STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's Baseline Care Plan policy, it was determined the facility failed to ensure the Baseline Care Plan was developed and implemented to provide effective person-centered care for one (1) of seventy-one (71) sampled residents (Resident #299). Resident #299's Baseline Care Plan, initiated on 03/17/2022, revealed the resident required isolation as warranted per the resident's condition. However, the facility failed to further implement the Baseline Care Plan to include interventions related to Resident #299's Droplet Precaution isolation. Observations on 03/20/2022, revealed staff entered the resident's room to provide care without appropriate Personal Protective Equipment (PPE). Further observations on 03/20/2022 revealed staff exited the resident's room without following proper infection control guidelines. The findings include: Review of the facility's policy, Baseline Care Plan Process, dated 07/18/2018, revealed the charge nurse who admitted residents to the facility initiated the Baseline Care Plan to ensure care needs were met, utilizing a person-centered focus. Additionally, the Baseline Care Plan would be the working tool (Care Plan) for the first forty-eight hours. During the first forty-eight hours, all disciplinary team members, along with the resident and/or resident's Power of Attorney (POA)/family, reviewed the Baseline Care Plan and used it to build a Comprehensive Care Plan. Further, the Baseline Care Plan was presented to the resident and/or representative prior to completion of the Comprehensive Care Plan. Review of Resident #229's, Resident Face Sheet, revealed the facility admitted the resident from an acute care hospital, on 03/17/2022, with diagnoses which included History of COVID-19, Urinary Tract Infection (UTI), and Metabolic Encephalopathy. Review of Resident #299's Physician's Orders, revealed an order, dated 03/17/2022, for isolation, droplet precautions related to the resident not being fully vaccinated against COVID-19. The order had an end date of 03/31/2022. Review of Resident #299's Baseline Care Plan, dated 03/17/2022, revealed a care plan component, Problem of Infection Control. The resident was at risk for active infection related to potential exposure to COVID-19. The goal was the resident would not demonstrate signs or symptoms of an active COVID-19 infectious process. Interventions included but were not limited to: Isolation as warranted per resident's condition; and, maintain appropriate Personal Protective Equipment (PPE) use according to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	State requirements and availability, dated 03/17/2022. Observation of Resident #299's room, on 03/20/2022 at 4:05 PM, revealed an open door with Droplet Precautions and Contact Precautions Isolation signs. Per the signage, droplet isolation required an N-95 face mask, a closed door, and use of dedicated equipment, which would stay in the resident's room. Continued observation revealed a don and doff (put on/ take off) PPE instructional sheet on the open door. Additional observations revealed a plastic three (3) drawer PPE cart at the door, in the hallway with gowns, gloves, and surgical masks. However, outside the room, there was no evidence of sanitizing wipes, N-95 masks, or brown bags for storage of dedicated masks. Further observation, on 03/20/2022 at 4:10 PM, revealed State Registered Nursing Assistant (SRNA) #1, SRNA #2, and Hospitality Aide (HA) #3 donned PPE in the hallway outside Resident #299's room. The staff members put on gowns and gloves, but the aides failed to change their dedicated mask to an N-95 mask. Instead, they all wore their dedicated surgical masks and eye protection into the room. Further observation revealed the staff assisted Resident #299 and his/her roommate Resident #12, who was in Contact isolation, without changing their PPE. Additional observations revealed the staff doffed the PPE, (gowns and gloves) in the isolation room and disposed of it in dedicated bins, washed their hands, and exited the room. However, staff brought a mechanical lift out of the room without sanitizing it, and they did not clean their eye protection or change their surgical masks after exiting the room. The lift was not disinfected, before it left the isolation room, and SRNA #1 parked the lift on the opposite hallway. The aides then went to the nurses' station. Interview with SRNA #1, SRNA #2 and HA #3 on 03/20/2022 at 4:15 PM, revealed she was aware Resident #299 was in Droplet Isolation related to not receiving all COVID-19 vaccines yet. She stated she read about Resident #299's care on the [NAME]. Further interviews with SRNA #1, SRNA #2 and HA #3, revealed they received training on care plans, and they were aware the care plans were on the [NAME], in a notebook at the nurse's station. Continued interview revealed they followed the Care Plan when caring for Resident #299 to ensure his/her safety and the safety of the staff. They stated that it was important to follow the care plan to maintain infection control practices per policy, in order to prevent the spread infection to other residents. Interview with the Unit Manager (UM)/Registered Nurse (RN) #3, on 03/26/2022 at 12:10 PM, revealed she had been in the UM role for three (3) weeks. Per her interview, she expected staff to follow the resident's care plan to ensure proper and safe care was provided per the resident's needs, as assessed. Continued interview revealed staff was expected to refer to the Care Plan each time they provided care to any resident because care interventions could have changed. Additionally, all staff was responsible for ensuring residents' care plans were implemented and followed. She further stated, aides, nurses, and supervisors were responsible for immediately intervening, addressing, and correcting care, if the resident's care plan was not being followed. The UM said she monitored care plan implementation by assisting with resident care, making observations of staff while providing care, and speaking with residents, family, and staff. She said if staff had questions about how to provide resident care, they could ask her or other staff nurses for help. The UM stated she had not identified concerns with implementation of resident care plans. Interview with SRNA #6, on 03/26/2022 at 1:00 PM, revealed she looked at resident Care Plans daily to verify the care needs of the residents. The SRNA stated it was important to follow the resident's Care Plan in order to provide resident care in a safe manner. Interview with RN/Minimum Data Set (MDS) Nurse #1, on 03/26/2022 at 3:41 PM, revealed she used the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policies and the Resident Assessment Instrument (RAI) manual for guidance when she completed the Minimum Data Set (MDS). Assessments. She stated, in addition, she used a worksheet with information gathered from the resident's chart, family, staff, and face- to-face, and hands on assessments. She stated the floor nurse initiated the Baseline Care Plan, and it would be reviewed at the next clinical meeting. Continued interview revealed the MDS nurse would continue to develop the care plan. RN/MDS Nurse #1 stated the care plan should be the guide for provision of resident care. Interview with the Director of Nursing (DON)/Infection Control Nurse on 03/26/2022 at 4:00 PM, revealed floor nurses, MDS nurses, and members of the Interdisciplinary Team (IDT) developed and revised the Baseline Care Plan. Continued interview revealed all staff was responsible for ensuring the Baseline Care Plan was followed. Additionally, she expected staff to refer to and follow the Baseline Care Plan, because it was developed according to the resident's needs. She stated she had not identified issues with staff not following Baseline Care Plans. After the SSA (State Survey Agency) Surveyor discussed the observations she made on 03/20/2022, the DON/Infection Control Nurse said staff should have followed the Baseline Care Plan. Interview with the Administrator, on 03/26/2022 at 4:30 PM, revealed all staff members were responsible for following the Baseline Care Plans for each resident, and for ensuring safe care was provided. The Administrator stated staff leaders made rounds and observed resident care to ensure Baseline Care Plans were followed. Further, he stated staff talked with residents, families, and staff; and that Baseline Care Plans were discussed in clinical morning meetings. The Administrator stated he had not identified concerns with Baseline Care Plans. Continued interview revealed after the SSA Surveyor discussed observations made on 03/20/2022, the Administrator stated ongoing education was necessary related to following the Baseline Care Plans, and maintaining proper infection control practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 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** Based on observation, interview, record review, policy review, and Centers for Medicare and Medicaid Services, Resident Assessment Instrument Manual 3.0, it was determined the facility failed to develop and/or implement a person-centered Comprehensive Care Plan (CCP) which included measurable objectives and timeframe's to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for two (2) of seventy-one (71) sampled residents (Residents #12 and #49) 1. Review of Resident #49's Comprehensive Care Plan (CCP) revealed an intervention to place the resident near the nurses' station when out of bed on 09/08/2020. On 05/28/2021, the facility added the intervention to keep the resident near the nurses' station when up in the wheelchair (w/c). On 09/27/2021, the facility initiated the intervention for the resident to be in the direct view of staff when up in the w/c. However, record review and staff interviews revealed they would be busy and unable to monitor the resident. Staff stated the resident often left the nurse's area and they would find the resident in his/her room on the floor from an unwitnessed fall. The resident sustained wounds from multiple falls that included: a nasal fracture; the skin and soft tissue on top of the right hand was completely rip from the hand (de-gloved); a dislocation of the left shoulder, and a cut to the forehead with extensive width which did not allow the area to be sutured. 2. Review of Resident #12's Comprehensive Care Plan (CCP) revealed the resident was on isolation precautions which required Transmission-Based Precautions (TBP). However, observations, on 03/22/2022, revealed the staff did not wear appropriate PPE (Personal Protective Equipment) into the resident's room while providing care to the resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 04/04/2022 and was determined to exist on 02/24/2021 in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation; F602 Free from Misappropriation Exploitation at a scope and severity (S/S) of K, and at 42 CFR 483.25 Quality of Care F 689 Free from Accidents/Hazards/Supervision/Devices at a S/S of J. Immediate Jeopardy was identified at 42 CFR 483.21 Comprehensive Person-Centered Care Plans F656 Comprehensive Resident Centered Care Plans at a S/S of J 42 CFR 483.45 Pharmacy Services F755 Pharmacy Services/Procedure /Pharmacist/Record at a S/S of K at 42 CFR 483.70 Administration F835 Administration and F837 Governing Body at a S/S of K at CFR 42 483.75 Quality Assurance and Performance Improvement F867 QAPI/QAA Improvement Activities at a S/S of K. The facility was notified of the Immediate Jeopardy on 04/05/2022. The facility provided an acceptable Immediate Jeopardy Removal Plan on 04/12/2022, with the facility alleging removal of the Immediate Jeopardy, on 04/09/2022. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 04/09/2022, prior to exit on 04/14/2022. The facility's remaining non-compliance was at a Scope and Severity of a F while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes. The findings include: Review of the facility's CCP policy, revised 07/19/2018, revealed the facility developed and maintained the CCP for each resident which identified the highest level of function a resident may be expected to attain. The facility developed the CCP's based on thorough assessments and designed the CCP (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to identify problem areas, add risk factors with the identified problem, reflect treatment, goals, timetable and objective in a measurable outcome, aide to prevent or reduce decline of a resident's functional status or level. The CCP included desired outcomes. The implementation of CCP interventions started after consideration of the resident's problem area and their causes. The intervention addressed the underlying source of the problem area, rather than to address the symptom or trigger. The intervention reflected action, treatment, or procedure to meet the objective toward the achievement of the resident's goals. 1. Review of Resident #49's clinical record revealed the facility admitted the resident on 04/02/2015, with diagnoses of Alzheimer's Disease, Parkinson's Disease, and Anxiety. The facility added the diagnosis of falls on 04/21/2020. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #49 with a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15). The facility determined the resident had a cognitive deficit and was not interviewable. The facility completed Quarterly MDS assessments on 02/01/2021, 05/04/2021, 08/04/2021, and an Annual MDS assessment on 11/04/2021. The facility assessed the resident required the extensive assistance of one (1) staff for transfers, toileting, and bed mobility. The resident used a w/c (wheel chair) for mobility. Review of the Comprehensive Care Plan (CCP), dated 12/11/2019, revealed Resident #49 was at risk for falls due to Parkinson's, Muscle Weakness, Psychotropic Medication, Incontinence, and history of falls. On 09/08/2020, the facility initiated the intervention to place the resident in his/her w/c at the nurses' station when out of bed. On 05/28/2021, the facility added the intervention to keep the resident near the nurses' station when up in the wheelchair. On 09/27/2021, the facility initiated the intervention for the resident to be in the direct view of staff when up in the w/c. Further review revealed the three (3) interventions were active on the resident's care plan. Review of Resident #49's event reports revealed the resident had twenty-four (24) falls from 02/12/2021 to 12/25/2021. Review of the Event Reports revealed on 02/12/2021, 03/15/2021, 03/26/2021, 04/05/2021, 05/01/2021, 05/04/2021, 05/08/2021, 05/12/2021, 05/17/2021, 05/28/2021, 06/05/2021, 06/10/2021, 06/16/2021, 07/15/2021, 07/29/2021 at 4:40 PM and 5:00 PM, 08/03/2021, 08/14/2021, 09/27/2021, 10/04/2021, 11/29/2021, 11/29/2021, 12/21/2021, and 12/25/2021 were unwitnessed falls while the resident was up in his/her wheelchair. Further review of the Event Reports with unwitnessed falls revealed, on 04/05/2021, Resident #49 sustained a nasal fracture from an unwitnessed fall in his/her bedroom. On 05/01/2021, the resident fell in his/her room and suffered a skin tear on the top of the right hand which required sutures and steri-strips because the skin tear exposed the resident's muscle. On 05/09/2021, Resident #49's right hand skin tear required antibiotic treatment due to an infection. On 06/16/2021, staff found Resident #49 in another resident's bathroom and he/she had dislocated his/her left shoulder. Continued review revealed, on 07/29/2021 at 5:00 PM, Resident #49 had an unwitnessed fall in the hallway which resulted in a cut to his/her head which could not be sutured due to the width of the head wound. Observation, on 03/30/2022 at 8:30 AM, revealed Resident #49 sat in a wheelchair and propelled himself/herself on the unit by his/her room. Interview with Family #14, on 03/31/2022 at 8:45 AM, revealed Resident #49 did not understand his/her physical limitations. The Family member stated the resident stood up while in the wheelchair or transferred himself/herself from the bed. Continued interview revealed the facility started watching (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident at the nurses' station related to the increased falls the resident experienced in 2021. However, the Family member stated the resident wandered in the w/c back to his/her room and staff would not be aware he/she had left the area. Family #14 stated they attended care plan meetings for the resident and the intervention regarding keeping the resident at the nurses' station was intended to keep the resident safe and to decrease injury and falls. Interview with State Registered Nurse Assistant (SRNA) #17, on 03/26/2022 at 10:00 AM, revealed Resident #49's interventions included to watch the resident at the nurses' station because the resident would stand up while in the w/c and fall. The SRNA stated the resident was mobile around the unit in the w/c. The aide stated staff would bring the resident to the nurses' station and the resident would later be found in his/her room on the floor. Continued interview revealed staff would not be aware the resident left. The SRNA stated the facility expected all staff to follow residents' care plans. Interview with SRNA #18, on 03/30/2022 at 4:00 PM, revealed Resident #49's care plan included to have the resident in eyesight of the nurses' station to monitor the resident. However, the