STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185277	A. Building B. Wing	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Heritage Hall Rehab & Well	331 South Main Street Lawrenceburg, KY 40342

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, record review, review of the facility's investigation, and review of the facility's policy, it was determined the facility failed to protect residents' rights and dignity for one (1) of sixty-one (61) sampled residents (Resident #73). Review of the Facility's Investigation revealed on 10/31/2022, State Registered Nurse Aide (SRNA) #2 told Resident #73 to use the bathroom in his/her brief. The findings include: Review of the facility's policy titled, Resident Rights, dated 06/01/2015, revealed all residents should have the right to be treated with respect and dignity, and these rights would be promoted and protected by the facility. The policy stated all residents would be treated in a manner and in an environment that promoted maintenance or enhancement of quality of life. Per the policy, when providing care and services, the stakeholders would respect the residents' individuality and value their input by providing them a dignified existence, through self-determination and communication with and access to persons and services inside and outside the facility. Additionally, under Section Two (2), the policy stated the resident was entitled to exercise his/her rights and privileges as a resident of the facility and as a citizen or resident of the United States, to the fullest extent possible without interference, coercion, discrimination, or reprisal. Furthermore, under Section Three (3), the policy stated the facility would make every effort to support each resident in exercising his/her right to ensure that the resident was always treated with respect, kindness, and dignity. Review of Resident #73's admission Record revealed the facility admitted the resident on 09/22/2022 with diagnoses of Age-Related Osteoporosis, Anxiety Disorder, and Other Abnormalities of Gait and Mobility. Review of Resident #73's admission Minimum Data Set (MDS) Assessment, dated 09/21/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of ten (10) of fifteen (15), which indicated the resident had moderately impaired cognition. Review of Resident #73's Care Plan, initiated on 09/22/2022, revealed a focus that stated Resident #73 would have a reduced risk regarding complications related to decreased mobility. The care plan stated Resident #73 would be transferred with two (2) staff assistance and use the walker for toileting. In addition, a mechanical lift was care planned to be used if needed for transfers. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation, dated 10/31/2022, revealed SRNA #2 told the Administrator, on 11/02/2022, she did ask Resident #73 to use his/her brief for toileting as she felt that Resident #73 was not safe to transfer with a lift due to a recent fall. Furthermore, the investigation revealed SRNA #2 was suspended at the time pending completion of the investigation. Resident #73 was not available for interview because he/she had been discharged from the facility in November 2022. During an interview, on 09/23/2023 at 12:45 PM, with SRNA #2, she stated she did ask Resident #73 to use the bathroom in his/her brief as she felt that Resident #73 was not safe to transfer with a lift due to a recent fall. SRNA #2 stated there was an agency nurse, Licensed Practical Nurse (LPN) #13, working with her that was available for assistance with Resident #73's care. However, LPN #13 no longer worked at the facility. The State Survey Agency (SSA) Surveyor called LPN #13, on 09/23/2023 at 2:00 PM, 09/25/2023 at 10:14 AM, and 09/26/2023 at 5:24 PM. A voice message was left; with no call returned. During an interview on 09/25/2023 at 10:24 AM, with the Interim Director of Nursing (DON)/Regional Nurse, she stated asking a resident to use the bathroom in a brief was inappropriate. She stated that residents should be toileted based on how the resident was care planned. During an additional interview on 09/25/2023 at 4:50 PM, the Interim DON/Regional Nurse stated that asking a resident to use the brief was a dignity issue and her expectation was that staff followed the facility's policy. In an interview on 09/26/2023 at 4:39 PM with the Interim Administrator, he stated asking a resident to use the bathroom in a brief was inappropriate and was a dignity issue. Furthermore, he stated his expectation was that all staff members, regardless of their discipline, were expected to follow the facility's Resident Rights policy.