STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breathitt Health & Rehabilitation	420 Jett Drive Jackson, KY 41339

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview, record review, and review of the facility's policy, the Map 14 form, the facility failed to protect the resident's rights to privacy in communications, including the right to receive mail unopened for 1 of 13 residents who attended the Group Interview (Resident (R) 40). R40 received an opened letter addressed to him from the Kentucky Public Pensions Authority. The findings include: Review of the facility's policy, titled Resident Rights, revised 11/01/2024, revealed its purpose was to protect and promote the rights of each resident. Per policy, each resident has a right to personal privacy, including the right to privacy in oral, written, and electronic communications and the right to receive mail unopened. Review of the facility's policy, titled Breathitt Health and Rehab Clinical Standard and Guidance Postal Services/ Mail Guideline, revealed its purpose was to ensure the facility protected the resident's rights to communication with individuals within and externally to the facility. Per policy, each resident has the right to send and promptly receive unopened mail, letters, and packages delivered by the USPS (United States Postal Service) and other authorized delivery services/carriers. Only if directed by the resident or the resident's Power of Attorney would any mail or package be opened by staff. During a Group Interview Meeting, conducted by the State Survey Agency Representative, on 02/04/2025 at 2:49 PM, R40 complained he had received a letter addressed to him that had been opened by facility staff. Review of R40's Electronic Medical Record (EMR), revealed a Quarterly Minimum Data Set (MDS) Assessment, dated 09/16/2024. Per the MDS, the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Review of R40's EMR, revealed no documented evidence R40 was informed his mail would be opened nor was this documented in the resident's Care Plan. Review of the Map 14-Commonwealth of Kentucky Cabinet for Health and Family Services Department for Medicaid Services Authorized Representative, revised 10/2021, revealed R40 signed this consent form, allowing the Business Manager to apply, report changes, recertify, and receive a copy of notices for his Medicaid eligibility. During interview with R40, on 02/05/2025 at 11:40 AM, the resident stated the facility's Business (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: 185112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager opened and read a letter from the Kentucky Public Pensions Authority which was addressed to him (R40). R40 stated the Business Manager stopped him outside her office and told him about the letter's contents. He further stated he had not given the Business Manager permission to open this letter. In continued interview, R40 stated he had been excited to receive this letter, and it upset him that he did not get to experience reading the content himself. R40 stated, staff reading his letter made him feel like he didn't exist. Review of R40's letter from the Kentucky Public Pensions Authority, revealed the letter was addressed to R40. During an interview with the Business Manager, on 02/05/2025 at 11:36 AM, she stated she had opened R40's letter which was addressed to R40 from the Kentucky Public Pensions Authority. She stated she thought R40 granted her permission to open his mail from the Kentucky Public Pensions Authority when he signed the Map 14 form. During an interview with the Administrator, on 02/06/2025 at 2:30 PM, she stated she expected all residents to receive unopened mail to protect their right to privacy in communication. The Administrator stated the Business Manager should only open the resident's mail if the letter was addressed to the business office or if the resident had given permission to open the mail.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review and review of the facility's policy, the facility failed to ensure each resident remained free from abuse for 1 of 19 sampled residents, (Resident (R)2). R2 alleged Certified Nursing Assistant (CNA)2 was rough while providing care on 12/24/2024. R2 further alleged CNA2 told her, if you report me, I will beat your ass. R2 was crying and told RN1 that she was afraid of CNA2. (Refer to F609, and 610) The findings include: Review of the facility's policy, titled Abuse Prevention Program, undated, revealed the facility would prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Further review revealed the program would be implemented when an employee or agent became aware of abuse or neglect of a resident, or if an allegation of suspected abuse or neglect of a resident was reported. Review of R2's electronic medical record (EMR), under the Face Sheet revealed the facility admitted the resident on 08/01/2024 with diagnoses that included Multiple Sclerosis, Anxiety and Depression. Review of R2's Comprehensive Care Plan revised 08/01/2024, located in the Electronic Medical Record (EMR), under the Care Plan tab, revealed no focus area noted for R2 related to any behaviors. Review of R2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/06/2024, located in the EMR under the MDS tab, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Further review of the MDS revealed R2 was dependent for transfers, utilized a wheelchair and was assessed as no ambulation. No behaviors were coded on the MDS. During an interview on 02/02/2025 at 1:58 PM, with R2, she stated on 12/24/2024, CNA2 was rough while providing care. Continued interview revealed CNA2 continued to provide rough care and R2 told the CNA that if she continued to be rough during care, she would report her. R2 