aide stated staff could not watch the resident due to responsibilities to other residents and Resident #49 would go back to his/her room. SRNA #18 stated staff were to follow residents' care plans as the CCP interventions were intended to keep residents safe. However, due to low staffing on variable days, staff could not follow Resident #49's care plan. The aide stated the facility expected staff to follow residents' care plans and interventions. Interview with Licensed Practical Nurse (LPN) #20, on 03/30/2022 at 3:45 PM, revealed Resident #49's interventions included to place the resident at the nurses' station area to monitor the resident. The nurse stated Resident #49 attempted to stand up from the w/c and would fall. LPN #20 stated staff moved the resident to the nurses' station to monitor, as per the care plan, on 11/29/2021 at 4:40 PM, because staff found the resident in his/her bathroom on the floor. However, staff continued with their duties and staff found the resident on the floor in the hallway with an injury to the head. Interview with Registered Nurse (RN) #1, on 03/30/2022 at 2:40 PM, revealed residents' care plans were found in the electronic record. The aides' care plans were available at the nurses' station. RN #1 stated Resident #49 had frequent falls and the resident's care plan included supervision at the nurses' station when the resident was awake. The nurse stated the resident moved around well in his/her wheelchair, and would leave the nurses' station without staff's knowledge, and often was found on the floor after an unwitnessed fall in his/her room. Further interview revealed staff did not follow the care plan because the resident left the area. RN #1 stated the facility expected all staff to follow residents' care plans because each intervention specifically addressed a resident's care needs. RN #1 stated two (2) of the resident's falls resulted in major injury. The RN stated Resident #49 had a dislocation of his/her shoulder and a skin tear which started at the resident's knuckles with the skin pulled away to the resident's wrist. RN #1 stated the scars on the resident's hands and forehead were due to the injuries from his/her falls. Interview with MDS Coordinator #1, on 10/30/2022 at 4:45 PM, revealed the facility developed resident care plans at admission, and revised them quarterly and, as needed. The Coordinator stated all residents were considered a fall risk at admission and the facility completed a fall risk assessment upon admission and quarterly. MDS Coordinator #1 stated moderate to high fall risk for falls triggered a fall care plan focus. Interventions would be started and individualized to meet the resident's needs. The Coordinator stated the care plans developed were to be followed by staff to keep the residents' safe and the clinical managers ensured staff followed the care plans. MDS Coordinator #1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated the facility expected staff to follow policies and to follow residents' care plans. Interview with the Assistant Director of Nursing (ADON), on 03/29/2022 at 5:10 PM, revealed the facility initially identified a resident's fall risk with a fall risk assessment. The facility used the John Hopkins assessment tool, diagnoses, and history to identify residents at risk for a fall. the MDS Coordinators gathered all the initial assessments and developed the individual CCP's. She stated the clinical IDT discussed resident falls daily and reviewed falls weekly at the AT RISK IDT team meeting. The ADON stated the teams would identify a new intervention, add to the care plan, and they notified staff. She stated staff were to follow resident care plans. The ADON stated the clinical IDT made sure staff followed residents' care plans by frequent daily walking rounds. She further stated the facility did not identify issues with staff not following resident care plans. Interview with the DON (Director of Nursing), on 03/31/2022 at 12:25 PM, revealed the facility identified residents at risk for falls at admission with the completion of a fall risk assessment and the resident's overall mobility. She stated the MDS Coordinators initiated the admission care plan. She further stated the clinical IDT team reviewed falls the next day and then weekly at the At-Risk IDT team meeting. Further interview revealed the facility expected staff to follow residents' care plans which provided safety and resident care needs. She stated Resident #49's care plan included to supervise the resident at the nurses' station when awake. The DON stated she completed walking rounds several times a day to observe staff providing care. She stated she had not identified any concerns of staff not following Resident #49's care plan. Interview with the Administrator, on 03/26/2022 at 4:00 PM, revealed the clinical IDT reviewed events daily and At-Risk residents weekly. He stated the clinical nursing team's responsibility included to ensure residents' care plans were followed. Continued interview revealed the clinical management team was on the residents' floors throughout the day and the tea had not reported issues with staff not following residents' care plans. He further stated the Quality Assurance and Performance Improvement (QAPI) had not identified issues with residents' care plans. 2. Interview with the Minimum Data Set (MDS) Coordinator, on 03/04/2022 at 12:00 PM, revealed the facility utilized the Centers for Medicare and Medicaid Services, Resident Assessment Instrument Manual 3.0, as a guideline for timely revision of residents' CCP. Review of the CMS Resident Assessment Instrument (RAI) Manual 3.0, dated October 2019, revealed the CCP was to be reviewed and revised periodically, and the services provided or arranged were to be consistent with each resident's written plan of care. Continued review revealed the CCP was driven not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths, and needs. Furthermore, review revealed a CCP was based on a thorough assessment and effective clinical decision making, compatible with current standards of clinical practice that provided a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. Further review revealed a well prepared assessment re-evaluating the resident's status at prescribed intervals (quarterly, annually, or when a significant change in a resident's status occurred) using the RAI process, ensured the resident's individualized CCP was modified as appropriate and necessary. Review of Resident #12's Electronic Medical Record (EMR) revealed the facility admitted the resident, on 06/17/2019, with diagnoses that included Chronic Respiratory Failure, unspecified whether with hypoxia or hypercapnia, Dementia with behavioral disturbance, Diabetes Mellitus with Diabetic Neuropathy, Recurrent Urinary Tract Infection, unspecified and Extended Spectrum Beta Lactamase (ESBL) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resistance. Review of Resident #12's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/20/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (09) which indicated the resident had moderate cognitive impairment. Record review revealed on 02/03/2022 and 03/16/2022, the facility placed Resident #12 on contact isolation due to Vancomycin Resistant Enterococcus (VRE) in his/her urine. VRE is a bacterial infection that is resistant to the antibiotic Vancomycin, which is commonly used to treat this type of infection. Transmission Based Precautions (TBP) was implemented to prevent the spread of infection. Review of Resident #12's Comprehensive Care Plan (CCP) revealed, on 02/03/2022, the facility care planned the resident for infection control due to the diagnosis of VRE. The goal was the resident's signs and symptoms would resolve as evidenced by a normal temperature, decreased urgency, decreased frequency, decreased complaints of abdominal pain, decreased complaints of burning on urination, decreased confusion, decreased weakness within forty-eight hours of start of antibiotic treatment. Interventions included but not limited to: Contact Isolation per order; vital signs every shift until completion of antibiotic; administer antibiotic, as ordered; observe for side effects related to antibiotic therapy; and report to physician (rash, itching, nausea/vomiting, diarrhea, difficulty breathing). Review of Resident #12's Physician's Orders, dated March 2022, revealed an order for contact isolation, dated 03/16/2022, for urinary tract infection (UTI) due to VRE in the urine culture. Further review revealed an order to start Macrobid (antibiotic) 50 mg (milligrams), oral every six (6) hours, times five (5) days. Additional review of Resident #12's IDT Progress Notes, dated 03/17/2022 at 4:19 PM, revealed antibiotic use for urinary tract infection; continue without adverse reactions, Care Plan updated and contact isolation in place. However, additional review of Resident #12's CCP revealed no documentation the facility developed an Infection Control care plan related to the resident's UTI and order for Contact Isolation. Observations on 03/20/2022 at 4:05 PM, revealed Resident #12 was in Contact Precautions. The door was open and there were two (2) isolation signs on the door. One (1) noted Contact Isolation and the other one (1) noted Droplet Precaution. Additional observations revealed the Droplet and Contact sign on the door listed: N95 mask, close door and use dedicated equipment. Continued observations revealed an instructional sheet on the door which noted how to don and doff (put on and take off) PPE. Further observations revealed a plastic three (3) drawer cart in the hallway at the doorway for PPE with gowns, gloves, and surgical mask; however, there was no evidence of sanitizing wipes or brown bags for dedicated mask outside the room. Continued observations on 03/20/2022 at 4:05 PM, revealed Certified Nursing Assistant (SRNA) #1, SRNA #2, and Hospitality Aide (HA) #3, don (put on) Personal Protective Equipment (PPE) in the hallway outside Resident #12's room. All three (3) aides donned a gown, then gloves, but failed to change their dedicated mask to a N95 mask; they all wore their dedicated surgical mask and eye protection into the room. Further observation revealed staff left the isolation door open, and as the State Survey Agency (SSA) observed from the hallway, the staff assisted both Resident #12, who was in contact isolation, and his/her roommate, who was in Droplet Precautions, without changing their PPE. Additional observations revealed the staff doff (took off) their PPE (gown, gloves) in the isolation room (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and disposed of it in the dedicated bins, washed their hands, and exited the room. However, staff did not clean their eye protection or change their surgical mask after exiting the room. The aides went to the nurses' station. Observation and interview of Resident #12, on 03/21/2022 at 8:40 AM, revealed he/she was lying in bed, watching television. There were no odors in the room and the resident was clean and dry; he/she voiced no complaints. Interview with Resident #12, at the time of the observation, revealed the resident did know why he/she had been placed in isolation; I often get this type of infection in my urine, and it is unfortunate and irritating at times. Interview with State Registered Nurse Aide (SRNA) #1, on 03/20/2022 at 4:15 PM, revealed Resident #12 was in Contact isolation related to a type of contagious bacteria in his/her urine. She stated she read about Resident #12's care on the Kardex. Further interviews with SRNA #1, SRNA #2 and HA #3, revealed they had received training on Care Plans, they stated they were aware that the Care Plans were on the Kardex, in a notebook at the nurse's station. Per interview, they should have followed the Care Plan when caring for Resident #12 to ensure his/her safety and the safety of the staff. Further interview revealed staff should follow the isolation precautions posted on the doors and encourage other staff to practice infection control measures to decrease the spread of infection. They stated that it was important to follow the care plan for all residents in order to provide the correct care. Interview on 03/22/2022 at 2:30 PM, with SRNA #2 revealed she referenced the Kardex (SRNA care plan for residents) for the type of care residents received. SRNA #2 added, the facility provided care plans for the staff and the nurses updated the Kardex with changes as needed. The aide stated the facility expected staff to follow both the care plan and Kardex to meet the residents' needs and safety. SRNA #2 stated she received training on the types of isolation, and how and what PPE to wear for each type of isolation. The SRNA stated, the facility expected all staff to wear PPE when the resident was care planned for contact isolation. Interview with SRNA #12 and SRNA #13 on 03/26/2022 at 2:54 PM, revealed all nursing staff worked together as a team, and an individualized resident Kardex (Care Plan) was located on all units, at each nursing station for all staff to reference for resident care needs. Continued interview revealed the Kardex was updated daily per the Unit Manager. Both SRNA's stated they were not aware if the care plan had been updated for Resident #12's current and active infection. Additionally, the aides used the Kardex routinely throughout shift; at the beginning of every shift the nurses performed rounds to discuss, reviewed and checked all residents for any changes in conditions and what type of specific care to provide. Continued interview revealed the direct care nursing staff reviewed the care plans, orders and updated the Kardex. Further, the nurse management routinely audited residents' records to ensure accuracy and resident safety. Interview with the Unit Manager, Registered Nurse (RN) #3, on 03/26/2022 at 12:10 PM, revealed residents' care plans were found in the electronic record and in the Kardex at every nursing station for the aides. Per interview, she expected staff to use the Care Plans and for the Care Plans to be revised and followed to ensure proper and safe care was provided per the assessed needs for the residents. Continued interview revealed staff were expected to refer to the care plan each time they provided care to any resident because the care could have changed. Additionally, all staff were responsible to ensure the care plan was implemented and revised to include active infection and interventions followed. All clinical staff were responsible to identify any concerns with the care plan being followed and immediately address and intervene to correct the care. RN #3 added, the floor nurses, MDS (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Coordinator and IDT were responsible for initiating and revision of care plans. Further, she ensured the Care Plan was implemented by participating in morning meetings, rounds and helping with care on the floor: making observations of care and speaking with residents, staff, and family. She revealed she had not identified concerns with care plans being developed or followed. Interview with RN/Minimum data Set (MDS) #1 on 03/26/2022 at 3:41 PM, revealed the facility's policy and Resident Assessment Instrument (RAI) manual was the guide she used to complete the Minimum Data Set (MDS). She stated she personally used a worksheet as a guide, information gathered from the chart, resident, family, staff, face to face and hands on assessments. She stated she used the MDS assessment data to develop care plans. However, the floor nurse initiated the Baseline Care Plan, at the next clinical meeting; and the staff reviewed the Baseline Care Plan, and Minimum Data Set (MDS) Nurse took over the process. Additionally, she stated care plans should be followed as a guide for care of the residents. Interview with the Infection Control Nurse/Director of Nursing, on 03/26/2022 at 4:00 PM revealed floor nurses, MDS Nurses, and members of the Interdisciplinary Team (IDT) developed and revised the Baseline Care Plans. Continued interview revealed all nursing staff were responsible to ensure the care plan was current and specific to the resident's identified needs. Additionally, she expected staff to refer to, and follow the care plan because it was developed according to the resident's individualized plan of care. Further, she had not identified any issues with the development or revisions. However, after review of observations by the State Survey Agency (SSA), on 03/20/2022, she stated staff should have updated/revised and followed the care plan for infection control. Interview with the Administrator, on 03/26/2022 at 4:30 PM, revealed all staff were responsible to initiate, revise and follow the Care Plans for each resident, to ensure their safety, their wishes and wellness were met. He stated to ensure care plans were followed, staff made rounds to observe care; talked to residents/families and staff. Additionally, care plans were discussed in morning meetings and the clinical management team was on the residents' floors throughout the day and had not reported issues with staff not following residents' care plans. Furthermore, he stated he had not identified any concerns with care plans not being developed. Continued interview revealed, after review of the SSA's observation on 03/20/2022, ongoing education was necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