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, record review and review of the facility's policy, it was determined the facility failed to notify the Medical Director (MD) of the change in the medical condition and the cause of death for one (1) of sixty-one (61) sampled residents (Resident #66). Interview with the MD revealed he was not notified that Resident #66 required supervision and monitoring during meals per the Speech Therapy (ST) evaluations. In addition, the MD was not informed that the resident's death was from choking on a cheeseburger on 06/24/2023. The findings include: Review of the facility's policy titled, Accidents and Incidents effective date 06/01/2015, revealed the intent was for the facility to provide an environment free from accidents and incidents that were avoidable. The facility investigates occurrences with applicable documentation and appropriate reporting. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall initiate and document investigation of the accident or incident. The time the resident's Physician was notified, as well as the time the physician responded and his or her instructions shall be documented. Review of the facility's policy titled, Charting and documentation, last reviewed on 04/14/2021, revealed incidents, accidents or changes in the resident's condition must be recorded. Documentation of the procedures and treatment shall include care-specific details and shall include at a minimum notification of the family, physician, or other staff. Record review revealed the facility admitted Resident #66 on 12/27/2019 with diagnoses that included Dementia, Anxiety, Dysphagia, and Oropharyngeal Phase. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/15/2023, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) which indicated the resident was cognitively intact. Review of Resident #66's Physician Orders, dated 06/09/2023, revealed an order for the Speech Therapist to evaluate and treat the resident, as indicated. Review of Resident #66's Speech Therapy (ST) Notes, dated 06/11/2023, revealed the resident's impulsivity continued; he/she required minimal to moderate verbal cues to slow the rate while eating and should consume appropriate bolus (bite) size. The ST Note, dated 06/12/2023, revealed Resident #66 was able to verbalize safe swallowing; however, he/she did not always do this independently. The ST Note dated 06/15/2023, revealed after the swallowing evaluation, education was provided with the resident and staff on general safe swallowing precautions. During an interview with ST #1, on 09/20/2023 at 8:48 AM, she stated Resident #66's diet order was puree with NTL. She provided Resident #66 with strategies for a safe swallow, and even with cues, the resident could not safely swallow and required supervision with a puree diet. She stated the Therapy Director attended the Interdisciplinary Team (IDT) meeting and was supposed to report any new information related to therapies. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN) #6, on 09/25/2023 at 9:10 AM, she stated on 06/24/2023 after the lunch meal, Resident #66 was found slumped over at the dining room table. RN #6 stated she was alerted to Resident #66 being slumped over the table in the dining room with a partially eaten cheeseburger on the table. The RN stated she attempted to clear Resident #66's mouth of food. She stated the resident remained unresponsive and Emergency Medical Services (EMS) was called. During an interview with Licensed Practical Nurse (LPN) #9, on 09/26/2023 at 1:01 PM, she stated she went to the dining room with Registered Nurse (RN) #6 and found Resident #66 laying over the table. LPN #9 stated she called EMS, then returned to the dining room to find RN #6 had Resident #66 on the floor. She stated she observed a cheeseburger with three (3) to four (4) bites sitting on the table where Resident #66 was found. Review of the EMS run sheet, dated 06/24/2023 at 3:23 PM revealed the resident was dead upon EMS' arrival. Review of the Progress Note, dated 06/24/2023 at 4:02 PM, revealed the Director of Nursing (DON) documented the Power of Attorney (POA) was notified; however, there was no documentation the Medical Director (MD) was notified. During an interview with the Medical Director, on 09/26/2023 at 12:26 PM, he stated he did not remember being notified of Resident #66 death. He stated he would remember an unusual death. The MD stated he was not aware of Resident #66 death until the Ad-hoc meeting on 06/29/2023. He stated he was not aware Resident #66 had eaten regular food. The MD stated he had not been made aware that Resident #66 required supervision and monitoring during meals. During an interview with the DON, on 09/28/2023 at 8:18 AM, she stated the MD was informed after the event. She stated the MD should be contacted immediately for death of a resident, reportable events, and medical errors. During interview with the Interim Administrator, on 09/28/2023 at 8:35 AM, he stated the Medical Director should be notified of any change in condition and should have been notified about Resident #66.