STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185210	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Harrodsburg	180 Lucky Man Way Harrodsburg, KY 40330

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, review of the facility's Hospice Services Agreement, and review of the facility's policy, the facility failed to implement a comprehensive person-centered care plan for 1 of 3 residents sampled for Hospice care, Resident (R) 30. The findings include: Review of the facility's policy titled, Comprehensive Care Plan Guideline, dated 05/22/2018, revealed the facility would ensure appropriateness of services and communication that would meet the resident's needs, severity/stability of condition, impairment, disability, or disease in accordance with state and federal guidelines. Review of the facility's Hospice Services Agreement, dated 05/09/2019, revealed the services provided by the facility as specified in the Plan of Care for a Hospice Patient included, but were not limited to providing food, including individualized request and dietary supplements; and assisting with activities of daily living (ADL) such as mobility and ambulation, dressing, grooming, bathing, transferring, eating, and toileting. Review of R30's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 08/20/2024 with diagnoses including senile degeneration of brain, unspecified dementia, and anxiety. Review of R30's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 08/26/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status [BIMS] score of 10 out of 15, which indicated moderate cognition impairment. Further review revealed R30's functional ability was dependent for: shower, bath, upper/lower body dressing, personal hygiene, rolling side-to-side, and eating. The definition of dependent was the helper does ALL of the effort; the resident does none of the effort to complete the activity. Review of R30's Comprehensive Care Plan [CCP], dated 08/27/2024, revealed a focus of requiring assistance with partial bathing twice weekly, daily oral care, repositioning twice in the night, and assistance with restorative dining. The interventions included repositioning twice during night shift, providing extensive assistance with dining, and aid with self-care including bathing and oral care. R30's CCP did not indicate there was a problem with the resident refusing assistance with ADLs, repositioning, or restorative dining with meals. Observation on 11/24/2024 at 10:32 AM revealed R30's full breakfast tray sitting on the bedside table due to the resident not being able to feed herself and needing restorative dining services 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	help her to receive her daily nutritional meals. Observation on 11/25/2024 at 3:15 PM revealed R30 had not had a bath and was wearing the same clothing as seen on 11/24/2024. In an interview with R30 on 11/25/2024 at 9:10 AM, she stated she did not receive a partial bath or oral care on 11/24/2024. R30 stated staff did not reposition her at all on night shift. In an interview with R30's son, Family (F) 1 on 11/24/2024 at 11:15 AM, he stated the facility had not been providing R30 with bathing, oral care, repositioning on night shift, or staff assistance with restorative dining. F1 stated on last Thursday, 11/21/2024 at 9:00 AM, he hung R30 a clean shirt out for the aide to bathe her and change R30's clothes. F1 stated when he returned the next day on 11/22/2024 at 8:30 AM, R30 was not bathed and was still wearing the same dirty clothes from the previous day. In an interview with Social Services Hospice on 11/27/2024 at 4:15 PM, she stated the facility had not been providing bathing, oral care, or restorative dining to R30. The Social Services Hospice stated she visited the facility three times a week, and R30 had not been bathed or had oral care at all in the current month of November. The Social Services Hospice stated R30 had told her many times she had not eaten at different mealtimes due to not receiving staff assistance of at least one person. In an interview with the Director of Health Services (DHS) on 11/28/2024 at 2:30 PM, she stated staff did not follow R30's CCP because there were not always enough staff members to attend to all the residents who required a one person assist. The DHS stated she was not aware R30 refused assistance with bath, oral care, repositioning, or restorative dining. In an interview with the Executive Director on 11/28/2024 at 4:57 PM, she stated her expectation for staff following care plans for residents in the facility was to always receive the highest level of care. She stated the facility did not have enough staff to assist with residents who required one-on-one assistance. However, she stated she would be investigating why R30 did not receive bathing, repositioning, oral care, or restorative dining.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide the assistance of one at mealtime, partial bathing assistance, and oral care for 1 of 3 residents sampled for Hospice care, Resident 30 (R30). During an observation of meal service on 11/24/2024, the facility failed to assist R30 with restorative dining services. In addition, R30 did not receive bathing assistance or oral care as per R30's Comprehensive Care Plan (CCP). The findings include: Review of the facility's policy titled, Resident Rights Guidelines, dated 05/11/2017, revealed the facility would ensure the resident's rights were respected and protected and provide an environment in which they could be exercised. Review of the facility's policy titled, Comprehensive Care Plan [CCP] Guideline, dated 05/22/2018, revealed the facility would ensure appropriateness of services and communication that would meet the resident's needs, severity/stability of condition, impairment, disability, or disease in accordance with state and federal guidelines. Review of the facility's document Hospice Services Agreement, dated 