stated CNA2 responded, if you report me, I will beat your ass. R2 stated CNA2's treatment of her on 12/24/2024, hurt her feelings. R2 stated, CNA1, who was assigned to the resident, was in her room assisting with pulling her up in bed during the incident. R2 stated she reported the incident to CNA6. During an interview on 02/05/2025 at 9:54 AM, with CNA6, she stated upon entering R2's room on 12/24/2024, the resident was crying. When CNA6 questioned R2, she stated CNA2 told her she would smack the fire out of her if she (R2) reported the rough care that she had provided. CNA6 stated this was her recollection of what R2 reported to her. CNA6 stated she did not document this and was not asked to write a statement. CNA6 stated she immediately reported this to Registered Nurse (RN)1. During an interview on 02/04/2025 at 3:06 PM, with CNA2, she stated she had not been in R2's room on 12/24/2024. Further, CNA2 stated she had not been in R2's room in more than a month prior to the allegation being made on 12/24/2024. CNA2 stated she could not recall why she had been instructed not to go into R2's room the month prior to the allegation, but thought the Director of Nursing (DON) may have been the person who instructed her not to go into R2's room. In further interview, CNA2 stated that on 12/24/2024, she was instructed by RN1 to go to the breakroom and was then informed of R2 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	alleging she (CNA2) had threatened to hit her. CNA2 stated the Administrator then spoke with her on the phone on 12/24/2024 and instructed her not to go back into R2's room or the hallway where R2 resided, but to continue working on another unit providing Resident care. During an interview on 02/05/2025 at 11:45 AM, with RN1, she stated on 12/24/2024 just after supper, around 5:00 PM, CNA6 reported an allegation related to CNA2. RN1 stated R2 reported to CNA6, that CNA2 told R2 if she did not quiet down, she would slap the shit out of her. RN1 stated she went to R2's room, and noticed R2 with the bed covers pulled under her chin. She stated R2 appeared agitated. RN1 stated R2 told her she was afraid of CNA2. In continued interview, RN1 stated she had CNA1 and CNA2 to remain in the break room while she contacted the Administrator by phone. RN1 stated the Administrator then had her to take the phone to R2 and the Administrator spoke with R2 for approximately 20 minutes. The RN stated CNA1 and CNA2 remained in the breakroom during this time. RN1 stated the Administrator spoke with CNA1 and CNA2 via phone after speaking with R2. RN1 stated she informed the Administrator of the allegation of verbal abuse as well as the allegation of rough care provided to R2 by CNA2. Additional interview on 02/05/2025 at 11:45 AM, with RN1, revealed after the Administrator spoke with R2, CNA1, and CNA2 via phone, the Administrator told RN1 to have CNA2 to go to the front hall and continue working. RN1 stated the Administrator informed her she was going to close the investigation because she did not suspect any abuse. RN1 stated the Administrator instructed her to ensure CNA2 did not go back down the hallway where R2 resided. During an interview on 02/04/2025 at 3:28 PM, with the DON, she stated she did not recall why CNA2 was instructed prior to the 12/24/2024 allegation, not to be in R2's room. However, it must have been some type of conflict. The DON stated CNA2 was not assigned to R2 on 12/24/2024, but may have been assisting another CNA on that day. During an interview on 02/03/2025 at 2:14 PM with R2's sister, she stated that on 12/24/2024 between 7:30-8:00 PM, upon entering the facility she was informed by RN1 that R2 had alleged rough care by CNA2 and reported CNA2 had told her she would beat the shit out of her if she reported her. The sister stated RN1 had also informed her that R2 had been crying and maybe she could help calm her down. Upon entering the room, R2 appeared to have been crying and stated her feelings were hurt. R2 then repeated to the sister the same allegation as RN1 had informed her of. During an interview, on 02/04/2025 at 11:27 AM, with the Administrator, she stated she was responsible for abuse investigations at the facility. She stated she was contacted on 12/24/2024 by RN1 and informed of the allegation made by R2. The Administrator stated after learning of the incident, she had a 20 minute conversation with R2 and during the call R2 could not explain what she meant by the CNA being rough. The Administrator stated after speaking with R2, CNA1, and CNA2, she did not identify an allegation of abuse. However, she stated she was not made aware R2 had alleged CNA2 stated she would beat the shit out of her. The Administrator stated she was only informed R2 had stated CNA2 was rough while providing care. However, during interview on 02/05/2025 at 11:45 AM, RN1 stated she informed the Administrator of the verbal statement and the rough care allegation made by R2. The Administrator stated she did not interview other residents regarding CNA2 as she stated she had never had any complaints regarding CNA2. During an interview on 02/06/2025 at 5:08 PM, with the Medical Director, he stated he was made aware of an allegation made by R2 on 12/24/2024. The Medical Director stated he was informed by the Administrator that R2 alleged an aide had been abusive or rough while providing care. The MD stated he (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was informed by the Administrator that the allegation had been worked out and R2 did not like CNA2 and there had not been any type of abuse. In further interview, the Medical Director stated he was informed R2 was unhappy with CNA2, therefore the facility had moved CNA2, so she would not have further contact with R2.