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 1. Review of the facility' investigation dated 08/29/2022 revealed staff found Resident #41 setting on the side of his/her roommate's bed (Resident #69) screaming at him/her. Resident #41 had Resident #69's right arm in his/her hand. Resident #69 had bruising on his/her right arm and scratches on the right side of his/her face. Resident #41 and Resident #69 were separated. Resident #41 was placed on 1:1 monitoring. Resident #69 was moved to another room. Review of Resident #41's admission Record revealed the facility admitted the resident on 04/13/2017 with diagnoses that included Alzheimer's Disease, Major Depressive Disorder, Anxiety Disorder, and Unspecified Dementia without Behavior. Review of Resident #41's Annual MDS Assessment, dated 07/22/2022, revealed the facility assessed the resident to have a BIMS' score of eight (8) out of fifteen (15) which indicated the resident had moderately impaired cognition. Review of Resident #69's admission Record revealed the facility admitted the resident on 02/17/2021 with diagnoses that included Unspecified Dementia without Behavior Disturbance, Schizoaffective Disorder, Cognitive Communication Disorder. Review of Resident #69's Quarterly MDS Assessment, dated 06/30/2022, revealed the facility assessed the resident to have a BIMS' score of zero (0) out of fifteen (15) which indicated severe cognitive deficit. Review of the Nurse's Progress Note, dated 08/24/2022 at 4:35 PM entered by Licensed Practical Nurse (LPN) #13, revealed Resident #41 had been seen grabbing Resident #69's arm and Resident #69 had a small scratch to his/her face with visible blood coming from the scratch. Review of Resident #69's care plan, dated 04/21/2022, revealed the resident was at risk and/or had active behavior problems, was physically abusive, and resistant to care. During an interview, on 09/24/2023 at 8:47 PM, with Housekeeper #2, he stated that he had heard yelling coming from Resident #41's and Resident #69's room. Housekeeper #2 stated when he looked in, he saw Resident #41 with Resident #69's arm in his/her hand and it appeared that he/she was trying to pull Resident #69 up out of the bed. He further stated that Resident #41 was saying to Resident #69 this is my bed. 2. Review of Resident #74's admission Record revealed the facility admitted the resident on 12/01/2015 with diagnoses that included Chronic Obstructive Pulmonary Disease, Dementia, Congestive Heart Failure, Major Depressive Disorder, Epilepsy, and Schizoaffective. Review of Resident #74's Quarterly MDS Assessment, dated 11/12/2022, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) which indicated the resident had severe impaired cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's admission Record revealed the facility admitted the resident on 05/27/2020 with diagnoses that included Unspecified Dementia, Dysphagia, generalized muscle weakness, and cognitive communication deficit. Review of Resident #35's Quarterly MDS Assessment, dated 12/20/2022, revealed the facility assessed the resident to have a BIMS' score of six (6) out of fifteen (15) which indicated the resident had severe impaired cognition. Review of the facility's investigation, dated 01/11/2023 revealed SRNA (State Registered Nurse Aide) #12/Restorative Aide heard verbal yelling. Upon entry to the room, SRNA #12/Restorative Aide witnessed Resident #74 grab his/her roommate's (Resident #35) right arm, which resulted in a skin tear. Per the investigation, Resident #74 was redirected to the nurses station for closer monitoring. Review of Resident #35's Physician Orders, dated 01/11/2023, revealed a new order to monitor Resident #35's right forearm for signs and symptoms of infection every shift until healed. Review of the Medication Administration Record (MAR) revealed starting on 01/11/2023 the staff documented monitoring of the injury, with no signs or symptoms of infection noted, until 01/31/2023, when the injury was healed. During an interview, on 09/24/2023 at 6:01 PM with SRNA #12/Restorative Aide, she stated she remembered the verbal yelling and Resident #74 grabbed Resident #35's arm causing a skin tear. She also stated she did not know of any other altercations between the two (2) residents. During interview with LPN (Licensed Practical Nurse)/Unit Manager #10, on 09/25/2023 at 9:24 AM, she stated this was the only incident between these two residents. 3. Review of the facility's investigation, dated 03/11/2023, revealed Resident #66 hit his/her roommate Resident #59 with his/her grabber (an assistive device used to pick up items). Resident #66 and Resident #59 were separated. Resident #66 was placed on 1:1 observation and moved to a private room. Further review of the investigation revealed a skin assessment was performed on Resident #59 with no injuries noted. Review of Resident #66's admission Record revealed the facility admitted the resident on 12/27/2019 with diagnoses that included Unspecified Dementia, Unspecified Lack of Coordination, Paranoid Personality Disorder, Other Schizoaffective Disorders, Epileptic Seizures related to external causes, and Type 2 Diabetes Mellitus with Diabetic Neuropathy. Review of Resident #66's Quarterly MDS Assessment, dated 03/10/2023, revealed the facility assessed the resident to have a BIMS' score