05/09/2019, revealed the facility was to provide services as specified in the plan of care for a hospice patient including, but not limited to: providing food, including individualized request and dietary supplements; assisting with activities of daily living (ADL), such as mobility and ambulation, dressing, grooming, bathing, transferring, eating, and toileting. Review of R30's Face Sheet revealed the facility admitted the resident on 08/20/2024 with diagnoses that included senile degeneration of the brain, unspecified dementia, and anxiety. Review of R30's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 08/30/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of eight out of 15. This score indicated moderate cognitive impairment. Review of R30's CCP, dated 08/27/2024, revealed a focus that the resident required assistance with partial bathing twice weekly, daily oral care, and restorative dining. The interventions included to provide extensive assistance with dining, and to aid with self-care, including bathing and oral care. Observation on 11/24/2024 at 10:32 AM revealed R30's full breakfast tray was sitting on the bedside table. According to the CCP, R30 required restorative dining services to assist in eating meals. Observation on 11/25/2024 at 3:15 PM revealed R30 had not had a bath and was wearing the same clothing as she was observed wearing on 11/24/2024. In an interview on 11/25/2024 at 9:10 AM, R30 stated she did not receive a partial bath or oral care on 11/24/2024. In an interview on 11/24/2024 at 11:15 AM with Family Member (F) 1, he stated the facility had not (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been providing R30 with bathing, oral care, or restorative dining. F1 stated on 11/21/2024 at 9:00 AM, he hung a clean shirt out for R30 so the aide could bathe her and change the resident's clothes. F1 stated when he returned the next day on 11/22/2024 at 8:30 AM, R30 was not bathed and was still wearing the same dirty clothes from the previous day. He stated the family had a scheduled meeting with the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), and the Social Services Director (SSD) on 11/27/2024 at 3:00 PM to discuss the issue. F1 requested the State Survey Agency (SSA) Surveyor be in attendance. Observation of the family conference on 11/27/2024 at 3:00 PM with R30's family, the DHS, the ADHS, the SSD, the SSA Surveyor, and the Federal Surveyor in attendance, revealed the family expressed they were not satisfied with the level of care provided to the resident. F1 stated the facility had failed to keep R30 free from moisture, had not provided fresh water at her bedside, and had not met her needs with bathing, repositioning, oral care, and restorative dining. During the family conference, the facility's staff in attendance took responsibility for failing to provide the standard of care for R30. F1, the DHS, the ADHS, and the SSD all agreed to meet via Zoom on Tuesdays, beginning 12/03/2024 at 1:00 PM, to discuss how the care for R30 was from the prior week. In an interview on 11/27/2024 at 4:37 PM, Hospice State Registered Nurse Aide (SRNA) 1 stated she provided bathing, oral care, and restorative dining to R30 when she was at the facility on Mondays, Wednesdays, and Fridays. SRNA1 stated there had been many times she had arrived at the facility and R30 had not received a bath or oral care, and her food was sitting on her bedside table, and it was cold. In an interview on 11/27/2024 at 4:15 PM, Social Services Hospice stated the facility had not been providing bathing, oral care, or restorative dining to R30. She stated she visited the facility three times a week, and R30 had not been bathed or had not received oral care during the month of November 2024. She stated R30's family had communicated with the facility's SSD on numerous occasions, and there had been no improvement in providing R30 with partial bathing, oral care, or restorative dining. The Social Services Hospice stated R30 had told her many times that she had not eaten at different meals because she had not been provided assistance. In an interview on 11/28/2024 at 2:30 PM, the DHS stated she was upset knowing R30 had not been receiving self-care and restorative dining. She stated she knew that R30 was not receiving self-care. She stated the lack of restorative dining services was a huge failure on the facility's behalf with staff not being able to attend to all the residents who required assistance. In an interview on 11/28/2024 at 4:57 PM, the Executive Director stated her expectation was for residents in the facility to always receive the highest level of care. She stated she was unsure where the ball was dropped with the care for R30. However, she stated she would be investigating why the resident did not receive bathing, oral care, or restorative dining. The Executive Director stated residents not receiving the proper care or services was not the facility's standard of practice.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of MapQuest, and review of the facility's policy, the facility failed to adequately supervise and ensure protection from accidents and injuries for 1 of 20 supplemental and sampled residents, Resident (R) 20. On 10/11/2024, R20 was assisted to bed with two Certified Resident Care Assistants (CRCA) using a mechanical lift. The resident was then re-positioned in bed with one CRCA, CRCA5. CRCA 5 rolled R20 away from her, which resulted in the resident being rolled off the bed and onto the floor. R20 sustained bilateral femur fractures. She was sent to the local emergency room on [DATE]. On 10/16/2024, R20 underwent surgical repair with Open Reduction and Internal Fixation (ORIF) of her bilateral femurs. The facility provided an acceptable Plan of Correction (POC) on 12/17/2024 alleging past noncompliance. The survey team validated the deficient practice was corrected on 11/06/2024, following the facility's