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F 0609

Level of Harm - Actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

Based on interview, record review, and review of the facility's policy, the facility failed to report an allegation of abuse to the State Agencies and local law enforcement for 1 of 19 sampled residents, (Resident (R)2).

The facility failed to report an allegation of abuse after R2, while crying, alleged on 12/24/2024, to CNA6 that Certified Nursing Assistant (CNA}2 was rough while providing care and told R2, if you report me, I will beat your ass. R2 then informed RN1 that she was afraid of CNA2. Registered Nurse1 (RN1) Refer to F600 and F610.

The findings include:

Review of the facility's policy, titled Abuse Reporting, undated, revealed the Administrator or person in charge, would notify immediately, the state licensing and certification agency, the resident's representative, the attending physician, and law enforcement officials when the facility received an allegation of abuse.

Review of R2's electronic medical record under the Face Sheet revealed the facility admitted the resident on 08/01/2024 with diagnoses which included Multiple Sclerosis, Anxiety and Depression.

Review of R2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

11/16/2024, located under the MDS tab, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated intact cognition. Additional review of the MDS, revealed the facility assessed the resident as having no behaviors, as totally dependent on staff for transfers, and as ambulation not occurring.

During an interview on 02/02/2025 at 1:58 PM, with R2, she stated on 12/24/2024, CNA2 was rough while providing care. R2 stated CNA2 continued to provide rough care and she told CNA2, if she continued to be rough during care, she would report her. R2 stated CNA2 then responded, if you report me, I will beat your ass. R2 stated she reported this to CNA6; however, she was unaware of the time of the occurrence or the time she reported it to CNA6. Further, R2 stated CNA1 was in the room assisting to pull R2 up in bed during this incident. R2 stated RN1 brought the phone in her room and R2 spoke with the Administrator. R2 stated she informed the Administrator of CNA2's statement that she would beat her ass if R2 reported her for being so rough while providing care.

During an interview on 02/05/2025 at 9:54 AM, with CNA6, she stated upon entering R2's room just after supper, the resident was crying. CNA6 stated R2 alleged CNA2 told her, she would smack the fire out of her if R2 reported her being rough with her care. CNA6 stated this was what she remembered related to the conversation. However, she was not asked to write a statement related to the allegation. CNA6 stated she immediately reported the allegation to Registered Nurse (RN)1.

During an interview on 02/05/2025 at 10:39 AM, with CNA1, she stated she could not remember if CNA2 was in R2's room on 12/24/2024.