of fifteen (15) out of fifteen (15) which indicated the resident had intact cognition. Review of Resident #66's CCP revealed the facility care planned the resident on 12/13/2022 for at risk and/or active behavior problems including being physically and verbally abusive as evidenced by combative behavior with staff, threatening, cursing and yelling at staff and others, sexually inappropriate toward staff. Interventions included: intervene as needed to protect the rights and safety of others; approach in calm manner; divert attention; remove from situation and take to another location as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #59's admission Record revealed the facility admitted the resident on 12/01/2015 with diagnoses that included History of Traumatic Brain Injury, Heart Failure, Unspecified Intracranial Injury, Seizures, and Aphasia. Review of Resident #59's Quarterly MDS Assessment, dated 02/16/2023, revealed the facility assessed the resident to have a BIMS' score of zero (0) out of fifteen (15) which indicated the resident had severely impaired cognition. Review of the Nursing Progress Note, dated 03/11/2023 at 4:37 PM entered by LPN #6, revealed Resident #66 had been witnessed hitting his/her roommate with a grabber and was combative cursing at staff. Review of the Nursing Progress Note, dated 03/11/2023 at 4:44 PM entered by LPN #6 revealed Resident #59 had been smacked with a grabber by his/her roommate with no marks or bruising at that time. During an interview, on 09/24/2023 at 7:12 PM with SRNA #10, she stated as she was walking down the hall at approximately 3:00 PM on 03/11/2023, she observed Resident #66 in his/her room with a grabber in his/her right hand. Resident #66 was sitting in his/her wheelchair beside Resident #59's bed. SRNA #10 stated Resident #66 proceeded to lift the grabber up behind his/her head and came down on Resident #59's chest while he/she was in bed. SRNA #10 further stated Resident #59 attempted to stop the grabber from hitting him/her and grabbed it. Based on observation, interview, record review and review of the facility's abuse policy, it was determined the facility failed to ensure an environment that was free from abuse involving eight (8) of sixty-one (61) sampled residents (Residents #9, #35, #41, #50, #59, #66, #69 and #74). 1. On 01/11/2023, Resident #74 grabbed Resident #35's right arm causing a skin tear. 2. On 08/24/2022, Resident #41 was observed sitting on the side of Resident #69's bed holding Resident #69's arm and yelling at Resident #69, resulting in a bruise to the arm and a scratch to Resident #69's face. 3. On 03/11/2023, Resident #66 hit Resident #59 with his/her grabber device. 4. On 09/13/2023, State Registered Nursing Assistant (SRNA) #6 observed SRNA #5 when she made a comment in the presence of Resident #9 and his/her spouse. SRNA #5 stated, Why do I have to be the one to wipe the asses. 5. On 03/29/2023, Hospitality Aide #1 was observed telling Resident #50 to go to hell after the resident had made a comment to her. The findings include: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, effective date 05/27/2016, revised on 07/06/2022, revealed it was the organizations's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of residents' property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Verbal abuse was defined as the use of any oral, written or gestured language that include any threat, or any frightening, disparaging or derogatory language, to the residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. 4. Record review revealed the facility admitted Resident #9 on 08/06/2023 with diagnoses which included Parkinson's Disease, Vascular Dementia and Anxiety. Review of the admission Minimum Data Set (MDS) Assessment, dated 08/13/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15), which indicated the resident was not interviewable. In an interview with State Registered Nursing Assistant (SRNA) #5, on 09/23/2023 at 4:42 PM, she stated she and SRNA #6 were providing incontinent care to Resident #9. While changing the resident, SRNA #5 jokingly said to SRNA #6, Why am I always wiping the asses? She stated she said this to her coworker in the presence of Resident #9 and the resident's spouse was at the bedside. In an interview with SRNA #6, on 09/23/2023 at 7:07 PM, she stated SRNA #5 made the comment about wiping the asses in front of the resident and his/her spouse. She said she felt this met the definition of abuse and reported the incident to Administration. A review of the facility's final investigation, dated 09/18/2023, revealed SRNA #5 was removed from the floor and suspended and the facility immediately initiated the investigation. Initial skin assessments and pain assessments were completed with no issues noted. Following the facility's investigation, SRNA #5 was terminated. In an interview with the Interim Director of Nursing (DON), on 09/18/2023 at 3:23 PM, she stated she expected staff to report any suspicion of abuse immediately. In an interview with the Interim Administrator, on 09/19/2023 at 2:34 PM, he stated all staff had been educated on abuse and the abuse policy. He also stated when abuse was reported, it was investigated. It was his expectation all staff would follow the facility's abuse policy. 