Based on observation, interview, and review of the facility's policy, it was determined the facility failed to store, handle, prepare, distribute, serve food, maintain safe temperatures of food in storage, in order to ensure food safety.

Observation, on 03/20/2022 during the initial kitchen tour at 2:00 PM, revealed dirty floors, staff members with their masks positioned below the nose, open food not labeled or dated, a dirty stove, pitchers of tea and coffee uncovered and not labeled, a trash can with its lid open, the dishwasher was broken, the sanitizing solution in the three (3) compartment sink and the sanitizing bucket were not maintained at the correct concentration.

Additionally, observation, on 03/20/2022, revealed inconsistencies with documentation logs for the standing refrigerator and dry storage, and the dishwasher was not in use/broken.

Further observation, on 03/21/2022 at 11:35 AM, during lunch meal service, revealed two (2) male staff with hair on their face and neck with no beard restraint, and another staff person was observed with the mask below the nose.

The findings include:

Review of the facility's policy titled, Manual Warewashing, dated 09/2017, revealed all cookware, dishware, and service ware that was not processed through the dish machine would be manually washed and sanitized. Additionally, the staff would be knowledgeable of proper techniques including wash temperature at no less than 110 F (Fahrenheit); chemical sanitizer testing and proper concentration of the sanitizing solutions. Further, appropriate test strips would be utilized to measure the concentration of the sanitizing solution. Results would be recorded on the three (3) compartment sink log.

Review of the facility's policy titled, Warewashing, dated 05/2014, revealed all dishware, serviceware, and utensils will be cleansed and sanitized after each use. Additionally, the dining staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. Further, temperature and/or sanitizer concentration logs would be completed as appropriate.

Review of the facility's policy titled, Equipment, dated 09/2017, revealed all food service equipment would be clean, sanitary and in proper working order. Additionally, all equipment would be routinely cleaned and maintained in accordance with the manufacturer's direction and training materials. All staff would be properly trained in the cleaning and maintenance of all equipment. All food contact equipment would be cleaned and sanitized after every use. All non-food contact equipment would be clean and free of debris. The Dining Service Director would submit requests for maintenance or repair to the Administrator and/or Maintenance Director, as needed. Copies of a service repair and preventative maintenance report would be submitted monthly.

Review of the facility's policy titled, Disposal of Garbage and Refuse, dated 08/2017, revealed all garbage and refuse would be collected and disposed of in a safe and efficient manner. Additionally, the Dining Service Director would ensure appropriately lined containers were available within the food service area for disposal of garbage. Appropriate lids were provided for containers. Garbage was removed from the kitchen area routinely during the day and at the end of the workday. Staff were to

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observe proper hand washing and glove practices after handling garbage. Further, the Dining Services Director would ensure appropriate recycling practices were in place as required by state and local authorities. Review of the ECOLAB Scout Pot and Pan Wash Procedure, dated 2011, revealed the Environmental Protection Agency (EPA) registered no rinse quat sanitizer that was effective across a dilution range of 0.25-0.67 per gallon of water. Further there were illustrations noted on the Paper Hydrion testing strips (withdrawal 2 inches); temperature 65-75 F, 10 second, compare to strip for acceptable range diagram on testing paper label. Review of the Sani Safe Quaternary Ammonia QUAT test paper label, revealed an expiration date of 11/01/2023. In addition, there were instructions to compare the paper strip when wet to the color-coded diagram listing with parts per million concentration (0-100-200-300-400). Review of Dining Services Department In-Service, dated 12-20-2021, revealed kitchen staff attended an in-service on Hair nets and beard guards, name tags, uniforms not worn during DM unit inspection. Review of Dining Services Department In-Service, dated 01/31/2022, revealed kitchen staff attended an in-service on New COVID/CDC regulations with quarantine, vaccines, wearing Personal Protective Equipment while in the facility. Observation during the initial kitchen tour, on 03/20/2022 at 2:00 PM, revealed the stove had a blackened substance on the backsplash of the stovetop, dried up substance with crumbs was noted beside the stovetop and the griddle. Additionally, there was a pitcher of tea and coffee in front of the coffee machines not covered, labeled, or dated. Continued observations revealed the lid of the trash can was raised up and leaning against the wall. The trash can was overflowing with a box containing coffee grounds and condiment cups. Review of the Refrigerator Temperature Log, dated March 2022, revealed staff did not consistently document AM and PM temperatures. Further review revealed the following: nineteen (19) blanks on 03/05/2022 AM; 03/15/2022 AM; 03/16/2022 AM and PM; 03/17/2022 AM and PM; 03/18/2022 AM and PM; and 03/19/2022 PM. Continued observations on 03/20/2022 at 2:00 PM, revealed the Dry Storage Temperature log, dated March 2022, revealed missing documentation of the AM and PM temperatures. There was a total of eight (8) blank spaces which included 03/15/2022 AM; 03/16/2022 AM; 03/17/2022 AM; 03/18/2022 AM; 03/16/2022 PM; 03/17/2022 PM; 03/18/2022 PM; and on 03/19/2022 PM. Observation on 03/20/2022 at 2:00 PM, revealed Dietary Aide #1 washing dishes at the three (3) compartment sink. Dietary Aide #2 was rinsing washed items at the solution sink; her face mask was below her nose. Per interview, at the time of the observation Dietary Aide #1 stated that she had just made the water and solution in the sink. Additionally, she did not know what the temperature of the water was, or the location of the thermometer. She stated she checked the water by touching it with her hand to ensure it was hot. Dietary Aide #2 stated she usually worked with the dish machine and was not familiar with the temperature, solution, and documentation for the three (3) compartment sink. Further, she stated she wore her mask below her nose because she was hot. However, she had received training on how to properly wear a face mask and on infection control. Continued observations revealed the sanitizing solution concentration in the three compartment sink and the solution in the red bucket were below 150 parts per million (PPM). The thermometer could not be found to take the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature of the water. Review of the Three (3) Compartment Sink Log, undated, revealed eight (8) blanks on the 15th, 16th, 17th, 18th, 19th lunch, and dinner meals and, on the 20th lunch meal were blank. Observation revealed there was no documentation of the time, temperature of the water, concentration, or staff initials. Further, the bottom of the log, to document to the Manufacturer Recommendation Sanitizer PPM was blank. Observations on 03/21/2022 at 11:35 AM, of the lunch tray line, revealed Dietary Aide #4, was plating food, but was not wearing a beard guard. Additional observations revealed Dietary Aide #2 plating food with a face mask below her nose. Further, the Dietary Manager was noted at the three (3) compartment sink, and was not wearing a beard guard. Observations on 03/23/2022 at 10:30 AM, revealed blackened food crumbs/substance on the stove burners. Interview with the District Manager, at the time of the observation, revealed the cook was responsible to clean the stove one (1) time a week to ensure food crumbs were cleaned off, so food served was not contaminated. Additional observations on 03/23/2022 at 10:30 AM, revealed a trash can by the coffee pot. The trash can lid was open with a brown dried food substance and dried liquid. The trash can was full to the top and contained old grapes in a bag, and open condiment containers. Interview with the District Manager, at the time of the observation, revealed the trash can lid should be clean and closed to maintain infection control and prevent contamination of food. Continued interview revealed the observations of the uncovered pitchers of coffee and tea, that were not tabled, should have been covered to prevent contamination. Interview on 03/20/2022 at 3:09 PM, with the Assistant Dietary Manager, revealed she had worked at the facility since June 2021, and her direct supervisor was the Dietary Manager. Per interview, the kitchen staff had been hand washing dishes for three (3) weeks since the dish machine had been down. Additionally, the three compartment sink log was completed by staff, each time the water was made (three {3} times a day), including the red bucket of sanitizing solution. Continued interview revealed the temperature of the water, the solution concentration and staff's initials should be documented on the log. The staff assigned to the dishes was responsible to complete the documentation after making the water/solution. It was important to have a record to prove the temperature and concentration could sanitize properly to prevent the spread of food borne illness and communicable illness. Per interview, she had not identified any issues with the temperature or concentration of water at the three compartment sink or the log. She also was unaware of any training provided to kitchen staff three (3) weeks ago (after the dish machine broke), related to the three compartment sink, temperatures of water, or concentration of the solution. Further, she normally looked at the refrigerator and dry storage temperature logs a couple times a week, to ensure temperatures were not too hot or cold; however, she had not identified any blanks in the logs. She was unsure why there were blanks on the logs, but they should have been filled in completely. Continued interview revealed the stove should be cleaned if it was visibly dirty with food crumbs or blackened food particles to ensure food being cooked was not contaminated. She stated it was everyone's responsibility that used the stove to ensure it was clean and the stove should be cleaned at least weekly. Per interview, the garbage can lid should be clean and placed on the can for infection control purposes, to ensure food and equipment were not contaminated. Lastly, she stated the pitchers of beverages, coffee and tea, should be covered to ensure they were not contaminated, and staff who filled the pitchers should have covered them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Dietary Manager, on 03/21/2022 at 10:08 AM, revealed that one (1) year ago he was a dish washer and cook at the facility. Since 02/28/2022, he had been the Dietary Manager in Training. Per interview, the Training Manager was in the building two (2) days a week and available via telephone, as needed, and the Registered Dietician (RD) was in the building twice a week. Continued interview revealed the RD completed meal tracker audits. The Training Manager completed audits for temperature logs, preparation of food, attended the morning meetings, and provided staff in-services. Additionally, the District Manager was in the building one (1) time a week, and he completed audits with the Dietary Manager on temperature logs, the three (3) compartment sinks, signs, the cooler and dry stock, and in-services with staff. The Dietary Manager stated there was no tracking process or policy for when test solution strips were changed, where they were stored, label requirements, etc. All staff members were responsible to change the strips, which were kept in the manager's office and also taped to wall by the three (3) compartment sink. After review of observations made on 03/20/2022 with the Manager, he stated there should be a label in the test strip box to note the expiration date to ensure the strips were viable. However, the strips taped to the wall by the sink, were observed to not have a label. He stated that he expected the staff to use the strips in the manager's office, and to know the expiration date, and the solution level using the ECO lab posters on the wall behind the sinks. Observation at the time of the interview revealed the manager searched his office drawers and found two (2) loose boxes of strips and said the one (1) taped on the wall was in the same lot as the strips in the office. The expiration date was 11/01/2023. Further interview with the Dietary Manager revealed that each log should be fully completed at the designated time and that he expected his staff to complete all of them. He stated he expected staff to wear masks appropriately, to decrease the risk for the spread of infection, and that staff had been educated in infection control and on wearing Personal Protective Equipment (PPE) appropriately. Staff was provided in-service education related to necessary changes in the process because the dish machine was broken, but staff was already aware of the expectation because it was the same process (3 compartment sink) before the dish machine broke. However, there was no documentation provided related to an in-service training for the kitchen staff approximately three (3) weeks ago related to the three compartment sink, sanitizing solution concentration, and test results of the sanitizing solution. Review of Dining Services Department In-Service, dated 02/11/2022, revealed kitchen staff attended an in-service on Fridge/freezer/dish machine logs filled out correctly, and tray-line accuracy. Review of Dining Services Department In-Service, dated 02/15/2022, revealed kitchen staff attended an in-service on Label and dating, temperature log usage, daily/weekly cleaning matrix, and menu compliance. Interview with the Training Manager, on 03/22/2022 at 8:30 AM, revealed he had been with the facility for one (1) year. Per interview, the repair company was at the facility on 03/22/2022, and was supposed to return in (2) days to repair the main board, which was the identified broken area. Continued interview with the Training Manager revealed they were made aware that the three (3) compartment sink on 03/20/2022, was not in appropriate range. She stated the facility had staff turnover and struggled to keep and train staff. She stated the new staff members were not familiar with policies and practices. Additionally, it was important that the water temperature and the sanitizer were at the right temperature and concentration to protect residents from contamination, and to decrease the risk for food borne illness. Continued interview with the Training Manager revealed documentation should be consistently completed each time the sink concentrations were made. Further, she was not aware of staff members in the kitchen who wore a face masks improperly, below the nose. She stated staff had been provided education on properly wearing face masks. The Dietary Manager provided education on beard (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	guards, and if a staff member had facial hair, the employee should have a beard guard on while in the kitchen. The Dietary Manager stated, We do not want hair to fall in the food. Per interview, monthly in-service education covered infection control, use of masks, documentation of temperatures and concentrations. Interview with the Staff Development Coordinator, on 03/21/2022 at 11:30 AM, revealed she had been in that role since 03/01/2022. Additionally, she had provided in-services on Personal Protective Equipment, handwashing and infection control. However, she had not provided in-servicing to kitchen staff. Further, she stated she was responsible to provide training and education related to all identified concerns in the building, for all staff, and all departments as applicable. Interview with Dietary Aide #1, on 03/24/2022 at 11:40 AM, revealed he had worked in the kitchen for two (2) and a half years, and had been trained on temperature logs, refrigerator logs, the three (3) compartment sink log, and the dry storage log. Per interview, it was important to have record of temperatures, in order to know they were in the right range to ensure food was not spoiled. He stated dishwater was made and tested every two (2) hours and he would know the right concentration was prepared by testing the sink water with the strip paper for 10 seconds. He said the strip's color would be compared to the color key on the side of the box of strips. He stated the strip dipped in the sanitizer treated water should read 200 PPM, because that would be the acceptable range. Continued interview with Dietary Aide #1 revealed the proper chemical concentration was important for proper sanitation of the cookware/dishware. In addition, he said the number was important, because if the dishes used for serving food were contaminated, that could lead to food borne illnesses. Per interview, he stated the water temperature should be 120 degrees Fahrenheit for soap water, rinse water should be 110 degrees Fahrenheit; and sanitizer water should measure 65-75 degrees Fahrenheit. The Dietary Aide stated the stove should be cleaned at least once a week, and the cook cleaned it. Further, the trash can lids were cleaned weekly, and the trash can tops should always be in the down position, to prevent food and refuse from falling on the floor. He said pitchers of beverages should be covered and labeled to prevent contamination. He stated it had been awhile since he received training on those issues, but he had received training on wearing beard guards in the kitchen, in order to keep hair out of the food. Interview with the Director of Nursing, on 03/26/2022 at 4:00 PM, revealed that she expected the kitchen to be clean and sanitary at all times to ensure Infection Control. Interview with the Administrator, on 03/26/2022 at 4:30 PM, revealed he expected the kitchen to be clean and sanitized at all times so food would be served in a safe manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview, record review, review of the facility's policy, and review of the facility's Administrator's Job Description, it was determined the facility failed to be administered in a manner which enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility's administration failed to ensure thorough actions were taken after the 02/25/2021 misappropriate/drug diversion involving eight (8) residents. In addition, the facility failed to ensure the safety of residents to prevent falls for a resident assessed as a high risk for falls. Additionally, the facility's administration failed to maintain substantial compliance, after the 01/24/2019, Recertification Survey, in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656, F657); 42 CFR 483.25 Quality of Life (F689); and 42 CFR 483.45 Pharmacy Services (F755). Further, the facility's administration failed to maintain substantial compliance, after the 11/05/2019, Abbreviated Survey, in the areas of CFR 483.12 Freedom from Abuse (F610); and 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656). The facility's failure to ensure it was administered effectively and failure to follow their policy has caused or is likely to cause serious injury, serious harm, or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 04/04/2022 and was determined to exist on 02/24/2021 in the area in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F602 Free from Misappropriation Exploitation at a scope and severity (S/S) of K; 42 CFR 483.21 Comprehensive Person-Centered Care Plans, F656 Comprehensive Resident Centered Care Plans at a S/S of J; 42 CFR 483.25 Quality of Care, F689 Free of Accidents/Hazards/Supervision/Devices at a S/S of J; 42 CFR 483.45 Pharmacy Services, F755 Pharmacy Services/Procedure/Pharmacist/ Record at a S/S of K; 42 CFR 483.70 Administration, F835 Administration and F837 Governing Body at a S/S of K; and at 42 CFR 483.75 Quality Assurance and Performance Improvement, F867 QAPI/QAA Improvement Activities at a S/S of K. The facility was notified of the IJ and SQC on 04/04/2022. The facility provided an acceptable Immediate Jeopardy Removal Plan on 04/12/2022, with the facility alleging removal of the Immediate Jeopardy, on 04/09/2022. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 04/09/2022, prior to exit on 04/14/2022. The facility's remaining non-compliance was at a Scope and Severity of a F while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes. The findings include: Review of the facility's policy, titled Facility Administration, last reviewed 09/05/2018, revealed the facility operated under the direction of the Administrator in accordance with Federal and State laws and professional standards. Additionally, current surveys by state and/or local health authorities were on file, along with the facility's plan of action to correct deficiencies. Continued review revealed the Administrator was part of the facility's Governing Body that was legally responsible for establishing and implementing policies regarding the management and operations of the facility. Further review revealed the facility's policies and procedures were maintained and updated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	periodically to reflect current professional standards and practice through annual review. Review of the facility's Job Description for the Administrator, dated December 2018, revealed the Administrator led and directed the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. Additionally, the Administrator identified and participated in process improvement initiatives to improve customer experiences, enhance workflow, and/or improve the work environment. Continued review revealed the Administrator was responsible for the Quality Assurance (QA) Program. Further, the Administrator maintained a working knowledge of and confirmed compliance with all governmental regulations. The Administrator consulted with department managers, concerning the operation of their department to assist in eliminating/correcting problem areas, and/or improvement of service. Review of the 01/24//2019 Recertification Survey's Plan of Correction (POC), the Abbreviated Survey's POC, dated 11/05/2019, and the 04/14/2022 Recertification Survey, revealed the facility failed to maintain compliance, and be administrated in a manner to provide quality care and services. The facility was previously cited, on the 09/30/2021 Recertification Survey and the Abbreviated Survey, dated 11/05/2019, the same areas of deficient practice as identified on the 04/14/2022 Recertification survey. Continued review of the 01/24/2019 Recertification Survey's POC revealed previously cited deficiencies, included F656, Care Plans, the facility failed to implement care plans related to Activities of Daily Living (ADL) needs; F657 Care Plans, failed to revise the care plans after falls with interventions to prevent falls; F689, Free of Accident Hazards, failed to ensure routine maintenance of assistive devices to prevent unavoidable accidents; and F755 Pharmacy Services, failed to ensure drug records were maintained to account for controlled medication. Further, the facility failed to provide effective Administrative oversight of day-to-day operations of the facility and failed to ensure an effective Quality Assurance program to provide quality care and services to meet the needs of the residents. Continued review of the 11/05/2019 Abbreviated Survey's POC revealed a previous cited deficiency, included F610, Investigate/Prevent/Correct/Alleged Violation, the facility failed to conduct a thorough investigation and protect residents from abuse after an allegation was made; and F656 Care Plan, failed to implement the care plan related to treatment of a wound. Interview with the Director of Nursing (DON), on 03/28/2022 at 5:19 PM, revealed she had worked at the facility for one (1) year as the DON, and was previously a Unit Manager for one (1) year at the facility. Per the interview, she directly reported to the Administrator. Continued interview revealed her job was to provide oversight to the nursing department and report any concerns to the Administrator. Additionally, she was responsible for the care needs of the facility's residents and supervision of its nursing staff. She ensured residents received the necessary care and services and provided the supervision of nursing staff as required through the departments morning clinical meeting, Quality Assurance (QA) audits, and daily rounds. Further interview revealed the Clinical Care Consultant was in the building at least bi-weekly and provided support and resources via email and telephone, as needed. In addition, the interview on 03/26/2022 at 11:09 AM with the DON, revealed on 02/25/2021, possible drug diversion/misappropriation of medications was identified. The facility investigated the allegation which included reconciliation of active medications only. The investigation did not identify any concerns with the facility's current practice of accounting for medication in the facility. She stated the allegation of drug diversion/misappropriation was discussed with the Clinical Care (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Consultant and the Administrator. Continued interview revealed the nurse leadership in the facility ensured discontinued medications were returned to the pharmacy after the allegation. However, the action plan implemented did not include documentation or reconciliation of non-controlled discontinued medication destroyed in the facility or returned to pharmacy.