implementation of the POC and before the start of the survey. The findings include: Review of the facility's policy titled, Fall Management Program Guidelines, effective 05/31/2017 and reviewed 12/31/2023, revealed the facility would put care plan interventions in place that addressed the resident's risk factors. Review of R20's Face Sheet revealed the facility admitted the resident on 10/31/2022 with diagnoses which included non-ST elevation myocardial infarction (heart attack); hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting the left, dominant side; other paralytic syndrome following cerebral infarction, osteoarthritis in bilateral knees, and morbid (severe) obesity with a body mass index of 50-59. Review of R20's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/19/2024 and the last one done before the 10/11/2024 fall, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating intact cognition. This assessment also revealed R20 was nonambulatory and for mobility used a manual wheelchair which required two to wheel at least 150 feet in a corridor; to roll left and right required substantial/maximum assistance; from sitting to lying and lying to sitting required substantial/maximum assistance; and in a transfer from chair/bed to chair and chair to chair/bed, R20 was dependent, with the helper doing all of the effort. Review of R20's Comprehensive Care Plan (CCP), created on 11/09/2022, revealed the focus for the Care Guide stated she was non-weight bearing and required a mechanical lift. Further review of the care plan category: Falls included interventions, as of 10/11/2024, after the fall, to include assist of two for bed mobility. Prior to that she was one assist for bed mobility. Review of R20's Event Report, dated 10/11/2024, revealed on 10/11/2024 at 8:00 PM, R20 had a BIMS score of 12, which indicated moderate cognitive impairment. Per the report, R20 was assisted to bed via a mechanical lift and two CRCA staff members, CRCA5 and CRCA9. The report stated R20 was identified as someone who would benefit from a bariatric bed and mobility bars to aid with bed mobility, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	neither of which were in place previously. The report stated R20 was turned in bed and rolled out the other side, resulting in a fall. The report revealed R20 used the word sore when talking about her pain after the fall. Per the report, on 10/13/2024, R20 was asked to go to the hospital. The report stated R20 told staff she did not want to, but she felt it would be better to know if something was wrong with her knees. Per the report, R20 was sent to the local hospital for evaluation and subsequently sent to a larger hospital for further treatment. During an interview on 12/17/2024 at 2:20 PM with the Director of Health Services (DHS), she stated R20's BIMS score of 12, as listed on the 10/11/2024 Event Report was an error. She stated R20 had and continued to have a BIMS score of 15, indicating no cognitive impairment. Review of R20's Progress Note, dated 10/11/2024 at 12:29 AM (actual date was 10/12/2024) by Registered Nurse (RN) 5 revealed a CRCA reported to the staff nurse at 8:00 PM that during incontinence care and assisting R20 to get ready to go to sleep, the resident rolled out of bed onto the floor. Per the note, R20 was assessed and was observed with her head down by the foot of the bed and slightly under the edge of the bed, lying on her back. The note stated, during the physical assessment by RN5, she observed a laceration with a loose skin flap on the lateral side of R20's right great toe, and bleeding from the toe was stopped with pressure held. Per the note, the toe wound site was cleansed, steri-strips were applied to secure the flap, and it was covered with medical foam. The note stated R20 complained of pain, rated at seven out of 10 to bilateral knees, with pain on the left greater than the right. Per the note, as needed oral Tylenol (a pain reliever) was provided at 8:56 PM with R20's bedtime medications. The note stated R20's vital signs and neurological checks were stable. Further review revealed RN5 stated that she, as the staff nurse, educated the staff involved in the incident, CRCA5 and CRCA9 on a change in the plan of care for this resident and the importance of having two persons assisting with care in bed to avoid reoccurrence of the incident. Per the note, R20 remained safe with her needs met and the call bell within reach. The note stated staff would continue to monitor the resident. During an interview on 11/26/2024 at 11:50 AM with R20, she stated she did not think she would need to go to the hospital at first, but she was hurting worse and worse. Then, she stated, by Saturday, when the CRCAs tried to turn her, the pain had increased to more than she could handle, and she started to cry. She stated she told RN2 she wanted to go to the hospital, so she was sent to the local Emergency Department (ED). She stated she was told both of her femurs were fractured, and she had surgery to fix them at a larger hospital. During an interview on 11/26/2024 at 9:15 AM with CRCA9, she stated she was asked to help transfer R20 to bed using the mechanical lift. She stated once she had done that she left the room to finish a task she had started in another room. She stated she was called back to R20's room by RN5 because R20 had rolled onto the floor. She stated RN5 assessed R20, and she saw blood coming from R20's right toe. CRCA9 stated that she, along with other staff, assisted R20 back to bed with the mechanical lift. She stated R20 appeared to handle it well During an interview on 11/26/2024 at 10:04 PM with RN5, she stated on 10/11/2024 at approximately 8:00 PM, CRCA5 requested CRCA9 to assist in using a mechanical lift to place R20 in the bed. She stated once the task was complete, CRCA9 left the room, and CRCA5 started to provide incontinence care to R20. She stated R20 was care