5. Record review revealed the facility admitted Resident #50 on 06/07/2019 with diagnoses which included Cerebral Infarction, Flaccid Hemiplegia, Major Depressive Disorder, Anxiety, Impulse Disorder, Personality Disorders and Dementia with Behaviors. Review of the most recent Quarterly MDS Assessment, dated 06/07/2023, revealed the facility assessed Resident #50 to have a BIMS' score of fourteen (14) out of fifteen (15) which indicated the resident was interviewable. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Hospitality Aide (HA) #2, on 09/22/2023 at 7:57 PM, she stated HA #1 became upset when Resident #50 raised his/her voice saying the resident had made a racial comment using the N word. HA #1 told the resident to go to hell as she was leaving the room. During further interview HA #1 stated the resident had a history of making inappropriate comments to staff while they were providing care. She stated she reported the incident to the nurses. In a interview with Resident #50, on 09/22/2023 at 9:30 AM, he/she stated remembering the incident with Hospitality Aide #1, but not the details. According to the resident, he/she recalled HA #1 saying something ugly to him/her. The resident stated he/she heard the HA got fired that day. In an interview with HA #1, on 09/24/2023 at 1:34 PM, she stated Resident #50 said something about her being black, which she stated she was not black. Review of the facility's final investigation, dated 04/01/2022, revealed after a thorough investigation, it was determined Hospitality Aide (HA) #1, was verbally abusive to Resident #50. The facility terminated HA #1. During an interview, on 09/18/2023 at 3:23 PM with the Special Projects Director of Nursing (SPDON), she stated that she expected staff to report any suspicion of abuse immediately and for all staff to follow the facility's policies. During an interview on 09/19/2023 at 2:34 PM with the Interim Administrator, he stated that he expected all staff to follow the facility's abuse policy.

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview, record review, review of the facility's investigation, review of the police report, and review of the facility's policies, and the Kentucky Incident Based Reporting System (KYIBRS) Report, it was determined the facility failed to ensure residents were free from misappropriation of property for four (4) of sixty-one (61) sampled residents (Residents #1, #2, #3, and 62). Three (3) residents, Resident #1, #2, and #3 had medication misappropriated. A facility employee acceptable ten thousand dollars ($10,000) from Resident #62. Licensed Practical Nurse (LPN) #4 reported to the Director of Nursing (DON) that Registered Nurse (RN) #1 was exhibiting suspicious behaviors of wearing a backpack at work; being in the bathroom for long periods of time, and acting weird. While the DON was in the facility, on 08/11/2023 at 3:00 AM, RN #1 stayed in the bathroom for extended periods and walked around with a backpack. However, the DON reported there were no concerns, and staff members' reports were just speculation. In an interview with LPN #3, she stated on 08/26/2023 she observed RN #1 take a bottle of Morphine out of her pocket and place it into the medication cart at approximately 11:30 PM. LPN #4, stated she observed RN #1 on 08/26/2023 at approximately 10:00 PM talking belligerently, slurring her words, and her pupils were pinpoint. LPN #4 stated at 10:46 PM, she observed RN #1 enter the bathroom, and she did not exit until 11:26 PM. LPN #4 stated she called the DON at 10:46 PM initially and told her that RN #1 was higher than a f .ing kite. LPN #4 stated she informed the DON that she wanted to call the police because she thought RN #1 had taken the Morphine that was delivered from the pharmacy at approximately 10:00 PM for Resident #2. In an interview with the Administrator, he stated on 08/27/2023 at 7:30 AM, he was made aware by the DON that the police had been called on 08/26/2023. The Administrator stated staff had texted the DON on 08/26/2023. However, she was not aware of the text until the next morning on 08/27/2023. He stated he was told by the DON that RN #1 had been arrested, and Morphine was found in RN #1's backpack. Despite this, the facility's initial investigation unsubstantiated the allegation of misappropriation due to the ongoing investigation by local law enforcement as they awaited a pending liquid medication analysis and toxicology report. However, the facility's Administrator and DON failed to immediately take action to investigate and report, implement corrective action consistent with the investigation's findings, and failed to take steps to eliminate any ongoing danger to the resident(s) in a timely manner. (See F610 and F835). The