Interview with the Clinical Care Consultant, on 03/25/2022 at 2:15 PM, revealed she had worked in her role for five (5) years; however, she had been assigned to other facilities since April of 2021. Per interview, it was her job to provide clinical resources and to support the DON and the Administrator as necessary. Continued interview revealed she worked closely with the leadership in the building. Further interview revealed if concerns were identified with clinical processes it was discussed with the DON and the Administrator.

Interview with the Administrator, on 03/28/2022 at 3:40 PM, revealed he had been in his role for nine (9) months. Per interview, he was responsible to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently, in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. He stated his responsibilities were accomplished through ongoing QA. Continued interview revealed his job description was reviewed with him by the Regional [NAME] President of Operations (RVPO) upon hire into the Administrator's role. Per interview, the Administrator stated he was responsible for the overall operations of the facility. He stated he was the DON's direct supervisor. Interview with the Administrator revealed he was not aware of the deficiencies which were cited during the 01/24/2019 Recertification Survey and the 11/05/2021 Abbreviated Survey because they occurred long ago. Per interview, it was his understanding that in February 2021, an allegation related to misappropriation of resident property (medication) was identified; however, QA discussed the allegation and implemented change to address discontinued medications. The Administrator stated he believed the facility had addressed the identified concern through its QA program. Further interview revealed he was uncertain if the QA Committee completed audits related to the POCs to include; Abuse; Comprehensive Resident Centered Care Plan; Quality of Care; and Pharmacy Services.

Review of the IJ Removal Plan revealed the facility implemented the following:

1. The Clinical Reimbursement Specialist reviewed the past thirty (30) days of falls on current residents to ensure the root cause was identified, new interventions were put in place, the Care Plan was revised to include supervision if it applied for recent falls. This was completed on 04/05/2022.

2. Regional Social Services reviewed the last thirty (30) days of progress notes for root cause was identified, new interventions were put in place with supervision, if the resident required it. This was completed on 04/05/2022.

3. The Regional Clinical Reimbursement Nurse (RCRN), the ADON, and the DON completed observations of Care Plan interventions to ensure they were effective and were implemented. They also reviewed all At Risk for Falls Care Plans, to ensure they reflected the correct intervention, determined the Root Cause of the fall and to put new interventions in place to include extra supervision for residents who required it.

4. The Pharmacy Consultant completed medication cart audits as compared to the Medication Administration Record (MAR) to ensure there was no discontinued medication present on the cart. This was completed on 04/07/2022 and no concerns were found.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

5. Two Regional Social Services Directors reviewed all current residents' progress notes, events, and grievances to ensure residents were free from misappropriation of property. This was completed by 04/05/2022.

6. Signature Care Consultant (SCC) collaborated with the Pharmacy Director on 04/06/2022 and put the following plan in place: the nurses will remove the medication from the carts; store them properly; the medications being sent back would be listed on a form and the driver or two (2) licensed nurses will sign the form once the driver picked up the medication and returned it to the pharmacy.

7. The [NAME] President of Regulatory Compliance educated the Administrator/Regional [NAME] President, Medical Director, the Regional Nurse Consultant and the DON on the CMS regulations F835 on 04/06/2022 and CMS regulations for F755, F689, F602, and F656 on 04/06/2022.

8. The facility conducted Ad Hoc Quality Assurance meetings which started 04/05/2022 and an Immediate Jeopardy Plan was developed and implemented. On 04/06/2022, another Quality Assurance meeting was held to review the plan and make needed revisions to include further education.

9. Starting on 04/07/2022, QAPI meetings were held the first seven (7) days, then weekly for four (4) weeks. These meetings will continue until monthly for ongoing recommendations and follow-up.

10. The QA Committee will determine as to what frequency these meetings will continue. The Administrator has the oversight to ensure the effective plan was in place and was working to meet the resident's needs. The Regional [NAME] President of Operations will provide oversight daily until the removal of immediacy.

The State Survey Agency validated the implementation of the IJ Removal Plan as follows:

1. Interview with the Clinical Reimbursement Consultant (CRC) on 04/14/2022 at 12:10 PM, revealed she audited the last thirty (30) days of event notes and interventions. She revealed she also looked at Root Causes for falls. The CRC revealed she went room-to-room and evaluated the equipment on hand, safety in the resident's room and the interventions being used. She revealed no concerns were found.

2. Interview with Social Service Director-Floaters (SSD) #1 and #2 on 04/14/2022 revealed they were called upon for special projects to review all clinical Progress Notes, events, and grievances for any concerns about misappropriation of resident property, to include medication. The look back period was for thirty (30) days. Both RSSD #1 and #2 reported no concerns were identified.

Record review on 04/13/2022 at 11:30 AM, revealed audits were completed of all residents' Progress Notes for misappropriation of resident property to include medications. Concerns found were addressed. Grievances were audited for misappropriation complaints and no concerns were found.

3. Interview with the Clinical Reimbursement Specialist (CRS) on 04/14/2022 at 12:10 PM, revealed she completed audits on the last thirty (30) event notes for new interventions and Care Plan updates. She also revealed she looked at root causes to see if the facility determined the actual cause of a fall; if the root cause was not documented it was discussed with the SCC for the team to address the findings in QAPI. She stated she completed room to room audits for safety, ensured required equipment was available and proper interventions were in place.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Observation completed by SSA on 04/13/2022 at 2:55 PM, revealed the pharmacy courier completed the new medication pick-up process. The courier scanned a list of medications which contained four (4) residents. Each resident had one (1) medication listed. The blue tote bag was secured with a pull tie and the pull tie had a number on it. Tag number five (#5) was written on the medication list. Once the medication was secured the courier met with the DON in the lobby and they reviewed the list. Medications remained locked up and were dropped off at the pharmacy. Interview with the Regional Pharmacy Consultant on 04/14/2022 at 1:30 PM, revealed each medication cart was audited and each resident's medications were reconciled to the Physician's Orders. All concerns were addressed at the time of the audits and discussed with the facility. Pharmacy audits will be ongoing. Record review on 04/13/2022 at 11:30 AM, revealed six (6) medication carts were audited. Audit findings were sent to the facility. Medications for Residents #19, #30, #63 and #77 were reconciled and no concerns were found. 5. Interview with Social Service Director-Floaters (SSD) #1 and #2 on 04/14/2022 revealed they were called upon for special projects to review all clinical Progress Notes, events, and grievances for any concerns about misappropriation of resident property, to include medication. The look back period was for thirty (30) days. Both RSSD #1 and #2 reported no concerns were identified. Record review on 04/13/2022 at 11:30 AM, revealed audits were completed of all residents' Progress Notes for misappropriation of resident property to include medications. Concerns found were addressed. Grievances were audited for misappropriation complaints and no concerns were found. 6. Observation on 04/13/2022 at 2:55 PM, revealed the pharmacy courier completed the new medication pick-up process. The courier scanned a list of medications which contained four (4) residents. Each resident had one (1) medication listed. The blue tote bag was secured with a pull tie and the pull tie had a number on it (five). Tag number five (#5) was written on the medication list. Once the medication was secured the courier met with the DON in the lobby and they reviewed the list. Medications remain locked up and were to be dropped off at the pharmacy. Interview with the Pharmacy Director (PD) on 04/13/2022 at 10:27 AM, revealed he worked with the SCC and the RVPRC to develop a plan for discontinued medications and how they would be returned to the pharmacy. Pharmacy Services will continue to have consultants present in the facility, for ongoing audits. The PD also revealed pharmacy staff were educated on the new process and expectation. Record review on 04/13/2022 at 11:30 AM, revealed six (6) medication carts were audited. Audit findings were sent to the facility. Medications for Resident #19, #30, #63 and #77 were reconciled and no concerns were found. 7. Interview with the Medical Director, Regional [NAME] President of Operations, the SCC and the DON on 04/14/2022 at 4:30 PM, revealed they all received reeducation on the Federal Regulations for F835 on 04/06/2022 and F656, F602, F689 and F755. They revealed they were each present during the meetings and discussed concerns as they came up. Policies were also discussed and it was reported the focus was to get the facility trained and get the immediacy removed. No ongoing concerns were found. 8. Interview with the Medical Director on 04/14/2022 at 3:25 PM, revealed he was present via phone for all Ad Hoc meetings since Immediate Jeopardy was determined. He was involved in all discussions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and ensured the audits were being completed as required. Through the meetings any concerns were addressed, and necessary changes were made. Interview with the Director of Nursing (DON) on 04/14/2022 at 3:35 PM, revealed she was present for the Ad Hoc meetings and all aspects of the IJs were discussed. 9. Interview with the [NAME] President of Operations (VPO) on 04/14/2022 at 2:45 PM, revealed he was present at the QAPI meetings to provide oversight via phone. The QAPI meetings were led by the Administrator and all questions and concerns were addressed. 10. Interview with the Regional [NAME] President of Regulatory Compliance on 04/14/2022 at 4:12 PM, revealed he will continue to monitor the IJ process and the QAPI meetings will continue as outlined in the plan. Any adjustments or concerns would be addressed as they arise.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0837

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.

Based on interview, record review, and review of the facility's policy, it was determined the facility's Governing Body failed to ensure facility policies were implemented regarding management and operation of the facility. The Governing Body failed to ensure compliance in the areas of 42 CFR 482.12 Freedom from Abuse, F600, F602, and F610; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F655, F656, F657; 42 CFR 483.25 Quality of Care, F689; 42 CFR 483.45 Pharmacy Services, F755; CRF 42 483.60 Food and Nutrition Services, F812; 42 CFR 483.70 Administration, F835 and F837; 42 CFR 483.75 Quality Assurance and Performance, F867; and 42 CFR 483.80 Infection Prevention and Control, F880 during the Recertification Survey 03/20/2022 through 04/14/2022. Continued non-compliance was cited during this Survey at 42 CFR 482.12 Freedom from Abuse, F610; 42 CFR 483.20; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656, F657; and 42 CFR 483.45 Pharmacy Services, F755.