During an interview on 02/04/2025 at 3:06 PM, with CNA2, she denied being in R2's room on 12/24/2024. CNA2 stated on 12/24/2024 she was instructed by RN1 to go to the breakroom and was then informed

(continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	that R2 had accused her (CNA2) of saying she was going to hit her. During an interview, on 02/05/2025 at 11:45 AM, with RN1, she stated on 12/24/2024 around 5:00 PM, CNA6 reported an allegation. RN1 stated per her recollection, R2 told CNA6, that CNA2 told her if she did not quiet down, she would slap the shit out of her. RN1 stated she then went immediately to R2's room and spoke with her. The RN stated during her conversation with R2, the resident told her she was afraid of CNA2. RN1 stated she did not document this allegation, but had CNA1 and CNA2 stay in the break room while she contacted the Administrator. RN1 stated the Administrator spoke with R2 on the phone while CNA1 and CNA2 remained in the breakroom, and then the Administrator spoke with CNA1 and CNA2 by phone. During an interview on 02/03/2025 at 2:14 PM with R2's sister, she stated that on 12/24/2024 between 7:30-8:00 PM, upon entering the facility she was informed by RN1 that R2 had alleged rough care by CNA2 and reported CNA2 had told her she would beat the shit out of her if she reported her. The sister stated RN1 had also informed her that R2 had been crying and maybe she could help calm her down. Upon entering the room, R2 appeared to have been crying and stated her feelings were hurt. R2 then repeated to the sister the same allegation as RN1 had informed her of. During interview with RN1, on 02/05/2025 at 11:45 AM, she stated after the Administrator spoke with R2, CNA1, and CNA2 by phone, which was just after 5:00 PM, the Administrator told her to have CNA2 to go to the front hall and continue working as she did not suspect any abuse. In further interview with RN1, she stated the Administrator instructed her to not allow CNA2 to go back down the hallway where R2 resided. RN 1 stated she informed the Administrator of the allegation of verbal abuse as well as the allegation of rough care provided to R2 by CNA2. During an interview on 02/04/2025 at 11:27 AM, with the Administrator, she stated on 12/24/2024 around 5:00 PM, RN1 informed her of an allegation of CNA2 providing rough care made by R2. The Administrator stated she then had a 20 minute conversation with R2 via phone, and during this call R2 was unable to explain what she meant by the CNA being rough. The Administrator stated she then spoke with CNA1, and CNA2. She stated after the phone interviews with R2, CNA1 and CNA2, she did not feel this was an allegation of abuse, but only a concern and therefore she did not report the allegation to State Agencies or local law enforcement. However, she stated she was not made aware R2 had alleged that CNA2 told her she would beat the shit out of her. The Administrator stated she was only informed R2 had stated CNA2 was rough while providing care. During an interview on 02/06/2025 at 5:08 PM, with the Medical Director, he stated he was made aware of an allegation made by R2 on 12/24/2024 by the Administrator. The Medical Director stated he was told R2 alleged an aide had been abusive or rough while providing care. He stated he was further informed the allegation had been worked out and although R2 did not like CNA2, there had not been any type of abuse. In further interview, the Medical Director stated he would expect the facility to report any allegations of abuse to the appropriate state entities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review and review of the facility's policy, the facility failed to conduct a thorough investigation in response to an alleged violation of abuse, for 1 of 19 sampled residents (Resident (R)2). R2 reported Certified Nursing Assistant (CNA)2 was rough while providing care on 12/24/2024. R2 reported CNA2 told her, if you report me, I will beat your ass. However, the facility failed to conduct a thorough investigation related to the allegation of abuse. CNA2 was allowed to continue working on 12/24/2024 unsupervised, allowing for the potential of further abuse. (Refer to F600, and F609) The findings include: Review of the facility's policy, titled Abuse Prevention Program, undated, revealed all incidents would be documented, whether abuse occurred, was alleged or suspected. Furthermore, any incident or allegation involving abuse or mistreatment would result in an abuse investigation. Review of the facility's policy titled Abuse Reporting, revealed the Administrator was the Abuse Coordinator. Review of R2's electronic medical record (EMR), under the Face Sheet revealed the facility admitted the resident on 08/01/2024 with diagnoses that included Multiple Sclerosis, Anxiety and Depression. Review of R2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/16/2024, located in the EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated intact cognition. Additional review of the MDS, revealed the facility assessed the resident as having no behaviors, as totally dependent on staff for transfers, and as ambulation not occurring. In an interview on 02/02/2024 at 1:58 PM, with R2, she stated on 12/24/2024, CNA2 was rough while providing care. R2 further stated CNA2 continued to provide care, and R2 told CNA2 that if she continued to be rough during care, she would report her. R2 stated CNA2 replied, if you report me, I will beat your ass. R2 stated she reported this to CNA6. Additionally, R2 stated CNA1 was in the room at the time of the incident assisting with pulling her up in the bed. In an interview on 02/05/2025 at 9:54 AM, with CNA6, she stated upon entering R2's room on 12/24/2024, the resident was crying. CNA6 stated when R2 was questioned, she stated CNA2 had said she would smack the fire out of her if she (R2) reported the rough care CNA2 had provided. CNA6 stated this was her recollection of what was stated to her by R2, as she did not document the allegation nor was she asked to write a statement. CNA6 stated she immediately reported the allegation to Registered Nurse (RN)1. In an interview on 02/05/2025 at 10:39 AM, CNA1 stated she could not remember if CNA2 was in R2's room on 12/24/2024. CNA1 stated the Administrator interviewed her over the phone related to the allegation, but she was not asked to write a statement. In an interview on 02/04/2025 at 3:06 PM, CNA2 stated she had not been in R2's room on 12/24/2024. CNA2 stated she had not been in R2's room in more than a month prior to the allegation being made on 12/24/2024. The CNA stated she could not remember why she had been told not to go into R2's room the month prior to the allegation, but the Director of Nursing (DON) may have been the person who instructed her not to go into R2's room. CNA2 stated on 12/24/2024, she was instructed by RN1 to go to (continued on next page)

