for dental care out of a total sample of 29 residents, Residents (R) 87 and R95. The findings include: Review of the facility policy titled, Dental Services, dated 12/12/2023, revealed the facility was expected to assist residents in obtaining routine dental services. Further review revealed the policy defined routine services as an annual inspection for signs of dental disease, dental cleaning, and dental x-rays. 1. Review of R87's admission Record revealed the facility admitted the resident on 02/02/2021 with diagnoses including early onset Alzheimer's disease, type 2 diabetes, and low body mass index. Review of R87's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/23/2025, revealed the facility assessed the resident as having both short and long term memory problems, as severely cognitively impaired, and as unable to make herself understood. Continued review of the MDS revealed the facility did not assess the resident as having pain in chewing and swallowing during the look back period. Observation on 02/28/2025 at 5:13 PM revealed R87 was missing teeth, but was eating without signs of pain. Review of the Summary Report from the visiting dentist, revealed the resident was last seen by a dentist on 04/03/2023, with findings of partial dentition. Per the report, no x-rays were taken because the resident was not yet due for x-rays. However, there was no further documented evidence of an annual dental exam after 04/03/2023. Review of R87's Comprehensive Care Plan (CCP), dated 11/06/2024, revealed the facility identified the resident's teeth were in poor condition, with some teeth missing and included the intervention to provide routine dental services. 2. Review of R95's admission Record revealed the facility admitted the resident on 07/14/2021 with diagnoses including Alzheimer's disease, bariatric surgery status, and alcohol dependence in remission. Observation on 02/28/2025 at 3:09 PM, revealed R95's resident's teeth were broken, decayed, and significantly yellowed. Review of R95's CCP, dated 06/29/2023, revealed the facility assessed the resident as having partial dentition and tooth decay. Further review revealed the facility documented in the CCP, the dentist recommended not pulling the decayed tooth unless it caused the resident pain. Continued review revealed the facility listed the intervention to coordinate for routine dental services. Review of the Summary Report from the visiting dentist, revealed R95 was last seen by a dentist on 08/04/2023, with findings of some tooth decay that was treated non-invasively during the appointment. However, there was no further documented evidence of an annual dental exam after 08/04/2023. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R95's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/08/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment. Further review of the MDS revealed the facility did assess the resident as having pain in chewing and swallowing during the look back period. Interview was conducted, on 02/28/2025 at 9:45 AM, with the 1C Unit Manager, who was in charge of the unit in which R87 and R95 resided. She stated she was not aware of any reason R87 and R95 would not have received routine dental care in 2024. In an interview, on 02/28/2025 at 11:01 AM, the Social Services Director (SSD) stated her role in the process of obtaining dental care for residents was to ensure the resident had orders and signed consents for dental services. She stated she would then add them to the list to be seen by the dentist who visited the facility. In further interview, the SSD stated she was not sure why R87 and R95 were not seen by the dentist in 2024, but she would check. The SSD failed to provide further information prior to survey exit. In an interview, on 02/28/2025 at 1:00 PM, the Director of Nursing (DON) stated she expected residents to receive routine dental services at least once per year. She further stated the SSD was responsible to make sure all residents were seen each year. In continued interview, the DON stated it was important to provide appropriate dental services to prevent oral pain and difficulty in chewing, which could lead to weight loss. In an interview, on 02/28/2025 at 2:43 PM, the Executive Director (ED) stated he was unsure how often residents should receive routine dental services, but he thought it was once per year. He further stated he expected the facility to follow their policy and ensure they made appropriate referrals to get residents seen by a dentist. In continued interview, the ED stated R87 and R95 were not seen by a dentist in 2024, and he would investigate where the process failed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 sampled residents reviewed with urinary catheters on Enhanced Barrier Precautions (EBP) out of a total sample of 29 residents, Resident (R) 75. Observation on 02/26/2025 at 2:59PM, revealed Licensed Practical Nurse (LPN)1 touched R75's privacy curtain and sink faucet handles while wearing gloves. She then failed to perform hand hygiene and