The facility failure to provide oversight to ensure compliance has caused or is likely to cause serious injury, serious harm, or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 04/04/2022 and were determined to exist on 02/24/2021 in the area in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F602 Free from Misappropriation Exploitation at a scope and severity (S/S) of K; 42 CFR 483.21 Comprehensive Person-Centered Care Plans, F656 Comprehensive Resident Centered Care Plans at a S/S of J; 42 CFR 483.25 Quality of Care, F689 Free of Accidents/Hazards/Supervision/Devices at a S/S of J; 42 CFR 483.45 Pharmacy Services, F755 Pharmacy Services/Procedure/Pharmacist/ Record at a S/S of K; 42 CFR 483.70 Administration, F835 Administration and F837 Governing Body at a S/S of K; and at 42 CFR 483.75 Quality Assurance and Performance Improvement, F867 QAPI/QAA Improvement Activities at a S/S of K. The facility was notified of the IJ and SQC on 04/04/2022.

The facility provided an acceptable Immediate Jeopardy Removal Plan on 04/12/2022, with the facility alleging removal of the Immediate Jeopardy on 04/09/2022. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 04/09/2022, prior to exit on 04/14/2022. The facility's remaining non-compliance was at a Scope and Severity of a F while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, Governing Body, dated 08/07/2019, revealed the Governing Body was responsible to establish and implement policy regarding the management and operation of the facility. The Administrator reported to the Governing Body and was responsible for management of the facility and was responsible and accountable for the Quality Assurance/Performance Improvement (QAPI) program at the facility. Additionally, the Governing Body was compromised of the Administrator, the Director of Nursing (DON), the Medical Director (MD), and an administrative services representative. Per policy, the Governing Body had authority and discretion for day-to-day operations of the facility. In addition, the review and approval of all policies and procedures established and implemented in the facility regarding management and operations of the facility; and the facility's QAPI program, review of clinical quality and care provided at the facility.

Review of the facility's, Job Description for the Administrator, dated December 2018, revealed the Administrator led and directed the overall operations of the facility in accordance with customers'

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	needs, government regulations and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. Additionally, the Administrator would identify and participate in process improvement initiatives to improve customer experiences, enhance workflow, and/or improve the work environment. Continued review revealed the Administrator was responsible for the Quality Assurance (QA) program. Further, the Administrator would maintain working knowledge of and confirm compliance with all governmental regulations. The Administrator would consult with department managers, concerning the operation of their department to assist in eliminating/correcting problem areas, and/or improvement of service. Review of the facility's, Job Description of the Director of Nursing (DON), dated December 2018, revealed the DON was responsible for the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices and governmental regulations to maintain excellent care of all resident's needs. Additionally, the DON would identify and participate in process improvement initiatives to improve customer experiences, enhance workflow, and/or improve the work environment. Continued review revealed the DON would train, develop, coach and counsel department staff. In addition, the DON would monitor clinical care, collaborate with the pharmacy and medical director, and take appropriate actions were taken to maintain compliance. Further, the DON, would plan, organize, implement, evaluate and direct the nursing services department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the long-term care facility. Continued review revealed the DON would inspect the facility and nursing practice for compliance with federal, state, and local standards and regulation. Review of the facility's policy, titled, Medical Director, last revised on 07/19/2018, revealed the MD coordinated medical care and provided clinical guidance and oversight in regard to implementation of resident medical care policies. The MD would collaborate with the facility's leadership, staff, practitioners, and consultants to help develop, implement, and evaluate resident care polices and procedures that reflect current standards of practice. Additionally, the MD would help the facility identify, evaluate, and address/resolve medical and clinical concerns that affected resident care, medical care, and quality of life. Continued review revealed the MD would be knowledgeable about current standards of practice in care for long-term care residents and how to coordinate and oversee related medical and clinical care providers. Further, the MD would participate in the implementation of resident care policies and procedures; integrated delivery of care and services, to include but not limited to medical, nursing, and pharmacy, which included clinical assessment and analysis of findings. Continued review revealed the MD would participate in Quality Assurance to include care and other health-related services and provide appropriate feedback. Review of the Statements of Deficiencies (SOD) for the Recertification Survey, dated 01/24/2019, revealed deficient practice was cited in the areas of 42 CFR 483.10 Resident Right (F550, F553) at s/s of E; 42 CFR 483.10 Resident Right (F584) at s/s of D; 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656, F657) at a s/s of D; 42 CFR 483.24 Quality of life (F677) at s/s of D; 42 CFR 483.25 Quality of Life (F689) at a s/s of G; 42 CFR 483.25 Quality of Life (F693) at a s/s of D; 42 CFR 483.35 Nursing Services (F725) at s/s of E; and 42 CFR 483.50 Pharmacy Services (F755, F61) at a s/s of E. Further, the review of the SOD for the Abbreviated Survey, dated 11/05/2019, revealed deficient practice was cited in the areas of 42 CFR 483.12 Freedom from Abuse (F610), at a s/s of D; and 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656) at a s/s of D. However, the Governing Body failed to ensure compliance was maintained after the 09/30/2021 and 12/16/2021 surveys. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During the 04/15/2022 Recertification Survey, repeat deficiencies were identified that were previously cited during the Recertification Survey, dated 01/24/2019 and the Abbreviated Survey, dated 11/05/2019. The areas included 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656, F657); 42 CFR 483.25 Quality of Life (F689); 42 CFR 483.50 Pharmacy Services (F755); and 42 CFR 483.12 Freedom from Abuse (F610). Further, review of the SOD for the Abbreviated Survey, dated 11/05/2019, revealed deficient practice was cited in the areas of 42 CFR 483.12 Freedom from Abuse (F610), at a s/s of D; and 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656) at a s/s of D. However, the Governing Body failed to ensure compliance was maintained after the 09/30/2021 and 12/16/2021 surveys. Interview with the Medical Director, on 03/28/2022 at 10:02 AM, revealed he was part of the facility's Governing Body. Additionally, he states he collaborated with leadership in the facility to assist with care policies and procedures. Continued interview revealed the facility had discussed previous surveys (01/24/2019 and 11/05/2019) during QA meetings; however, he could not confirm, if the facility had ongoing audits for repeat deficient practice (F 602, F610, F656, F657, F689, F755 and F880) identified during the 03/20/2022-04/14/2022 survey. Further, he had not been notified of any identified concerns with clinical systems in the facility. Interview with the Director of Nursing (DON), on 03/28/2022 at 5:19 PM, revealed she had worked at the facility for one (1) year as the DON, and was previously a Unit Manager for one (1) year at the facility. Per the interview, she was part of the Governing Body, as per the facility's policy. Additionally, she audited clinical systems, Quality Indicators and reviewed the overall operational status of the nursing department. She stated she also provided Quality Assurance (QA) review reports to the Administrator and the QA Committee. Further, interview revealed she was not aware of the deficiencies cited during the last Recertification Survey dated 01/24/2019 or the last Abbreviated Survey dated 11/05/2019 or the POCs. Further, she had not identified clinical systemic issues identified by the State Survey Agency (SSA), that were currently occurring in the facility, infection control, pharmacy services, or abuse. Interview with the Administrator, on 03/28/2022 at 3:40 PM, revealed he had been in his role for nine (9) months. Per interview, the facility's Governing Body included the Administrator, the DON, and the MD. He stated it was his responsibility, as the Administrator, to ensure all processes established in the facility were maintained, to include the Quality Assurance and Assessment/Quality Assessment Performance Improvement (QAA/QAPI) Program. Continued interview revealed the Administrator was not aware of the previous Plans of Correction for the Recertification Survey dated 01/24/2019 or the Abbreviated Survey dated 11/05/2019. Further, he was not aware of any current clinical systemic issues at the facility or issues identified by the SSA during the 03/20/2022 through 04/14/2022 Recertification Survey. Interview with the Division [NAME] President of Operations (DVPO), on 03/28/2022 at 4:11 PM, revealed he had worked with the facility eleven (11) months. His current role was to provide support to the facility's Administrator. Continued interview revealed he was not aware of any care concerns in the facility which had been identified by the State Survey Agency (SSA) for the current survey. Per interview, he provided direct oversight of the facility and the Administrator. The DVPO revealed he was in contact with the Administrator at least weekly and made routine visits to the facility to provide support and resources. Additionally, he was aware of the 09/30/2021 and the 12/16/2021 survey results and the facility's POC. He revealed the facility had implemented audits, per the POCs, and through the QA process, to ensure the deficient practice did not reoccur. Continued interview revealed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	he had not been notified related to any concerns/issues with clinical care in the facility Review of the IJ Removal Plan revealed the facility implemented the following: 1. The Clinical Reimbursement Specialist reviewed the past thirty (30) days of falls on current residents to ensure the root cause was identified, new interventions were put in place, the Care Plan was revised to include supervision if it applied for recent falls. This was completed on 04/05/2022. 2. Regional Social Services reviewed the last thirty (30) days of progress notes for root cause was identified, new interventions were put in place with supervision if resident required it. This was completed on 04/05/2022. 3. The Regional Clinical Reimbursement Nurse (RCRN), the ADON, and the DON completed observations of Care Plan interventions to ensure they were effective and were implemented. They also reviewed all At Risk for Falls Care Plan, to ensure they reflected the correct intervention, determine Root Cause of the fall and to put new interventions in place to include extra supervision for residents who required it. 4. The Pharmacy Consultant completed medication cart audit as compared to the Medication Administration Record (MAR) to ensure there was no discontinued medication present on the cart. This was completed on 04/07/2022 and no concerns were found. 5. Two Regional Social Services Directors reviewed all current residents' progress notes, events, and grievances to ensure residents were free from misappropriation of property. This was completed by 04/05/2022. 6. Signature Care Consultant (SCC) collaborated with the Pharmacy Director on 04/06/2022 and put the following plan in place: the nurses will remove the medication from the carts, store them properly. The medications being sent back would be listed on a form and the driver or two licensed nurses will sign the form once the driver picked up the medication and returned it to the pharmacy. 7. The [NAME] President of Regulatory Compliance educated the facility's Administrator/Regional [NAME] President, Medical Director, the Regional Nurse Consultant and the DON on the CMS regulations F835 on 04/06/2022; and, the CMS regulations for F755, F689, F602, and F656 on 04/06/2022. 8. The facility conducted Ad Hoc Quality Assurance meetings which started 04/05/2022 and an Immediate Jeopardy Plan was developed and implemented. On 04/06/2022, another Quality Assurance meeting was held to review the plan and to make needed revisions to include further education. 9. Starting on 04/07/2022, QAPI meetings were held the first seven (7) days, then weekly for four (4) weeks. These meetings will continue until monthly for ongoing recommendations and follow-up. 10. The QA Committee will determine as to what frequency these meetings will continue. The Administrator has the oversight to ensure the effective plan was in place and was working to meet the resident's needs. The Regional [NAME] President of Operations will provide oversight daily until the removal of immediacy. The State Survey Agency validated the implementation of the IJ Removal Plan as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Interview with the Clinical Reimbursement Consultant (CRC) on 04/14/2022 at 12:10 PM, revealed she audited the last thirty (30) days of event notes and interventions. She revealed she also looked at Root Causes for falls. The CRC revealed she went room-to-room and evaluated the equipment on hand, safety in the resident's room and the interventions being used. She revealed no concerns were found. 2. Interview with Social Service Director-Floaters (SSD) #1 and #2 on 04/14/2022 revealed they were called upon for special projects to review all clinical progress notes, events, and grievances for any concerns about misappropriation of resident property, to include medication. The look back period was for thirty (30) days. RSSD #1 and #2 reported no concerns were identified. Record review on 04/13/2022 at 11:30 AM, revealed audits were completed of all resident's progress notes for misappropriation of resident property to include medications. Concerns found were addressed. Grievances were audited for misappropriation complaints and no concerns were found. 3. Interview with the Clinical Reimbursement Specialist (CRS) on 04/14/2022 at 12:10 PM, revealed she completed audits on the last thirty (30) on event notes for new interventions and Care Plan updates. She also revealed she looked at root causes to see if the facility determined the actual cause of a fall; if the root cause was not documented it was discussed with the SCC for the team to address the findings in QAPI. She completed room to room audits for safety, ensured required equipment was available and proper interventions were in place. 4. Observation completed by SSA on 04/13/2022 at 2:55 PM, revealed the pharmacy courier completed the new medication pick-up process. The courier scanned a list of medications which contained four (4) residents. Each resident had one (1) medication listed. The blue tote bag was secured with a pull tie and the pull tie had a number on it. Tag number five (#5) was written on the medication list. Once the medication is secured the courier meets with the DON in the lobby and they review the list. Medications remain locked up and are dropped off at the pharmacy. Interview with Regional Pharmacy Consultant on 04/14/2022 at 1:30 PM, revealed each medication cart was audited and each resident's medications were reconciled to the physician's orders. All concerns were addressed at the time of the audits and discussed with the facility. Pharmacy audits will be ongoing. Record review on 04/13/2022 at 11:30 AM, revealed six (6) medication carts were audited. Audit findings were sent to the facility. Medications for Resident #19, #30, #63 and #77 were reconciled and no concerns were found. 5. Interview with Social Service Director-Floaters (SSD) #1 and #2 on 04/14/2022 revealed they were called upon for special project to review all clinical progress notes, events, and grievances for any concerns about misappropriation of resident property, to include medication. The look back period was for thirty (30) days. RSSD #1 and #2 reported no concerns were identified. Record review on 04/13/2022 at 11:30 AM, revealed audits were completed of all residents' progress notes for misappropriation of resident property to include medications. Concerns found were addressed. Grievances were audited for misappropriation complaints and no concerns were found. 6. Observation completed by SSA on 04/13/2022 at 2:55 PM, revealed the pharmacy courier completed the new medication pick-up process. The courier scanned a list of medications which contained four (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(4) residents. Each resident had one (1) medication listed. The blue tote bag was secured with a pull tie and the pull tie had a number on it (five). Tag number five (#5) was written on the medication list. Once the medication was secured the courier met with the DON in the lobby and they reviewed the list. Medications remained locked up and were dropped off at the pharmacy. Interview with the Pharmacy Director (PD) on 04/13/2022 at 10:27 AM, revealed he worked with the SCC and the RVPRC to develop a plan for discontinued medications and how they would be returned to the pharmacy. Pharmacy Services will continue to have consultants present in the facility, for ongoing audits. The PD also revealed pharmacy staff were educated on the new process and expectation. Record review on 04/13/2022 at 11:30 AM, revealed six (6) medication carts were audited. Audit findings were sent to the facility. Medications for Residents #19, #30, #63 and #77 were reconciled and no concerns were found. 7. Interview with the Medical Director, Regional [NAME] President of Operations, the SCC and the DON on 04/14/2022 at 4:30 PM, revealed they all received reeducation on the Federal Regulations for F835 on 04/06/2022 and F656, F602, F689 and F755. They revealed they were each present during the meetings and discussed concerns as they came up. Policies were also discussed and it was reported the focus was to get the facility trained and get the immediacy removed. No ongoing concerns were found. 8. Interview with the Medical Director on 04/14/2022 at 3:25 PM, revealed he was present via phone for all Ad Hoc meetings since Immediate Jeopardy was determined. He was involved in all discussions and ensured the audits were being completed as required. Through the meetings any concerns were addressed, and necessary changes were made. Interview with the Director of Nursing (DON) on 04/14/2022 at 3:35 PM, revealed she was present for the Ad Hoc meetings and all aspects of the IJs were discussed. 9. Interview with the [NAME] President of Operations (VPO) on 04/14/2022 at 2:45 PM, revealed he was present at the QAPI meetings to provide oversight via phone. The QAPI meetings were led by the Administrator and all questions and concerns were addressed. 10. Interview with the Regional [NAME] President of Regulatory Compliance on 04/14/2022 at 4:12 PM, revealed he will continue to monitor the IJ process and the QAPI meetings will continue as outlined in the plan. Any adjustments or concerns would be addressed as the arise.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0867

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

Based on observation, interview, record review, review of the facility's policy, and review of the facility's Plans of Correction (POC) submitted for the 01/24/2019 and 11/05/2019 surveys, it was determined the facility failed to have effective processes in place to address system failures through regularly scheduled Quality Assurance Performance Improvement (QAPI) meetings. As a result, the facility failed to identify quality of care deficiencies; failed to develop and implement plans of action to correct identified quality of care deficiencies; and failed to ensure standards for quality of care regarding performance improvement measures were achieved and sustained. This was evidenced by deficient practice cited at F656, F657, F689, and F755, on the 01/24/2019 survey; and F610, and F656, which were cited on the 11/05/2019 survey.