planned for one assist for bed mobility. She stated R20 rolled to the side of the bed, using the edge of the mattress to pull herself and rolled too far, falling off the side of the bed. RN5 stated she evaluated R20 and determined R20 had a skin tear to her toe, and first aid was applied. RN5 stated there was no deformity, redness, or edema, and R20 rated her pain at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a 5 out of 10. RN5 stated she gave R20 Tylenol and documented the decreased pain, as manifested by the resident falling asleep. RN5 stated she was off for the next few days after that, and when she returned, she was surprised R20 had been admitted to the hospital. Review of R20's Progress Note, dated 10/13/2024 at 4:37 PM, revealed RN2 documented (a late entry on 10/14/2024 at 2:08 PM) R20 requested to go to the hospital due to pain in her legs, especially when moving, with the left more painful than the right. The note stated R20 was now crying when moving her left leg, and it was painful to palpation approximately two palms widths above the knee, but she was unable to determine if the left leg was shorter than the right leg due to R20's inability to move legs well. The note stated the APRN was notified by RN2, and Emergency Medical Services (EMS) accepted R20 for transport to the local hospital emergency department (ED, located eight miles from the facility per mapquest.com) for evaluation and treatment. Review of R20's hospital Discharge Summary, from the second and larger hospital, located approximately 33 miles from the facility per MapQuest.com, revealed R20 was admitted on [DATE], after an X-ray of her legs showed left and right femur comminuted (a fractured bone that had shattered into multiple pieces which could be caused by a serious fall) and displaced distal femur diaphysis fracture (the area of the femur just above the knee joint). The X-rays also showed surrounding soft tissue edema and vascular calcifications. The left and right knee radiology reports revealed severe tricompartmental joint space narrowing (indicated cartilage loss and severe osteoarthritis) and the femur fractures. Further review revealed on 10/16/2024, R20 had a surgical repair of her fractures with an open reduction and internal fixation (ORIF) of bilateral femurs. Per the record, R20 had no complications and was discharged back to the facility on [DATE] in stable condition. Review of R20's Progress Note, dated 10/19/2024 at 3:53 PM, revealed R20 was returned to the facility via private EMS, with an assist of four to transfer the resident from the stretcher to her bed. Per the note, R20's surgical dressings were clean, dry and intact. The note stated R20 rated her pain a six out of 10, and Tylenol was given per order. The note stated a follow-up was scheduled for 11/01/2024 with the orthopedic surgeon. During an interview on 11/27/2024 at 10:17 AM with RN2, she stated she worked with R20 during the day shift on 10/12/2024 and 10/13/2024. She stated, on 10/12/2024, R20's pain was a 7 out of 10, and RN2 provided Tylenol per order and topical Biofreeze. On 10/13/2024 at 4:37 PM, RN2 stated R20 was in tears and had increased pain. RN2 stated the Nurse Practitioner was notified, and an order was obtained to send R20 to the ED for evaluation and treatment. During an interview on 11/26/2024 at 2:59 PM with the Physician and the Nurse Practitioner, the Physician stated he was aware of R20's fall, and it had resulted in bilateral femur fractures. During an interview on 11/27/2024 at 1:47 PM with the Assistant Director of Health Services (ADHS) and the Director of Health Services (DHS), the DHS stated she expected an immediate intervention to be put in place after a fall. During an interview on 12/17/2024 at 2:24 PM with the Executive Director, when asked what she had the most concern with regarding this incident, she stated the occurrence of the fall and that the staff was educated on how to prevent one like it in the future. The facility provided an acceptable Plan of Correction on 12/17/2024 alleging past non-compliance of the deficient practice and a date of compliance of 11/06/2024 with corrective actions as follows (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	verbatim: 1. Corrective actions for identified resident(s) affected by the deficient practice. a. On 10/11/24 at 8pm, The resident was immediately-assessed post incident by RN #1 (RN5). The RN #1 (RN5) noted no obvious injuries except a laceration to right great toe and treatment was initiated. The residents' pain level was monitored post incident and Tylenol was administered as needed. Tylenol was effective after each administration bringing pain level to baseline. Residents' average pain level is a 3 on a 0/10 scale due to chronic pain to bilateral knees related to diagnosis of osteoarthritis to bilateral knees and osteoporosis. The Physician was notified of the fall on 10/11/24 post incident. b. On 10/11/24, RN #1 (RN5) provided one on one education to CNA #1 (CRCA5) immediately by RN #1 (RN5) to ensure two assist with care in bed to avoid reoccurrence. c. On 10/13/24 at 4:37pm, RN#2 assessed resident and noted increased pain with movement and resident requested to be sent to ER. APRN was notified of the resident's condition. Resident was sent to ER. d. On 10/19/24 at 3:53pm, resident returned to facility with post-surgical intervention and resident expressed she was glad to be back home. Order for PT, OT and is non-weight bearing and follow up with ortho on 11/1/24. e. On 11/1/24, the resident returned from her ortho appointment with satisfactory condition post-surgical follow up. The resident remains non-weight bearing status. f. On 10/15/24, the IDT (Interdisciplinary Team) reviewed and revised the residents care plan to include 2 assist with bed mobility, per the RN#l (RN5) immediate intervention. 2. Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur. a. All residents requiring extensive to maximum assist with bed mobility could potentially be affected. b. A one-time audit of 100% health center residents was reviewed by [NAME] President of Clinical Operations and MDSC (Minimum Data Set Coordinator) on 10/23/24 reviewing the resident's most recent MDS section GG and ensuring care plan was appropriate for assist status. Any concerns that were identified were corrected immediately. 3. Measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur. a. On 10/14/24 education was initiated by DHS and ADHS regarding falls and care plans. Education was provided to licensed nursing staff and CRCAs. On 10/23/24 additional education from [NAME] President of Clinical Operations was provided to DHS, ADHS, MDS (MDSC), ED to include on rolling resident toward the care giver, ensuring profiles are completed on admission, following care plans, and notifying DHS or ADHS of all falls (injury or (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	non-injury). This additional education was then provided to licensed nursing staff and CRCAs. Education concluded on 10/24/24. After 10/24/24, any newly hired staff will be educated through orientation by DHS and/or ADHS. Campus does not use agency staff. b. Starting on 10/24/24, as part of the facility's ongoing quality improvement plan the DHS, ADHS, SDC (Staff Development Coordinator), and/or clinical support will observe a total of 3 staff members completing bed mobility to ensure care plan/care profile is being followed weekly x 4 weeks, then 2 staff members weekly x 4 weeks, then 1 staff member weekly x 4 weeks, then 1 staff member monthly x 3 months. This will ensure staff members have retained the education provided on standards of care related to bed mobility. c. The findings of this audit will be presented to the Quality Assurance and Performance Improvement Committee (QAPI) consisting of the Executive Director, Director of Health Services, Assist director of health services, and medical director monthly. 4. Describe the Quality Assurance & Process Improvement Program that will be put into place. a. An Ad Hoc Quality Assurance meeting was held on 10/14/24 regarding the incident on 10/11/24 regarding resident fall with injury and the facility's corrective action, the facility QAPI Committee to review the findings of audits plan of correction to ensure the plan is effective. b. The findings of this audit will be presented to the QAPI committee consisting of ED, DHS, ADHS, MD (Medical Director), MDS will review monthly. The QAPI meetings will determine when compliance is achieved or if ongoing monitoring is required. The State Survey Agency (SSA) validated the facility's Plan of Correction for past noncompliance which determined the facility had corrected the deficient practice for F689 on 11/06/2024 as alleged. 1. Record review of R20's progress notes, incident report, discharge summary, internal investigation with witness statements, and the medication administration record (MAR), revealed R20 was immediately assessed post-incident by RN5, who noted no obvious injuries except a laceration to her right great toe and treatment was initiated. R20's pain level was monitored post incident, and oral Tylenol and Biofreeze were administered as needed. Tylenol was effective after each administration bringing R20's pain level to her baseline pain level of three. On 10/11/2024, immediately after the incident RN5 provided education to CRCA5 to ensure a two-person assist for R20 with care in bed to avoid recurrence. On 10/15/2024, the IDT reviewed and revised R20's care plan to include a two-person assist with bed mobility, per RN5's immediate intervention. 2. Record of two residents identified as potentially at risk to be affected were reviewed, R27 and R30. Record review for R27 revealed the current care plan and profile care guide was last reviewed on 11/27/2024, updated on bed mobility with assist x 1, with a start date of 10/23/2024; and transfers: assist x 2; mechanical lift. Further review revealed the resident profile and the care plan matched. Record review for R30 revealed the current care plan and profile care guide was last reviewed on 11/27/2024, updated on bed mobility with assist x 1, with a start date of 10/23/2024; and transfers with assist x 2; mechanical lift. Further review revealed the resident profile and the care plan matched. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In interviews with CRCA3 on 12/18/2024 at 8:49 AM; CRCA13 on 12/17/2024 at 3:35 PM; and CRCA16 on 12/17/2024 at 3:27 PM, they stated they knew how to look at the profile care guide to verify the level of assist needed for residents and verbally described how they would always ensure they rolled the resident toward them and never away from them. Review of the letter dated 10/23/2024 revealed the Vice-President of Clinical Operations (VPCO) and the Minimum Data Set Coordinator (MDSC) conducted a one-time audit on 100 percent (%) of the facility's most recent MDS section on functional ability to ensure residents' care plans were appropriate to residents' assist status. The letter was signed by the VPCO and the MDSC. 3. Review of sign-in sheets for mandatory fall education performed by the DHS and ADHS that included fall policy and educations on following the care plan; profiles completed upon admission and following fall; notify DHS/ADHS regardless of injury; if one assist, roll resident toward staff and not away from staff, revealed all active nursing staff employees, licensed nurses and CRCAs, completed the education. Review of the provided employee list to check for education revealed 47 out of 47 active nursing staff employees received the previously listed fall education as of 10/24/2024. In an interview with the Executive Director on 12/17/2024 at 4:08 PM, she stated, on the provided employee list, the names that had a slash mark through them on the sign-off sheet were employees that were no longer employed at the facility. Review of the Audit Tool, dated October 2024, revealed the DHS, ADHS, Staff Development Coordinator (SDC), and/or Clinical support would observe a total of three staff members completing bed mobility. Further review revealed audits were performed on 10/24/2024 and 10/31/2024. Review of the Audit Tool, dated November 2024, revealed audits were performed on 11/07/2024, 11/14/2024, 11/21/2024 (2 staff members observed), and 11/28/2024 (2 staff members observed). Review of the Audit Tool, dated December 2024, revealed audits were performed on 12/5/2024 (2 staff members observed) and 12/12/2024 (2 staff members observed). The audit results indicated that all observed clinical staff members had no problems identified with providing correct bed mobility to residents. 