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F 0610

Level of Harm - Actual harm

Residents Affected - Few

the breakroom and was then informed of R2's allegation that she (CNA2) had threatened to hit the resident.

In continued interview with CNA2, she stated she had spoken on the phone with the Administrator on the evening of 12/24/2024. She stated she was instructed to continue working her shift, but to stay on the front hall away from R2's room. CNA2 stated she was not asked to write a statement and continued to work as scheduled.

In an interview with RN1, on 02/05/2025 at 11:45 AM, she stated on 12/24/2024 around 5:00 PM, CNA6 reported to her an allegation made by R2. RN1 stated CNA6 reported she was informed by R2, that CNA2 told R2 if she didn't quiet down, CNA2 would slap the shit out of her. RN1 stated this was her recollection of what was stated to her by R2, as she did not document this nor was she asked to write a statement. RN1 stated she went to R2's room and noted the resident had her blanket pulled up to her chin and stated she was afraid of CNA2.

In interview with RN1, on 02/05/2025 at 11:45 AM, she stated she instructed CNA1 and CNA2 to remain in the break room while she contacted the Administrator by phone. RN 1 stated she informed the Administrator of the allegation of verbal abuse and the allegation of rough care provided to R2 by CNA2. RN1 stated the Administrator had her to take the phone to R2 and the Administrator spoke with R2 on the phone for approximately 20 minutes while CNA1 and CNA2 remained in the breakroom. RN1 stated the Administrator then spoke with CNA1 and CNA2 via phone. She stated that after the Administrator spoke with her, CNA1, and CNA2 she informed her that she was going to end the investigation because she did not suspect any abuse. She stated the Administrator instructed her to have CNA2 to go to the front hall and continue working and to ensure CNA2 did not go back down the hall where the resident resided. RN1 stated the Administrator did not instruct her to complete any documentation, investigation, or monitoring regarding the allegation other than to ensure CNA2 did not go back down the hall where R1 resided. During the interview with RN1she stated she did not document any monitoring of CNA2 to ensure CNA2 did not got to R2's hallway.

In an interview on 02/04/2025 at 11:40 AM, with the Social Services Director (SSD), she stated on 12/24/2024 the Administrator notified her by phone that R2 had made a complaint stating that CNA2 had provided rough care. The SSD stated this was discussed in the morning standup meeting on Monday morning following the incident. The SSD stated the Director of Nursing (DON), Assistant Director of Nursing (ADON), and she monitored R2 for three (3) days with no issues noted. However, the SSD stated she could not locate any documentation for the follow-up or monitoring of R2.

In an interview with the ADON, on 02/04/2025 at 3:35 PM, she stated she was informed by the Administrator of the allegation by R2, and was told CNA2 had provided rough care. The ADON stated she assisted with monitoring of R2 for three (3) days following the allegation and R2 did not mention anything regarding the incident. However, the ADON was unable to submit documented evidence of the three (3) day monitoring. During the interview, the ADON stated if abuse was alleged or suspected, the alleged perpetrator should be removed from the building and an investigation should be completed. However, she stated CNA2 was not sent home after the allegation because R2 only stated CNA2 provided rough care. The ADON stated she did not complete any interviews related to the allegation as she was not instructed to do so by the Administrator, who was responsible for the investigation.