During the 04/14/2022 Recertification Survey, Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse (F602), at a scope and severity (S/S) of K; 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656), at a S/S of J; 42 CFR 483.25 Quality of Care (F689), at a S/S of J; 42 CFR 483.45 Pharmacy Services (F755), at a S/S of K; 42 CFR 483.70 Administration (F835, F837), at the S/S of K; and 42 CFR 483.75 Quality Assurance Performance Improvement (F867), at the S/S of K. Refer to F602, F689, F656, F755, F835, F837, and F867.

The facility's failure to an effective process in place to address system failures through QAPI has caused or is likely to cause serious injury, serious harm, or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 04/04/2022 and were determined to exist on 02/24/2021 in the area in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F602 Free from Misappropriation Exploitation at a scope and severity (S/S) of K; 42 CFR 483.21 Comprehensive Person-Centered Care Plans, F656 Comprehensive Resident Centered Care Plans at a S/S of J; 42 CFR 483.25 Quality of Care, F689 Free of Accidents/Hazards/Supervision/Devices at a S/S of J; 42 CFR 483.45 Pharmacy Services, F755 Pharmacy Services/Procedure/Pharmacist/ Record at a S/S of K; 42 CFR 483.70 Administration, F835 Administration and F837 Governing Body at a S/S of K; and at 42 CFR 483.75 Quality Assurance and Performance Improvement, F867 QAPI/QAA Improvement Activities at a S/S of K. The facility was notified of the IJ and SQC on 04/04/2022.

The facility provided an acceptable Immediate Jeopardy Removal Plan on 04/12/2022, with the facility alleging removal of the Immediate Jeopardy, on 04/09/2022. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 04/09/2022, prior to exit on 04/14/2022. The facility's remaining non-compliance was at a Scope and Severity of a F while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Program, dated 10/02/2019, revealed the purpose of the QAPI program was to provide a process that would enhance the care and experience for all residents, improve the work environment for employees, and quality of all services provided by the facility. Additionally, the facility would have an ongoing QAPI program to systemically monitor, evaluate and improve the quality and appropriateness of resident care. Per the facility's policy, QAPI supported the overall goals of the facility and examined outcomes and processes relevant to outcomes with the objective of improving the organization's overall performance. Continued review revealed the program would be a coordinated effort among all departments

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and services within the facility and would meet at least monthly and as needed. Further the QAPI committee was composed of but not limited to: the Administrator, the Director of Nursing (DON), the Medical Director, and Pharmacy. Continued review revealed the QAPI Committee would select some aspects of care for performance improvement based on problem areas/aspects of care which in the past produced a problem for staff or residents. Review of the facility's, Job Description for the Administrator, dated December 2018, revealed the Administrator was responsible for the Quality Assurance (QA) Program. Further review revealed the Administrator would identify and participate in process improvement initiatives that would improve the customer's experience, enhance workflow, and/or improve the work environment. Review of the Acceptable Plan of Correction (POC), for the Recertification Survey, dated 01/24/2019, revealed for the deficient practice which had been cited at F656, the facility had provided education to nursing staff regarding the facility's policy on Care Plans-Comprehensive to ensure development and implementation. Continued review of the POC revealed for the deficient practice cited at F689, the facility had provided education to nursing staff on the facility's policy, Accident and Incident-Investigating and Reporting Falls, to ensure accidents were investigated and residents' environments remained as free of accident hazards as possible. Additional review of the POC revealed for the deficient practice cited at F755, the facility had educated all licensed nurses on the importance of maintaining an accurate account for all controlled medications. Further review of the Plan of Correction (POC), for the survey, dated 01/24/2019, revealed at the QAPI meetings the audit results for F656, F689 and F755 would be reviewed by the Administrator and Committee, monthly until substantial compliance was achieved. Finally, review of the POC for the 09/30/2021 survey revealed compliance was the responsibility of the Administrator. Review of the Acceptable Plan of Correction (POC), for the Abbreviated Survey dated 11/05/2019, revealed for the deficient practice which had been cited at F610, the facility had provided education to the Administrator, the Interim DON, the reporting nurse, and all clinical staff (licensed nurses and aides) regarding abuse to ensure proper investigations. Further review of the POC revealed for the deficient practice cited at F656, the facility provided education to all clinical staff (licensed nurses) on updating the Care Plan with Physician's Orders. Further review of the Plan of Correction (POC), for the survey dated 11/05/2019, revealed at the QAPI meetings the audit results for F610 and F656 would be reviewed by the Administrator and Committee, monthly until substantial compliance was achieved. Review of the facility's Quality Assurance (QA) Committee meeting documentation revealed meetings had been held on at least monthly and revealed attendees included but were not limited to the Administrator, the Medical Director, and the Director of Nursing (DON). Interview with the Medical Director, on 03/28/2022 at 10:02 AM, revealed he participated in the facility's QAPI/QA Committee. Additionally, the facility had discussed previous surveys (01/24/2019 and 11/05/2019) during QA meetings; however, he could not confirm, if the facility had ongoing audits for repeat deficiencies (F602, F610, F656, F657, F689, F755 and F880) identified during the 03/20/2022-04/14/2022 survey. Further, he had not been notified of any identified concerns with clinical systems in the facility. Interview with the Minimum Data Set (MDS) Nurse #2, on 03/28/2022 at 11:45 AM, revealed she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	attended monthly QAPI meetings and was an active participate of the QA Committee. Per interview, she recalled attending an Ad Hoc QAPI meeting on 02/26/2019 related to an allegation of drug diversion/misappropriation. She stated she was not aware of details of the investigation that was reviewed. Additionally, she could not recall details about the audits that were completed during the investigation. Further, she could not remember if the QA Committee discussed or developed an action plan related to pharmacy services to implement after the allegation. Interview with Director of Nursing (DON), on 03/28/2022 at 5:19 PM, revealed she had been in the role for one (1) year and was previously a Unit Manager for one (1) year at the facility. Per interview, she led the Clinical Morning Meetings Monday through Friday. She also conducted ongoing rounds in the facility to monitor for Quality Assurance and regulatory compliance for all nursing practices and protocols. Additionally, she worked closely with the Clinical Care Consultant for guidance and support related to clinical Quality Assurance. Continued interview revealed the 02/25/2019 incident of misappropriation and drug diversion was discussed by the QA Committee, on 02/26/2019. However, she did not recall if any action plan was discussed or implemented related to a different process for ensuring non-controlled medications were accounted for before they were sent back to the pharmacy. Per interview, she had not reviewed the 2019 survey results and was not aware of the POCs for the surveys (01/24/2019 and 11/05/2019). The survey results were discussed in QAPI meetings monthly and it was her understanding that all POC audits from previous surveys were ongoing. Further, she provided support to the facility and ensured the safety and well-being of residents as well as delegating responsibilities for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policy and procedures. Continued interview revealed he/she was responsible to assist with the revisions of clinical policies and procedures to ensure compliance with governmental regulations and current standards of practice within the facility, after the corporation made policy changes as needed. Per interview, the facility until recently, did not have a Staff Development Coordinator and she was responsible to ensure the staff received all necessary education/training. Interview revealed the QA Committee had not identified any repeat deficient practice previously cited on the 01/24/2019 or 11/05/2019 surveys through the ongoing POC audits or other quality assurance efforts in the facility. She had not identified any issues concerning abuse, care plans, falls, infection control, or pharmacy practices. Interview with the Administrator, on 03/28/2022 at 3:40 PM, revealed he was not aware of the audits for POCs dated 01/24/2019 and 11/05/2019 or if the QAPI Committee had identified any deficient practices through the POC audits. However, the QAPI Committee met monthly, and the Director of Nursing (DON) brought any clinical concerns to the QAPI Committee meetings. Further interview revealed he was not aware of any current concerns with the clinical practices within the facility. In addition, the Administrator revealed it was his responsibility to ensure all facility processes established by the Governing Body were maintained, including the facility's Quality Assessment and Assurance (QAA) and QAPI programs. Continued interview revealed, he had been made aware of the allegation of misappropriation which occurred in February 2019; however, the alleged misappropriation, on 02/25/2021 was strictly an intentional criminal act by LPN #7 and the facility did not identify any systemic issues with their process to account for medication in the facility. He stated the QAPI Committee discussed the identified issues and initiated audits in February 2019; however, the QAPI Committee did not develop a plan to follow the medication audits. Interview with the Regional [NAME] President of Operations (RVPO), on 03/28/2022 at 4:11 PM, revealed he had worked with the facility eleven (11) months. Per interview, he was unaware of any concerns which had been identified at the facility, prior to the State Survey Agency's (SSA) entrance related to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	abuse, care plans, falls, infection control or pharmacy services. However, he was aware of the 01/24/2019 and the 11/05/2019 survey results and the facility's POC. He stated the facility had implemented audits, per the POCs, and through the QA process, to ensure the deficient practice did not reoccur. Further, he had not been notified related to any concerns/issues with clinical care in the facility. Review of the IJ Removal Plan revealed the facility implemented the following: 1. The Clinical Reimbursement Specialist reviewed the past thirty (30) days of falls on current residents to ensure the root cause was identified, new interventions were put in place, the Care Plan was revised to include supervision if it applied for recent falls. This was completed on 04/05/2022. 2. Regional Social Services reviewed the last thirty (30) days of Progress Notes for root cause was identified, new interventions were put in place with supervision, if the resident required it. This was completed on 04/05/2022. 3. The Regional Clinical Reimbursement Nurse (RCRN), the ADON, and the DON completed observations of Care Plan interventions to ensure they were effective and were implemented. They also reviewed all At Risk for Falls Care Plan, to ensure they reflected the correct intervention, determined Root Cause of the fall and to put new interventions in place to include extra supervision for residents who required it. 4. The Pharmacy Consultant completed medication cart audits as compared to the Medication Administration Record (MAR) to ensure there was no discontinued medication present on the cart. This was completed on 04/07/2022 and no concerns were found. 5. Two Regional Social Services Directors reviewed all current residents' Progress Notes, events, and grievances to ensure residents were free from misappropriation of property. This was completed by 04/05/2022. 6. Signature Care Consultant (SCC) collaborated with the Pharmacy Director on 04/06/2022 and put the following plan in place: the nurses will remove the medication from the carts and store them properly. The medications being sent back will be listed on a form and the driver or two (2) licensed nurses will sign the form once the driver picked up the medication and returned it to the pharmacy. 7. The [NAME] President of Regulatory Compliance educated the Administrator/Regional [NAME] President, Medical Director, the Regional Nurse Consultant and the DON on the CMS regulations F835 on 04/06/2022 and the CMS regulations for F755, F689, F602, and F656 on 04/06/2022. 8. The facility conducted Ad Hoc Quality Assurance meetings which started 04/05/2022 and an Immediate Jeopardy Plan was developed and implemented. On 04/06/2022, another Quality Assurance meeting was held to review the plan and make needed revisions to include further education. 9. Starting on 04/07/2022, QAPI meetings were held the first seven (7) days, then weekly for four (4) weeks. These meetings will continue until monthly for ongoing recommendations and follow-up. 10. The QA Committee will determine as to what frequency these meetings will continue. The Administrator has the oversight to ensure the effective plan was in place and was working to meet the resident's needs. The Regional [NAME] President of Operations will provide oversight daily until the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	removal of immediacy. The State Survey Agency validated the implementation of the IJ Removal Plan as follows: 1. Interview with the Clinical Reimbursement Consultant (CRC) on 04/14/2022 at 12:10 PM, revealed she audited the last thirty (30) days of event notes and interventions. She revealed she also looked at Root Causes for falls. The CRC revealed she went room-to-room and evaluated the equipment on hand, safety in the resident's room and the interventions being used. She revealed no concerns were found. 2. Interview with Social Service Director-Floaters (SSD) #1 and #2 on 04/14/2022 revealed they were called upon for special projects to review all clinical Progress Notes, events, and grievances for any concerns about misappropriation of resident property, to include medication. The look back period was for thirty (30) days. Both RSSD #1 and #2 reported no concerns were identified. Record review on 04/13/2022 at 11:30 AM, revealed audits were completed of all residents' Progress Notes for misappropriation of resident property to include medications. Concerns found were addressed. Grievances were audited for misappropriation complaints and no concerns were found. 3. Interview with the Clinical Reimbursement Specialist (CRS) on 04/14/2022 at 12:10 PM, revealed she completed audits on the last thirty (30) event notes for new interventions and Care Plan updates. She also revealed she looked at root causes to see if the facility determined the actual cause of a fall; if the root cause was not documented it was discussed with the SCC for the team to address the findings in QAPI. She completed room to room audits for safety, ensured required equipment was available and proper interventions were in place. 4. Observation completed by SSA on 04/13/2022 at 2:55 PM, revealed the pharmacy courier completed the new medication pick-up process. The courier scanned a list of medications which contained four (4) residents. Each resident had one (1) medication listed. The blue tote bag was secured with a pull tie and the pull tie had a number on it. Tag number five (#5) was written on the medication list. Once the medication was secured the courier met with the DON in the lobby and they reviewed the list. Medications remain locked up and were dropped off at the pharmacy. Interview with the Regional Pharmacy Consultant on 04/14/2022 at 1:30 PM, revealed each medication cart was audited and each resident's medications were reconciled with the Physician's Orders. All concerns were addressed at the time of the audits and discussed with the facility. Pharmacy audits will be ongoing. Record review on 04/13/2022 at 11:30 AM, revealed six (6) medication carts were audited. Audit findings were sent to the facility. Medications for Residents #19, #30, #63 and #77 were reconciled and no concerns were found. 5. Interview with Social Service Director-Floaters (SSD) #1 and #2 on 04/14/2022 revealed they were called upon for special projects to review all clinical progress notes, events, and grievances for any concerns about misappropriation of resident property, to include medication. The look back period was for thirty (30) days. Both RSSD #1 and #2 reported no concerns were identified. Record review on 04/13/2022 at 11:30 AM, revealed audits were completed of all residents' Progress Notes for misappropriation of resident property to include medications. Concerns found were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER: Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 717 North Lincoln Boulevard, Hodgenville, KY 42748	