4. Review of the meeting minutes of the Ad Hoc QAPI meeting on 10/14/2024 included the initiation of education, provided by the DHS and ADHS to all health center nursing staff on following the care plans, completing resident profiles upon admission and following resident profiles and a schedule of systemic monitoring for the assurance of retraining and education. The QAPI meeting on 11/05/2024 included the Executive Director (ED), DHS, Business Office Manager (BOM), MDS, Director of Social Services (DSS), Corporate Clinical Support (CCS), Pharmacist, Medical Director, and Nurse Practitioner and revealed the total falls, falls with major injury, trend versus target fall rate for 90 days prior, as well as root causes were reviewed. The QAPI meeting on 12/12/2024 included the ED, DHS, ADHS, MDS, DSS, CCS, Pharmacist, Medical Director, and Nurse Practitioner, and revealed a discussion of the investigation of R20's root cause of her fall; measures put in place to make her a two-person assist; notification to the DHS/ADHS for all falls, with or without injury; education, care plan, resident profile on admission; systemic monitoring; audit reviews; and falls tracking. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Executive Director, DHS, MDS, BOM, and DSS on 12/18/2024 from 12:12 PM to 12:30 PM, they all stated they attended QAPI meetings, and they discussed R20's fall, the root cause, and staff would utilize a two person assist with R20 in bed mobility; the education of CRCA5 and all nursing staff on how to assist residents with bed mobility so that residents would roll toward the staff; audits would be done per schedule observing staff providing care with resident bed mobility, and these audits would be and were reviewed in the meetings.

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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. 2. Observation on 11/27/2024 at 2:30 PM of the 200 Hall medication storage room with Registered Nurse (RN) 2 revealed one opened case of TwoCal nutritional supplement. The case had a use by date of 07/01/2024. In interview on 11/27/2024 at 2:30 PM, RN1 stated the open case with a use by date of 07/01/2024 should not be used. She stated she was unaware of who was responsible for going through the supplements to ensure none were used past its use by date. However, she stated it was not the nurses. In interview on 11/27/2024 at 3:15 PM, the Assistant Director of Health Services (ADHS) stated the nurses placed the stock in the medication storage rooms and were responsible to rotate the stock to ensure items did not expire. She stated she or the DHS periodically checked the stock in the medication room, and if they found expired items they would remove the items and educate staff. The ADHS stated she could not recall when she last audited for expired items in the medication rooms. She further stated the facility removed expired supplements so they were not used for residents. She also stated the facility did not want to use expired nutritional supplements as they would no longer be good to use, and no one liked anything expired. In interview on 11/27/2024 at 4:20 PM, the DHS stated the nurses had their supplies in the medication room and conducted random checks for expiration dates. She stated she and the ADHS checked the medication rooms and got rid of anything they saw expired. The DHS also stated the medication rooms were audited the previous week, although she could not remember who conducted that audit. The DHS further stated the audit results were communicated verbally, and nothing was reported out of date. She further stated several nurses go into the medication rooms, and no one reported anything expired. In interview on 12/17/2024 at 1:03 PM with the Executive Director, she stated her expectation was for all nutritional supplements to be used within their expiration dates, and if it was expired it should be removed by the person who identified it was expired. She stated if the supplement was needed immediately it could have been obtained by a new order or borrowing from a sister facility and would be received the same day. She stated checking expiration dates on supplements was very important for resident safety due to the supplements being consumed, and the facility would not want a resident to consume any expired supplements. Based on observation, interview, and review of the facility's policy, the facility failed to store and safely serve food. Observations on 11/24/2024 at 9:49 AM and 11:12 AM revealed a case of bananas was left sitting directly on the floor, and staff continued to walk around the case. Observation on 11/27/2024 at 2:30 PM revealed the medication room on the 200 Hall had one expired open case of TwoCal supplements with a use-by-date of 07/01/2024. The findings include: Review of the facility's Serve Safe policy titled, Food Storage, dated 04/28/2020, revealed the best practice was to store food in designated clean food storage areas, away from walls, and at least six inches off the floor. Per the policy, food was to be stored away from dust and other possible