In an interview on 02/04/2025 with the DON, she stated she assisted with monitoring of R2 for two to three (2-3) days after the 12/24/2024 allegation was made. The DON stated the resident did not appear in any distress nor did she have any complaints. However, the DON was unable to submit

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breathitt Health & Rehabilitation	420 Jett Drive Jackson, KY 41339

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 0610 Level of Harm - Actual harm Residents Affected - Few	documented evidence of the monitoring. During further interview, the DON stated she did not recall why CNA2 was instructed prior to the 12/242024 allegation, not to be in R2's room, but it was over some type of conflict. The DON stated she did not conduct any interviews related to the allegation, as the Administrator did not instruct her to do so. Review of a handwritten document, dated 12/24/2024, signed by the Administrator, revealed the Administrator was contacted around 7:00 PM by RN1. Per the document, RN1 reported R2 had stated CNA2 was rough with her while providing care. However, the the Administrator was unable to submit further investigation related to the allegation. In an interview with the Administrator, on 02/04/2025 at 11:27 AM, she stated she was contacted on 12/24/2024 by RN1 and informed of the allegation made by R2. She stated she had a 20-minute conversation with R2 and throughout the call, R2 could not explain what she meant by the CNA being rough. The Administrator stated after speaking with R2, CNA1, and CNA2 she thought this was only a concern as she was only informed R2 had stated CNA2 was rough while providing care. She stated she did not think there needed to be an abuse investigation nor did she think CNA2 needed to be removed from resident care. However, during continued interview with the Administrator, she stated she was not made aware that CNA2 had told R2 she would beat the shit out of her. In an interview, on 02/06/2025 at 5:08 PM, with the Medical Director, he verified the Administrator made him aware of an allegation made by R2 on 12/24/2024. He stated R2 alleged CNA2 had been abusive or rough while providing care. He stated the DON and the ADON had conducted interviews and concluded there was no physical or verbal abuse. The Medical Director stated he would expect the facility to conduct a thorough investigation and CNA2 be removed from the facility while an investigation was completed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policies, the facility failed to store, prepare, distribute, and serve food in a sanitary manner. Dietary staff failed to check six (6) of 12 food temperatures on the steam table during the dinner meal on 02/02/2025. Additionally, dietary staff failed to discard eight (8) expired food items. The findings include: 1. Review of the facility's policy titled, Food & Beverage Temperature Control, undated, revealed food and beverage temperatures were checked and recorded prior to meal service. Further review revealed all staff would ensure residents received safe food served at acceptable temperatures. Observation on 02/02/2025 at 5:07 PM, revealed Cook1 failed to check the food temperatures for the mashed potatoes, beef goulash, pureed green beans, pureed rice, pureed bread, and pureed beef goulash on the steam table prior to serving the dinner meal. During an interview with Cook1, on 02/02/2025 at 5:07 PM, she stated she only checked the temperature of the foods on the main steam table, not the pureed foods. 2. Review of the facility's policy titled,Food Safety, undated, revealed food or beverage items that had exceeded the manufacturer's expiration date would be discarded. Observation on 02/02/2025 at 2:02 PM, revealed seven (7) expired food items in the walk-in refrigerator and one (1) expired food item in the pantry. The expired food items in the walk-in refrigerator included Dill Pickle Chips with an expiration date of 12/24/2024; Less Sodium Soy Sauce with an expiration date of 12/20/2024; another Less Sodium Soy Sauce with no lid with an expiration date of 06/2021; Wishbone Zesty [NAME] Italian Dressing with an expiration date of 03/10/2024; Worcestershire Sauce with an expiration date of 12/24/2024; and two (2) bottles of Lemon Juice with expiration dates of 08/24/2024 and 12/12/2024. Observation of the pantry revealed one (1) pack of flour tortillas in saran wrap that was hardened with a date of 07/16/2024 and 07/19/2024 handwritten on the saran wrap. During interview with the Dietary Manager, on 02/04/2025 at 1:07 PM, she stated all food served to residents should have a temperature check prior to serving. The Dietary Manager further stated if the food was not the correct temperature it could cause the residents to become sick. Continued interview revealed it was all dietary staff's responsibility to check the pantry, freezers, and refrigerators for expired food. During an interview with the Administrator, on 02/06/2025 at 2:32 PM, she stated checking the temperature of all foods prior to serving should be part of the dietary staff's routine. She further stated it was important to check food temperatures at the steam table prior to serving because if the food temperatures were not the correct temperatures, this could lead to foodborne illnesses for the residents. The Administrator stated there should not be any expired food in the kitchen as expired (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food could possibly cause residents to become sick.