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	addressed. Grievances were audited for misappropriation complaints and no concerns were found. 6. Observation completed by SSA on 04/13/2022 at 2:55 PM, revealed the pharmacy courier completed the new medication pick-up process. The courier scanned a list of medications which contained four (4) residents. Each resident had one (1) medication listed. The blue tote bag was secured with a pull tie and the pull tie had a number on it (five). Tag number five (#5) was written on the medication list. Once the medication was secured the courier met with the DON in the lobby and they reviewed the list. Medications remain locked up and were dropped off at the pharmacy. Interview with the Pharmacy Director (PD) on 04/13/2022 at 10:27 AM, revealed he worked with the SCC and the RVPRC to develop a plan for discontinued medications and how they would be returned to the pharmacy. Pharmacy Services will continue to have consultants present in the facility, for ongoing audits. The PD also revealed pharmacy staff were educated on the new process and expectation. Record review on 04/13/2022 at 11:30 AM, revealed six (6) medication carts were audited. The audit findings were sent to the facility. Medications for Residents #19, #30, #63 and #77 were reconciled and no concerns were found. 7. Interview with the Medical Director, Regional [NAME] President of Operations, the SCC and the DON on 04/14/2022 at 4:30 PM, revealed they all received reeducation on the Federal Regulations for F835 on 04/06/2022 and F656, F602, F689 and F755. They revealed they were each present during the meetings and discussed concerns as they came up. Policies were also discussed and it was reported the focus was to get the facility trained and get the immediacy removed. No ongoing concerns were found. 8. Interview with the Medical Director on 04/14/2022 at 3:25 PM, revealed he was present via phone for all Ad Hoc meetings since Immediate Jeopardy was determined. He was involved in all discussions and ensured the audits were being completed as required. Through the meetings any concerns were addressed, and necessary changes were made. Interview with the Director of Nursing (DON) on 04/14/2022 at 3:35 PM, revealed she was present for the Ad Hoc meetings and all aspects of the IJs were discussed. 9. Interview with the [NAME] President of Operations (VPO) on 04/14/2022 at 2:45 PM, revealed he was present at the QAPI meetings to provide oversight via phone. The QAPI meetings were led by the Administrator and all questions and concerns were addressed. 10. Interview with the Regional [NAME] President of Regulatory Compliance on 04/14/2022 at 4:12 PM, revealed he will continue to monitor the IJ process and the QAPI meetings will continued as outlined in the plan. Any adjustments or concerns would be addressed as the arise.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's policies, review of the Centers' for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS) guidelines; and the CDC's website, HTTPS://www/Coronavirus, it was determined the facility failed to implement the CDC's and CMS's interventions to establish and maintain an infection prevention and control program designed to provide a safe, and sanitary environment to help prevent and control the development and transmission of communicable diseases including COVID-19. Total census was 97. Observations on 03/20/2022, revealed staff did not use Personal Protective Equipment (PPE) in residents' rooms, who were under Droplet Precautions and Contact Precautions. Resident #299 and Resident #12 had Physician's Orders to be in isolation. However, observations revealed the facility's staff entered Resident #299's and Resident #12's room without donning (putting on) PPE required in order to enter the room. An additional observation revealed staff exited Resident #299's and Resident #12's isolation room, into a common hallway with a mechanical lift brought from the isolation room. Observations revealed staff left the lift in the hallway without disinfecting it after it was used in the room. In addition, staff continued with resident care without cleaning their eye protection worn in the room, and did not change the surgical masks worn in the room. Observation of the facility's mechanical lifts (ML)s revealed the calf rests had dried brown and black matter on the surface, and the lift handles had dried white matter. Interviews revealed staff was unsure when the mechanical lifts were routinely disinfected. In addition, the facility could not provide documentation to show staff cleaned the mechanical lifts/equipment on a scheduled time frame. The findings include: Review of the facility's policy, Infection Control (IC), revised 10/2018 revealed the facility intended to maintain a safe, sanitary and comfortable environment to help prevent and manage transmission of disease and infection. The objectives with the IC policies and practice included to prevent, detect, investigate and control infections in the facility and provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. Review of the facility's policy, Resident Lift, dated 05/30/2018, revealed the policy did not address infection control guidance after or with use of the equipment. Review of the facility's policy titled, Personal Protective Equipment (PPE), revised 10/2018, revealed the facility provided PPE for specific requirements for staff. Review of the facility's policy titled, Novel Coronavirus (COVID-19), revised 03/18/2022, revealed general prevention measures included PPE. Review of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions (TBP), revised 10/2018, revealed TBP included additional measures which protected staff from becoming infected. The three (3) types included contact, droplet, and airborne. Review of CDC's website (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html#anchor 1564058155), Transmission-Based Precautions, Droplet Precautions, review date of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/21/2022, revealed before entering a resident's room who was on the precautions, the person(s) entering the room ensured their eyes, nose and mouth were fully covered and were to remove the face protection prior to leaving the room. Review of the CDC guide titled, How to safely remove PPE., undated, revealed upon exit of the area, masks were to be discarded in the waste container. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/2018, revealed all Durable Medical Equipment (DME) must be cleaned and disinfected before reuse by another resident. Review on 03/24/2022 at 3:45 PM, of a sign posted in the nurses' station, revealed the Hoyer (brand name of a mechanical lift) was to be cleaned weekly and when visibly soiled. Review of the sign titled, Special Droplet/Contact Precautions, dated 03/09/2020, revealed Personal Protective Equipment should be worn and included: gown, gloves, eye protection, and a N-95 mask. Additionally, before leaving an isolation room, the gown, and gloves should be disposed of, and all shared equipment should be cleaned and disinfected. Furthermore, the room door was to be closed at all times. Review of the facility's Education In-Service Attendance Record, dated 10/20/2021, revealed eighty (80) staff, including nurses, aides, housekeeping, dietary, maintenance, laundry, therapy, administrative, social services, and human resource staff received training that included review of the CDC Module, Responding to Coronavirus and Keeping COVID-19 Out. Further review revealed the facility's training included hand hygiene; donning and doffing Personal Protective Equipment (PPE); COVID-19; and following Transmission Based Precautions (TBP). Review of Resident #229's Electronic Medical Record (EMR), revealed the facility admitted the resident from an acute hospital, on 03/17/2022, with diagnoses that included History of COVID-19, Urinary Tract Infection (UTI), and Metabolic Encephalopathy. Review of Resident #299's Physician's Orders, revealed an order, dated 03/17/2022, for Isolation, Droplet Precautions related to not being fully COVID-19 vaccinated. The order had an end date of 03/31/2022. Review of Resident #299's Immunization record revealed he/she had received one (1) Moderna COVID-19 vaccine on 09/07/2021. Review of Resident #299's Baseline Care Plan, dated 03/17/2022, revealed a Problem for Infection Control, because the resident was at risk for active infection related to potential exposure to COVID-19. The goal was the resident would not demonstrate signs or symptoms of active COVID-19 infectious process. Interventions included but were not limited to: Isolation as warranted per resident's condition and Maintain appropriate Personal Protective Equipment (PPE) use according to state requirements and availability. Observation of Resident #299's room, on 03/20/2022 at 4:05 PM, revealed an open door with Droplet Precautions and Contact Precautions Isolation signs. Per the signage, droplet isolation required an N-95 face mask, gown, a closed door, and dedicated equipment. Continued review revealed a don and doff (put on/take off) PPE instructional sheet was on the open door. Additional observations revealed a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plastic three (3) drawer PPE cart at the door in the hallway with gowns, gloves and surgical masks; however, there was no evidence of availability of sanitizing wipes, N-95 masks, or brown bags for storing dedicated masks. Further observation, 03/20/2022 at 4:10 PM revealed State Registered Nursing Assistant (SRNA) #1, SRNA #2, and Hospitality Aide (HA) #3 put on PPE in the hallway outside Resident #299's room. Gowns and gloves were donned, but the aides failed to change their dedicated mask to a N-95 mask, and they all wore their dedicated surgical mask and eye protection into the room. Further, staff left the isolation door open, and the State Survey Agency observed from the hallway, while the staff assisted Resident #299 and his/her roommate, who was in Contact isolation, without changing PPE. Additional observations revealed the staff doffed and disposed of their PPE (gown, gloves) in the isolation room, washed their hands, and exited room. SRNA #1 brought the mechanical lift out of the room without sanitizing it, and they did not clean their eye protection or change their surgical mask after exiting the room. The lift, that was used in the room, was not disinfected, but SRNA parked it on the opposite hallway (Civil War). Then the aides went to the nurses' station. Interview with SRNA #1, SRNA #2 and HA #3, on 03/20/2022 at 4:15 PM revealed they had received training on infection control, including COVID-19, types of Transmission-based Precautions (TBP), what PPE to wear in each type of isolation, using dedicated equipment recently (2-3 months ago). Per interview, they should have changed their surgical masks and cleaned their eye protection with Clorox (brand of bleach) wipes; however, they forgot to do it because the SSA was watching and they didn't check the PPE container to see if they were available. Further review revealed they should not have pushed the mechanical lift out of the isolation room into the clean hallway and placed at the other hallway without wiping it down/cleaning it with Clorox wipes. She stated they did not check to see if there were wipes available to clean the lift and they forgot they should clean the lift. They stated that it was important to maintain infection control practices per policy to not contaminate other residents and spread infection. Interview with Licensed Practical Nurse (LPN) Staff Development Coordinator, on 03/21/2022 at 11:30 AM, revealed that she had been in the role since 03/01/2022. Per interview, since she had been in the role, she had provided In-Service education on use of PPE, handwashing and general infection control refreshers. She said she had not identified concerns related to infection control. Interview with the Unit Manager (UM)/Registered Nurse (RN) #3, on 03/26/2022 at 12:10 PM, revealed she had been in the role for three (3) weeks. Per interview, she expected staff to follow Infection Control Guidelines, policies, and practices related to isolation on a daily basis. She stated residents in contact isolation required staff to wear PPE per the instructions posted on the door. Additionally, staff members were expected to don and doff and use the appropriate PPE when providing care when droplet isolation precautions were in effect. The UM stated nursing staff should obtain the isolation order, ensure PPE, signage, and other necessary supplies were in place per the guidelines and policy. The UM stated there was adequate PPE available in the facility, and she had not identified concerns with Infection Control practices on Two (2) North or with the isolation rooms. However, she stated she had not conducted walking floor rounds to observe for potential infection control issues on equipment and that proper isolation supplies/equipment were available. She stated she did participate in Ambassador rounds, and resident rooms were checked for cleanliness, availability of Personal Protective Equipment, and that door signs for isolation were in place. She stated the rounds were completed daily and all management staff participated and were responsible for assigned rooms, but she was unaware if the rounds were documented as completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations, that were made on 03/20/2022, at Resident #299's room, were discussed with the UM, and she stated the information provided would not be acceptable practice. She stated droplet isolation required staff to wear an N-95 mask, and residents not fully vaccinated were treated as potentially positive for COVID-19. She said if staff did not wear the proper mask while caring for that resident, there was a potential for spreading infection to other residents. The UM stated the lift used in Resident #299's should have been disinfected before it was parked in the hallway, because it could have been soiled by respiratory droplets while in use in the resident's room. She stated the direct care staff should have cleaned their eye protection and changed their masks after caring for Resident #299, and before they exited the room. The UM said the direct care staff should have located and donned the appropriate PPE before entering the room, because it was important to maintain IFC practices, and prevent the potential for the spread of infection to other residents at the facility. The UM said she had received annual and as need IFC training. Interview with the Infection Control Nurse/Director of Nursing (DON), on 03/26/2022 at 4:00 PM, revealed she had been in that role for one (1) year, and had previously served as the Unit Manager for one (1) year. She stated Infection Control policies were based on information from the Centers for Disease Control and Prevention (CDC) and reviewed by the corporation. When the Corporation sent the policies to the facility, she ensured staff was educated on the policy. Continued interview revealed it was the facility's practice to screen new admissions related to their COVID-19 vaccination status and their diagnoses. If residents were not completely vaccinated for COVID-19, the resident would be placed under Droplet Precautions for ten (10) days. She stated direct care nurses were responsible for ensuring all necessary orders, equipment, and signs were in place for residents who required isolation. She stated nurse managers completed rounds to ensure PPE was available on the floors and in central supply. Further interview revealed the facility completed education on infection control and would continue to provide training to ensure, as much as possible, that the facility maintained practices that prevented the spread of germs/bacteria. After discussion of the infection control concerns identified on Sunday 03/20/2022, the DON stated the observations were not acceptable. She stated the staff had been provided ongoing education and should have been able to provide Resident #299's care in a safe/acceptable manner. Interview with the Administrator, on 03/26/2022 at 4:30 PM, revealed he had served as administrator since 06/01/2021. He stated all staff were responsible for following infection control guidelines and policies. He stated infection control practices were essential for halting the spread of infections. Per interview, education for infection control was ongoing, and any issues identified were discussed in the facility's Quality Assurance Performance Improvement (QAPI) meetings. The Administrator stated no issues had been identified related to infection control. After the SSA Surveyor discussed the infection control concerns identified on Sunday 03/20/2022, he stated the observed practices were not acceptable, and the policy guidelines should always be followed to stop the spread of infection. 2. Review of the facility's mechanical lifts manifest revealed the facility had full body lifts #1, #4, #7 and #9, and stand assist lifts #3, #6, #8, and #10. Observation on 03/20/2022 at 2:50 PM, revealed lifts #3 and #6 were in the hallway by room [ROOM NUMBER] and 2304. Both lifts had white and brown matter crusted on the bilateral calf rests and a white and brown matter on the footrests. Interview with Registered Nurse (RN) #1, on 03/20/2022 at 3:30 PM, revealed she could not identify the white or brown encrusted matter on lifts #3 and #6 without a microscope. The RN stated she did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not have knowledge of a cleaning schedule, or a form which identified when the lifts were to be cleaned, and who was responsible to clean the lifts. She stated she would have to ask the supervisor about a log for cleaning the lifts. The RN did not provide the requested information during the survey. Observations on 03/24/2022 at 12:51 PM, revealed lifts #3 and #6 were in the hallway next to resident rooms [ROOM NUMBERS]. Observation of lift #3 revealed brown and white matter on the footrests and on the back of the calf rests. The left and right handles had white encrusted matter on the surfaces. Observation of lift #6 revealed splattered brown matter on both lower calf rests; the footrest had white, brown, and black debris; and, the left handle had a white encrusted matter on the surface. Observation on 03/24/2022 at 2:00 PM, revealed SA lift #8 and FB lift #1 were observed on the resident hallways with a sling. Lift #8 had white crusted matter on the left handle the size of one-half (1/2) of a dime and white and brown matter on the entire surface of the footrest/surface. Observations of lift #1 revealed the footrests had a white powdery substance with brown crumb-like matter over the entire footrest. Interview and observation with LPN #4, on 03/24/2022 at 2:52 PM, revealed she observed lifts #1 and #8. The lifts had brown and white matter on both lifts and white dried matter on lift #8's handle. She stated she did not know what the matter was and when asked to provide a cleaning log for the lifts or an equipment cleaning log for the unit, the LPN stated she would have to ask the supervisor about the logs. Interview with Registered Nurse (RN) #13, on 03/24/2022 at 2:52 PM, revealed with the State Survey Agency Surveyor present, she observed lifts #1 and #8 with brown and white matter on the lift foot rests and white dried matter on the handle of lift #8. She said she could not identify the matter. Observation on 03/24/2022 at 2:55 PM, revealed RN #13 obtained a wipe from the medication cart. The container was labeled as Sani-wipe (a no-rinse disposable wipe which kills common viruses and bacteria). The RN returned to lifts #1 and #8 and wiped the handles, calf rests, and footrest. The use of the wipe by the RN removed the brown matter and the matter on the handles of the lifts. The white matter was identified by the RN as possible break down of the pad. Continued interview with RN #13, on 03/24/2022 at 3:00 PM, revealed the Sani- wipe removed the brown, black substance on the calf rests and footrest and the white substance on the handles. She stated the lifts were dirty and obviously not cleaned by staff. She said the lifts were to be cleaned after use with a resident and weekly. However, she was unsure when the weekly cleaning occur. Observation, on 03/24/2022 at 2:16 PM, revealed a lift identified as #10. Observations revealed the calf rest and footrest had white and brown crusted matter on the surface and a quarter size brown sticky matter on the left leg rest. Continued observations revealed the right black handle had white raised matter. Further observation of lift #7 revealed the base of the lift had white and brown matter scattered over the surface on the base of the lift. Interview with SRNA #7, on 03/24/2022 at 2:24 PM, revealed with the State Survey Agency Surveyor present, the SRNA identified matter on lifts #7 and #10 as dried brown and white dirt. The aide stated after resident use, staff cleaned the lifts when they removed the lift from the room. The aide stated the facility cleaned the lifts to prevent cross contamination and possible spread of infection. The aide stated when staff did not clean multi-resident use equipment (lifts) bacteria could be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferred to another resident which could cause the resident to get sick. The aide stated staff should clean the lifts with a bleach wipe or Sani-wipe. The aide stated the units had a checklist to document when staff routinely cleaned the lifts. However, the aide stated she was not sure what day or shift the lifts were to be cleaned. She said the facility provided education for prevention of the spread of infection, and anyone in m,the facility could clean a lift. Interview with the ADON, on 03/24/2022 at 3:45 PM, revealed staff cleaned the lifts after each use, weekly, and when dirty. She stated the staff did not document on a form when they completed weekly cleaning of the lifts and to her knowledge the facility did not have a log. She stated the nurses' stations had a sign with instructions about when to clean the lifts. Continued interview with the Assistant Director of Nursing (ADON), on 03/24/2022 at 3:45 PM, revealed the units completed the lift cleaning task on different days. However, she did not know what days the different units completed the task. She stated the facility wanted to make sure the lifts were cleaned to prevent the risk of the transmission of infection. The ADON stated if cross contamination occurred, residents could get sick or decline. She stated staff was to follow the policy for infection control in order to prevent cross contamination. Further interview revealed staff members were to clean the lifts after use with a resident who was under isolation precautions. She said anyone in the facility could clean a lift. Interview with the DON (Director of Nursing), on 03/26/2022 at 3:10 PM, revealed direct care staff cleaned all lifts on Friday nights, after use with a resident, and after a lift was used for a resident under isolation precautions. However, observation, during the interview revealed a posted sign for weekly cleaning of lifts did not specify a day, a shift, or which staff members were responsible for the weekly disinfection of the lifts. She stated clinical staff observed lifts for cleanliness during walking rounds. She further stated staff was educated on infection control prevention measures. The DON stated the staff cleaned the lifts to prevent the spread of infections. The DON said the clinical IDT had not identified issues with dirty lifts. Interview with the Administrator, on 03/26/2022 at 4:30 PM, revealed all staff members were responsible for following Infection Control guidelines and policies. Additionally, he stated Infection Control measures were the most important steps to stop the spread of infections. He stated the facility provided ongoing Infection Control education, and any issues identified were discussed in Quality Assurance Performance Improvement (QAPI) meetings. However, he stated dirty mechanical lifts had not been an identified issue. 2. Review of the facility's Electronic Medical Record (EMR) for Resident #12 revealed the facility admitted the resident, on 06/17/2019, with diagnoses that included Chronic Respiratory Failure, unspecified whether with hypoxia or hypercapnia, Dementia with behavioral disturbance, Diabetes Mellitus with Diabetic Neuropathy, Recurrent Urinary Tract Infection, unspecified and Extended Spectrum Beta Lactamase (ESBL) resistance. Review of Resident #12's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/20/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (09) which indicated he/she had moderate cognitive impairment. Review of Resident #12 record revealed on 02/03/2022 and 03/16/2022, the resident was placed on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Contact Isolation due to Vancomycin Resistant Enterococcus (VRE) in his/her urine; a bacterial infection that is resistant to the antibiotic Vancomycin, which is commonly used to treat this type of bacteria and required transmission- based precautions (TBP) to prevent the spread of infection. Review of Resident #12's Comprehensive Care Plan (CCP) revealed, on 02/03/2022, the resident was care planned for Infection Control due to a diagnosis of VRE. The goal was the resident's signs and symptoms would resolve as evidenced by a normal temperature, decreased urgency, decreased frequency, decreased complaints of abdominal pain, decreased complaints of burning on urination, decreased confusion, decreased weakness within forty-eight hours of start of antibiotic treatment. Interventions included Contact Isolation per order; vital signs every shift until completion of antibiotic; administer antibiotic, as ordered; observe for side effects related to antibiotic therapy; and report to physician (rash, itching, nausea/vomiting, diarrhea, difficulty breathing. Review of Resident #12's CCP revealed no documentation the facility revised the most recent Infection Control order of Contact Isolation, with VRE in urine, dated 03/16/2022. Review of Resident #12's Physician Orders, dated February 2022, revealed an order dated 02/03/2022, for Contact Isolation, due to Vancomycin Resistant Enterococcus (VRE) in urine. Further review revealed an order to start Linezolid (antibiotic) 600 milligram (mg) per oral every twelve (12) hours times seven (7) days. Review of Resident #12's Interdisciplinary Team (IDT), Progress Note, dated 02/04/2022 at 9:27 AM, revealed the resident remained in isolation precautions; IDT discussed antibiotic use with no adverse drug reaction (ADR) noted. Review of Resident #12's Physician Orders, dated March 2022, revealed an order for Contact Isolation, dated 03/16/2022, for urinary tract infection (UTI) due to VRE in urine culture results. Further review revealed an order to start Macrobid (antibiotic) 50 mg, oral every six (6) hours, times five (5) days. Continued review of Resident #12's Progress Note dated 03/16/2022 at 3:50 PM, revealed urinalysis results of VRE greater than one-hundred (100) colony forming unit (cfu) per milliliter (ml). Observation on 03/20/2022 at 4:05 PM, revealed Resident #12 was in Contact Precautions. The door was open and there were two (2) isolation signs on the door. One (1) noted Contact Isolation and the other one (1) noted Droplet Precaution. Additional observations revealed the Droplet and Contact sign on door listed precautions: N95 mask, close door and use dedicated equipment. Continued observations revealed an instructional sheet on the door which noted how to don (put on) and doff (take off) PPE. Further observations revealed a plastic three (3) drawer cart in the hallway at the doorway for PPE with gowns, gloves, and surgical mask; however, there was no evidence of sanitizing wipes or brown bags for dedicated mask outside the room. Continued observations on 03/20/2022 at 4:05 PM, revealed Certified Nursing Assistant (SRNA) #1, SRNA #2, and Hospitality Aide (HA) #3, don Personal Protective Equipment (PPE) in hallway outside Resident #12's room. All three aides donned gown, then gloves, but failed to change their dedicated mask to a N95 mask; they all wore their dedicated surgical mask and eye protection into the room. Further observation revealed the staff assisted both Resident #12 who was in Contact isolation, and his/her roommate, who was in Droplet Precautions, without changing PPE. Additional observations revealed the staff doffed the PPE (gown, gloves) in the isolation room and disposes it in dedicated bins, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2022
NAME OF PROVIDER OR SUPPLIER: Sunrise Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 717 North Lincoln Boulevard Hodgenville, KY 42748	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	washed their hands, and exited the room. However, staff brought a mechanical lift out of the room without sanitizing it and staff did not clean their eye protection or change their surgical mask after exiting the room. The lift was not cleaned before leaving the isolation room and was parked on the opposite hallway. The aides went to the nursing station. Observation and interview of Resident #12, on 03/21/2022 at 8:40 AM, revealed he/she was lying in bed, watching ('television) without any signs/symptoms of distress noted. There were no odors in the room and the resident was clean and dry; he/she voiced no complaints. Interview with Resident #12, at the time of the observation, revealed the resident did know why he/she had been placed in isolation; I often get this type of infection in my urine, and it is unfortunate and irritating at times. Interview with SRNA #1, on 03/20/2022 at 4:15 PM, revealed Resident #12 was in contact isolation related to a type of contagious bacteria in his/her urine. Additionally, SRNA #1 stated it was required to wear gown, gloves, mask, and eye protection in the isolation room. SRNA #1 added, ongoing Infection Control trainings and education occurred to stop the spread of bacteria and germs. Interview with SRNA #1, SRNA # 2 and HA #3, on 03/20/2022 at 4:15 PM revealed they received training on infection control, including COVID-19, types of Transmission-based Precautions (TBP), what PPE to wear in each type of isolation, using dedicated equipment two (2) to three (3) months ago. Additionally, they stated they should have worn PPE per the signs on the door and changed their PPE in between residents. Per interview, they also should have changed their surgical masks and cleaned their eye protection with Clorox wipes when they exited the isolation room; however, they forgot. Further, they should not have pushed the mechanical lift out of the isolation room into the clean hallway and placed at the other hallway without wiping it down/cleaning it with Clorox wipes; they did not check to see if there were wipes available to clean the lift and they forgot they should clean the lift. However, it was important to maintain infection control practices per policy to not contaminate other residents and spread infection. Interview on 03/22/2022 at 2:30 PM, with SRNA #2 revealed she received training on types of isolation, and how and what type of PPE to wear for each type of isolation. SRNA #2 added Resident #12 was in isolation due to infection of VRE in his/her urine. She revealed staff should always follow the isolation precautions posted on doors and encourage residents in isolation to stay in their rooms. Further, staff should also encourage residents to practice infection control measures to decrease the spread of infection to other people in the facility. Interview with SRNA #12 and SRNA #13, on 03/26/2022 at 2:54 PM, revealed all nursing staff worked together as a team, and an individualized resident Kardex (Care Plan) was located on all units, at each nursing station for all staff to reference for resident care needs. Continued interview revealed the Kardex was updated daily per the Unit Manager. Additionally, the aides used the Kardex routinely throughout shift; at the beginning of every shift the nurses perform rounds to discuss, review and check all residents for any changes in conditions and what type of specific care to provide, including TBP. Continued interview revealed the admissions office notified the nurse management team and the Unit Manager of the type of TBP's a newly admitted residents required. Additionally, the Unit Manager ordered the needed supplies for the new resident. Per interview, the direct care nursing staff would prepare all supplies for the infection control cart to be placed in front of the room and place proper signage/type of TBP's on the door. Further, the nurse management in the facility routinely audited and made observations of resident rooms and staff's performance to ensure proper type of isolation was ordered and provided. Continued interview revealed Administration took infection control practices very serious, all staff were monitored routinely and if they were not performing properly (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185057	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Nursing Home	717 North Lincoln Boulevard Hodgenville, KY 42748