contaminants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Observation on 11/24/2024 at 9:49 AM, during the initial kitchen tour, revealed a case of bananas on the floor, and staff was observed walking by and around the banana case. Additional observation on 11/24/2024 at 11:12 PM, revealed the banana case remained on the floor, with staff walking by and around the case of bananas. In an interview with the Director of Food Services, Serve Safe Certified, on 11/25/2024 at 10:57 AM, he stated the bananas were moved to the floor and not placed onto the rolling rack. He stated there was a potential for cross-contamination with the banana case on the floor. In an interview with the Director of Health Services (DHS) on 11/27/2024 at 3:00 PM, she stated it was not acceptable to keep the banana case on the floor. In an interview with the Executive Director on 11/27/2024 at 3:07 PM, she stated the bananas should be elevated off the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policies, the facility failed to have an effective system in place to implement infection control practices for 2 of 20 sampled and supplemental residents, Resident (R) 1 and R19 and 1 of 2 medication room refrigerators on the 300 Hall. Observations during the survey revealed 1) a nurse touched a resident's medication with bare hands; 2) there was not enhanced barrier precautions signage or a personal protective equipment (PPE) cart at Resident (R) 1's room; 3) R1's gastrostomy (g-tube) dressing change was completed by the nurse without enhanced barrier precautions (EBP) used; and 4) the 300 Hall medication room nutritional refrigerator had flu vaccine stored on the same shelf with nutritional supplements and yogurt. The findings include: Review of the facility's policy titled, Infection Prevention and Control Program (IPCP), reviewed 12/31/2023, revealed the infection control program was designed to provide a sanitary environment and to help prevent the development and transmission of communicable diseases and infections, following accepted national standards. Review of the facility's policy titled, Enhanced Barrier Precautions Standard Operating Procedure, dated 04/01/2024, revealed EBP would be in place during high-contact care activities for all residents with indwelling medical devices, which included feeding tubes. Per the polcy, PPE should be used even if blood and body fluid exposure was not anticipated. The policy revealed, at a minimum, staff should wear gloves and gowns during high-contact care activities. Review of the facility's Enhanced Barrier Precautions signage, from the United States (U.S.) Department of Health and Human Services CDC and posted at resident doorways, revealed providers and staff must wear a gown for high-contact resident care activities. Those activities included device care or use of a feeding tube and wound care of any skin opening requiring a dressing. 1. Review of Resident (R) 1's Face Sheet revealed the facility admitted the resident on 12/01/2015 and re-admitted the resident on 04/15/2022. The resident's diagnoses included paralytic syndrome, dysphagia, and gastrostomy (feeding tube). Review of R1's Physician Orders, revealed an order for EBP, wearing a gown and gloves at a minimum during high-contact care activities, dated 07/29/2024. a. Observation of R1 on 11/24/2024 at 9:27 AM, 11/24/2024 at 11:26 AM, 11/25/2024 at 8:20 AM, 11/25/2024 at 8:49 AM, 11/25/2024 at 11:17 AM, 11/26/2024 at 10:57 AM, 11/26/2024 at 12:41 PM, 11/26/2024 at 2:58 PM, and 11/26/2024 at 4:17 PM, revealed the resident's room did not have signage posted for EBPs or a PPE cart at or in the resident's room. b. Observation on 11/26/2024 at 2:58 PM revealed Licensed Practical Nurse (LPN) 1 changed R1's feeding tube site dressing with the assistance of Certified Resident Care Assistant (CRCA) 6. While LPN1 performed the dressing change, CRCA6 assisted to position the resident and held the resident's left hand during the dressing change. Neither staff wore a gown during the change. In interview on 11/26/2024 at 3:18 PM, CRCA6 stated he was unsure if R1 needed EBP. He stated when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident was in EBP there was a sign and cart outside the room. He stated he was not sure who was responsible to place the signs or carts, however he knew it was not the CRCAs. In interview on 11/26/2024 at 3:25 PM, LPN1 stated EBPs were required for the type of dressing change with bacteria in the wound. She stated she was not informed R1 was placed in EBP. She stated the EBP was to prevent spreading anything to others or to introduce bacteria to them. In interview on 11/27/2024 at 3:15 PM, the Assistant Director of Health Services (ADHS) stated she and the Director of Health Services (DHS) shared the duties as the facility's Infection Preventionist (IP). She stated the EBP signs stated what PPE was needed to wear and when. The ADHS also stated the nurses were responsible to place the EBP signs as she or the DHS might not be in the facility when the resident first came to the facility or needed the EBP. She stated without the sign, there was a risk to enter the resident's room and spread infection. She further stated if the resident was already in the facility, the nurse would receive the results that showed the need for EBP, and it would need implementing immediately. The ADHS stated the nurses were responsible to post the EBP signs and get the isolation cart prepared with supplies specific to the type of precaution the resident was in. The ADHS stated she was shocked R1 did not have the EBP sign or PPE cart as she personally placed those at his room. She also stated she completed weekly wound rounds, although she did not provide wound care to R1's feeding tube site in the last few weeks. She stated the purpose of the EBP was for resident safety and to prevent cross contamination from resident to resident. In interview on 11/27/2024 at 4:20 PM, the DHS stated she and the