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of the facility's policies, the facility failed to maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (3) of 19 sampled residents (Resident (R)7, R28, and R50). 1. Observation on 02/02/2025 at 6:00 PM, revealed Certified Nursing Assistant (CNA)7 failed to don (put on) Personal Protective Equipment (PPE) prior to providing care for R7 who was on Enhanced Barrier Precautions (EBP). Additionally, CNA7 failed to wash or sanitize hands upon exiting R7's room after providing care. 2. Observations on 02/02/2025; 02/03/2025; 02/05/2025; and 02/06/2025, revealed R28's urinal was not labeled with the resident's name, nor was it dated or covered. R28's urinal was either lying on the floor or hanging from the rail in the bathroom. 3. Observation on 02/03/2025 at 9:47 AM, revealed R50's bathroom had two (2) unlabeled, undated, uncovered urinals on the back of the commode, and an uncovered bedpan. The findings include: Review of the facility's policy, titled Enhanced Barrier Precautions (EBP), dated 03/08/2024, revealed the EBP policy was implemented to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility. EBP would be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities. Further review revealed high contact care activities included assisting with providing hands on care. 1. Review of R7's Face Sheet in the Electronic Medical Record (EMR), under the clinical information tab, revealed the facility admitted the resident on 09/12/2024 with diagnoses including lack of coordination and failure to thrive. Review of R7's Physician's Orders dated 10/10/2024, revealed orders for Enhanced Barrier Precautions (EBP- infection control intervention designed to reduce transmission of multidrug-resistant organisms) related to a history of Methicillin-resistant Staphylococcus aureus (MRSA) found in the wound. EBP included wearing the appropriate Personal Protective Equipment (PPE) which included a disposable gown and gloves. Observation on 02/02/2025 at 6:00 PM, revealed an orange dot at R7's door which meant the resident was on EBP. Additionally, there was a sign on the door that stated Enhanced Barrier Precautions. Further observation revealed there was a cart at the door which contained boxes of gloves and disposable gowns. During observation of dinner meal pass on 02/02/2025 at 6:00 PM, Certified Nursing Assistant (CNA)7 failed to don Personal Protective Equipment (PPE) prior to entering R7's room with a meal tray. CNA7 proceeded to lower the head of the bed and assist the resident up higher in the bed by holding the resident under her shoulder while the resident bent her knees and pushed herself up. After assisting R7 up higher in the bed, CNA7 failed to wash or sanitize her hands upon exiting the room. CNA7 then proceeded to the beverage cart outside of R7's room in the hallway to obtain water and orange (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	juice for R7. CNA7 was observed going back into R7's room without donning PPE and proceeded to assist the resident with her dinner tray. During an interview with CNA7, on 02/05/2025 at 9:22 AM, she stated if PPE was not donned appropriately for Enhanced Barrier Precautions (EBP), it placed the resident, other residents and staff at risk for spread of infection. CNA 7 stated all residents on EBP should not be touched by staff unless staff was wearing gloves and a disposable gown. CNA7 stated, she always tried to don appropriate PPE prior to entering R7's room and she knew she should wash or sanitize her hands upon exiting the room. She stated, I must have been in a hurry. I would never put any of my residents at risk for getting an infection or bacteria. During interview with Registered Nurse (RN) 1, on 02/02/2025 at 6:18 PM, she stated all staff had been educated on infection control policies and an orange dot on the resident's room number indicated the resident was on EBP. RN 1 stated all staff should be aware they were to don the appropriate PPE before providing any type of care for residents on EBP. RN1 stated she monitored as she was going down the halls and if staff was identified not wearing appropriate PPE, she would immediately educate them. The RN stated the Director of Nursing (DON) completed daily rounds for infection control measures as well. During an interview, on 02/05/2025 at 1:46 PM, the Director of Nursing/Infection Preventionist (DON/IP), stated she expected nursing staff to follow the facility's policies regarding PPE and EBP. The DON/IP stated if she ever saw any staff not following proper infection control procedures, she would immediately provide them education on what they did wrong and the corrective actions needed. The DON/IP stated following infection control policies and procedures for a resident on EBP was important in order to prevent other residents or staff from being exposed. Further, she stated it was important to use good hand hygiene after providing care, and upon exiting a resident's room. The DON/IP further stated she had been the DON and IP for almost five (5) years. She stated she tried to make daily rounds and educate staff regarding infection control procedures as needed. 2. Review of the facility's policy, titled Bedpan/Urinal, Offering/Removing, undated, revealed per the general guidelines, bedpans and/or urinals were required to be labeled with the resident's name and would be stored in a clean and dignified manner. Continued review revealed bedpans or urinals would not be left in the bathroom or on the floor. During the initial tour of the facility, on 02/02/2025 at 2:40 PM, there was a urinal which was not labeled with R28's name, was not dated, and was uncovered. The urinal was sitting on the floor next to R28's bed, which was out of reach for the resident. Interview with R28 on 02/02/2025 at 2:40 PM, revealed staff assisted him with using the urinal so he would not have placed the urinal on the floor. Further interview revealed the resident required staff to check his brief as he was sometimes incontinent. Review of R28's Quarterly Minimum Data Set (MDS), dated 11/07/2024, located in the electronic medical record, revealed the facility assessed the resident as having a Brief Interview for Mental Status score of 15 out of 15, which indicated intact cognition. Continued review revealed the facility assessed R28 as being frequently incontinent of bladder. Observations on 02/02/2025 at 5:16 PM; 02/03/2025 at 10:15 AM; 02/05/2025 at 2:43 PM; and 02/06/2025 at 9:23 AM, revealed R28's urinal was unlabeled with the resident's name, undated, and uncovered (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the floor or hanging from the rail in the bathroom. During interview with CNA5, on 02/02/2025 at 2:58 PM, she stated R28 was totally dependent on staff for toileting and was not able to place the urinal on the floor. CNA5 stated she was not sure who placed the urinal on the floor, but it had to be a staff member. CNA5 stated she had been trained on bedpans and urinals and both were to be labeled with the resident's name, dated and stored in a bag to prevent the spread of bacteria. The CNA stated urinals were not to be placed on the floor per the facility's policy. During interview with Registered Nurse (RN)1, on 02/02/2025 at 3:14 PM, she stated urinals were to be labeled with the resident's name, dated and placed in a bag and kept in the bathroom unless the resident had a preference of keeping it on a bedside table for easier reach. However, RN1 stated R28 was totally dependent for urinary needs and would not be able to use the urinal independently. She stated it was an infection control issue if the urinals weren't labeled with the resident's name, dated and bagged as it could spread bacteria to not only that resident but to another resident. 3. During observation on 02/03/2025 at 9:47 AM, R50's bathroom had two (2) urinals which were unlabeled with the resident's name, undated, and uncovered sitting on the back of the commode. Additionally, there was an uncovered bedpan on the back of the commode. During an interview on 02/05/2025 at 1:46 PM with the Director of Nursing/Infection Preventionist (DON/IP), she stated the urinals should be labeled with resident's name, dated, bagged, and stored per facility policy. She stated the urinals should be stored per the resident's preference. The DON/IP stated she made daily rounds. However, she did not go into residents' bathrooms during those rounds. She stated it was an infection control issue if urinals and bed pans were not labeled, dated and bagged as it could potentially cause the spread of bacteria which could lead to urinary tract infections. She stated all nursing staff was responsible for making sure the policy was followed. During an interview, on 02/06/2025 at 2:32 PM, with the Administrator, she stated general hand washing was number one, and donning PPE as indicated was expected of all staff. She stated she left it to her clinical management to make rounds to ensure there were no infection control concerns. She stated she expected all staff to follow the facility's infection control policies.