don new gloves prior to performing suprapubic catheter care. The findings include: Review of the facility's policy titled, Infection Prevention and Control Program, dated 01/02/2024, revealed, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. All staff shall demonstrate competence in relevant infection control practices. Review of the facility's policy titled, Indwelling Catheter, dated 01/01/2024, revealed, If an indwelling catheter is in use, the facility will provide appropriate care for catheter in accordance with current professional standard of practice and resident care policies and procedures that include, but are not limited to: Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. Review of the (CDC) guidelines, dated 02/27/2024, revealed Gloves should be used whenever healthcare workers anticipate contact with blood, bodily fluids, mucous membranes, nonintact skin, or potentially contaminated surfaces and equipment. The CDC stresses that gloves must be changed between, patient contacts and when moving from contaminated to clean tasks for the same patient. This practice helps ensure that microorganisms are not inadvertently spread . Review of R75's Face Sheet, located in the resident's electronic health record (EHR), revealed the facility admitted the resident on 02/02/2023 with diagnoses to include unspecified intellectual disabilities, obstructed and reflux uropathy, and chronic kidney disease. Review of R75's Comprehensive Care Plan, dated, 06/27/2023, revealed R75 was care planned for at risk for infection/complications related to suprapubic catheter, and to use Enhanced Barrier Precautions. Interventions included wear gloves and gown during high contact care, initiated 04/03/2024. Other interventions included catheter/peri care at least every shift and as needed, initiated 02/02/2023. Review of R75's Quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/26/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 04 out of 15, which indicated severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R75's Physician Orders, located in the EHR, revealed an order for daily cleansing of suprapubic catheter using soap and water. Observation on 02/26/2025 at 2:59PM, revealed LPN1 donned a gown and gloves, closed the privacy curtain, walked to the sink faucet and touched the handles to turn on the faucet and saturate the washcloth with water and cleanser from a bottled no rinse cleanser provided by the facility to all residents. LPN1 then returned to the bedside and proceeded to clean R75's suprapubic catheter wearing the same gloves in which she had touched the privacy curtain and sink faucet handles. Continued observations revealed LPN 1 first wiped catheter with saturated washcloth, working away from the body, several times, changing areas to use on washcloth. LPN1 then folded the washcloth and cleansed skin area around catheter. The skin air dried before LPN1 applied a 4x4 gauze with split middle around catheter and secured with tape. During an interview with the Infection Preventionist (IP), on 02/28/2025 at 10:14 AM, she stated the general process for suprapubic catheter care was to use aseptic technique. When questioned what was to be used to clean the suprapubic catheter, she stated she would have to check the policy. She further stated catheter care involved washing hands, donning gloves and wiping the catheter with a clean wash cloth. The IP stated she planned to implement education on enhanced barrier precautions. She further stated she currently did not perform audits for catheter care, but would perform on the spot correction if she saw a concern. In continued interview with the IP, on 02/28/2025 at 10:14 AM, she stated she provided education related to catheter care during orientation, but there was not an annual skills checkoff or annual training specific to catheter care. The IP stated the purpose of wearing clean gloves while providing catheter care was in order to not introduce new germs to that area. She stated if a staff member donned gloves and then touched the privacy curtain and sink faucet and then performed catheter care with the same gloves, there was the potential to transmit infection to the catheter. During an interview, with the Director of Nursing (DON), on 02/28/2025 at 1:38PM, she stated it was her expectation staff would doff gloves after touching a resident's privacy curtain and sink faucet handles, and then wash hands and don new gloves before performing suprapubic catheter care. The DON stated ongoing training for suprapubic catheter care was completed by watching a video and not an in-person skills check off, and she thought it was completed by staff quarterly. During an interview with the Executive Director, on 02/28/2025 at 2:47 PM, he stated it was his expectation for staff to follow guidelines that would include changing gloves on a regular basis and as necessary. The Administrator stated, after touching potentially contaminated surfaces, staff should wash hands and put on new gloves prior to performing catheter care.