ADHS shared the responsibilities of the IP for the facility. She stated the nurses were responsible to place a resident in isolation precautions. She stated the nurses were responsible to place the precautions signage on the door and place the required PPE in the cart. The DHS also stated the morning clinical meeting conducted audits to look for everything to be in place. She stated EBPs were required only when working with what the precautions were related to. She stated the precautions cart should be in the resident's room, and there should be a sign on the resident's door or on top of the PPE cart. She further stated she did not notice R1 did not have the EBP sign or PPE cart. She stated he was in the EBP for the feeding tube, which had feedings, medications, and dressing changes. She also stated she placed the EBP sign on his door and placed the PPE cart inside his room yesterday (11/26/2024). She stated the purpose of the precautions was to reduce the spread of infection. 2. Observation on 11/26/2024 at 8:19 AM of Registered Nurse (RN) 4 during medication administration revealed the RN prepared a medication for R19. Observation revealed RN4 removed the medication from the pill pack with her bare hand and placed the medication in a medication cup. The nurse then put the medication package in the med cart drawer and was ready to administer the medication before the State Survey Agency (SSA) Surveyor stopped the RN. In interview on 11/26/2024 at 8:19 AM, RN4 stated she just sanitized her hands before preparing the medication. She stated it was possible for her hands to have something microscopic on them. She stated she was trained in orientation regarding medication administration with return demonstration. The nurse stated she should not give the medication to the resident as the resident could get germs from her. In continued interview on 11/27/2024 at 3:15 PM with the ADHS, she stated the nurse should wear gloves during medication administration and should not give the medication with bare hands. She stated she personally had not conducted any audits of medication administration and was unaware if the DHS completed those audits. She also stated nurses were trained on how to administer medications with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	return demonstration. The ADHS further stated the facility had not identified anyone handling medication pills with bare hands. She stated the purpose of not touching medication with bare hands was to prevent contamination. In continued interview on 11/27/2024 at 4:20 PM with the DHS, she stated although the nurses were not required to wear gloves to remove the pills from the packaging, they should pop the pills into a cup or tear the package and empty the medication into a cup, without touching the medication. She stated the medication should not be touched with bare hands to prevent the spread of germs. She stated she sporadically audited and watched administration and had not identified anyone removing medications with bare hands. She stated the medication touched by the nurse should be thrown away and not given. The DHS also stated medication administration education was provided annually. 3. Observation of the 300 Hall medication storage room on 11/27/2024 at 2:05 PM with RN7 revealed the medication room had a small medication refrigerator and a large nutritional refrigerator. Observation revealed a shelf on the large refrigerator door contained three cartons of Med Pass (a nutritional supplement), four bottles of Glucerna (a nutritional supplement), two yogurt containers, and three open boxes of flu vaccine, all on the same shelf together. In interview on 11/27/2024 at 2:05 PM, RN7 stated the flu vaccine should not be stored with the nutritional supplements and yogurt. She stated the flu vaccine was like a medication, and there was a potential for cross contamination to the other items on the shelf. In interview on 11/27/2024 at 2:30 PM, RN2 stated medications should not be mixed with food products in the refrigerator. She stated the refrigerator was opened a lot and could affect the temperature. She also stated she was not sure who was responsible for checking the refrigerators for medications mixed with food items. In continued interview on 11/27/2024 at 3:15 PM, the ADHS stated the flu vaccine should be stored in the medication rooms. She stated pharmacy checked the medication rooms, in addition to the facility's checks of the medication rooms. The ADHS stated the flu vaccine was stored in the large refrigerator, as it had more space for storage. She stated if the flu vaccine was stored on the same shelf as nutritional supplements and if the medication was opened, it could come into contact and contaminate the supplements. She stated she periodically checked the refrigerators and had not found any issues. In continued interview on 11/27/2024 at 4:20 PM, the DHS stated the large refrigerators in the medication rooms stored the nutritional supplements and the flu vaccines. She stated the facility had too many vaccines to store in the medication refrigerators. She stated she did not see an issue with storing the flu vaccine on the same shelf as the supplements; however, if there was cross contamination the facility would throw away what was contaminated. She stated it was possible the items could become damaged and leak. In interview on 12/17/2024 at 1:03 PM with the Executive Director, she stated she did not have a clinical background, but the expectation was orally ingested food supplements and injectable medications and biologicals should not be stored together due to the risk of cross contamination. She stated the expectation was for all employees to follow the facility's policies and procedures pertaining to Infection Prevention and Control which were based on the CDC guidelines. She stated all staff (continued on next page)

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