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or safely staff would be written up; would require re-training's and a performance improvement was placed in the staff records. Interview with SRNA #10, on 03/26/2022 at 9:20 AM, revealed she was provided education on ways to help residents minimize the spread of COVID-19 and transmission-based infections such as in hand washing, wearing masks, following isolation precautions, and social distancing. Continued interview with the aide revealed the staff encouraged all residents and other staff to practice and promote the correct type of isolation practices when in isolation rooms and providing nursing care to residents. SRNA #10 stated, it was necessary for all staff to practice correct and proper infection control practices in order, to prevent the spread of germs and to keep the residents well. Interview with Licensed Practical Nurse (LPN)/ Staff Development Coordinator #23, on 03/21/2022 at 11:30 AM, revealed she provided In-services, re-education on PPE, handwashing, and infection control, as refreshers. The SDC stated she had not identified any concerns in those areas. Additionally, LPN/SDC #23 added, if any identified concern would arise, she would provide education to all staff in all departments as applicable. Interview with RN #3 (Unit Manager on Two (2) North and Two (2) South), on 03/24/2022 at 10:03 AM, revealed she received infection control training which included the types of transmission-based precautions (TBP) to use; what PPE to wear in each type of isolation, and the proper use of and how to properly don/doff (put on/take off) PPE. Per interview, RN #3 stated the facility placed the resident in contact isolation for VRE in his/her urine. She stated antibiotics were started on 03/16/2022 and completed on 03/21/2022. Continued interview with RN #3, revealed all staff should don PPE each time they entered an isolation room regardless of whether the resident was in their room or not. RN #3 additionally stated, it was important for residents[TRUNCATED]