facility's failure to ensure residents were protected from misappropriation of narcotics and to take immediate action and have a system in place to ensure the residents were protected is likely to cause serious injury, impairment, or death. Immediate Jeopardy (IJ) and Substandard Quality of Care were identified on 09/21/2023 and determined to exist on 08/26/2023 in the area of 42 CFR 483.12 Freedom from Abuse and Neglect, F602 and F610 with a Scope and Severity of a J. The facility was notified of the Immediate Jeopardy on 09/21/2023. The IJ is ongoing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In addition, on 06/27/2022, Housekeeper #1 accepted $10,000 as a gift from Resident #62. The money was to be used to provide dental work for Housekeeper #1's daughter. The findings include: Review of the facility's policy, Abuse, Neglect, or Misappropriation of Resident Property, revised 10/17/2022, revealed the facility's intention was to prevent the occurrences of misappropriation of resident property and to assure all alleged violations of federal or state laws which involved misappropriation of resident property were investigated and reported immediately to the Facility's Administrator, and the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. Per the policy, the organization would include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare and rights of each resident residing in the facility. Further, the policy revealed the Administrator, or designee, would conduct a reasonable investigation of each alleged violation. In addition, the Administrator would make reasonable efforts to determine the root cause of the alleged violation and would implement corrective actions consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents. Continued review revealed the Administrator would identify, intervene, and correct situations in which reported abuse, neglect, exploitation, or misappropriation of resident property might recur. Further review of the policy revealed exploitation was defined as taking advantage of a resident for personal gain, through the use of manipulation, initiation, threats, or coercion; and, misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The policy stated, Under no circumstances shall any Stakeholder accept any money, property, inheritance or anything else of value from a resident or resident's family member, nor enter into any joint ownership of any property, bank account, business, or anything else of value, with a resident, unless the resident is a family member of the Stakeholder. Additionally, the policy stated the facility trained employees on hire and annual thereafter related to abuse, including misappropriation of resident property. Review of the facility's policy, Controlled Medication and Drug Diversion Policy, revised 07/07/2022, revealed the facility was to investigate and make every reasonable effort to reconcile reported narcotic discrepancies. Per the policy, if a major discrepancy or a pattern of discrepancies occurred or if there was apparent criminal activity, the Director of Nursing (DON) would notify the Chief Executive Officer (CEO), Nurse Care Consultant (NCC), Regional Vice-President (RVP), and pharmacy immediately. Review of the facility's policy, Elder Justice Act Policy and Procedure, revision 04/05/2016, revealed it was the intent of the facility to uphold The Elder Justice Act as established under the Social Security Act and Patient Protection and Affordable Care Act of 2010 which required covered individuals to report reasonable suspicion of a crime to their state regulatory agency and to local law enforcement within specific time frames. The guide of the Elder Justice Act was if a covered individual had a reasonable suspicion, that individual must report this directly to both local law enforcement and the state survey agency without fear of retaliation. Per the policy, the Administrator, Director of Nursing (DON) or Abuse Coordinator could report the suspicion on behalf of a covered individual if that was the desire of the individual. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Registered Nurse (RN) #1's Employee File revealed a hire date of 03/02/2023, with the most recently received abuse education Agency Orientation Guide/Checklist, dated March 2023. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 08/10/2021, with diagnoses that included Cerebral Palsy, Respiratory Failure with Hypoxia, Psychosis, and Severe Intellectual Disabilities. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 06/14/2023, revealed the facility could not assess the resident with a Brief Interview for Mental Status (BIMS) score due to Resident #1 being never or rarely understood. Review of Resident #1's care plan, initiated on 02/08/2021, revealed a problem for pain with a long-term goal target date of 12/12/2023, that Resident #1 would verbalize or demonstrate relief or reduction of pain within one (1) hour after receiving interventions. Interventions included to administer medications as ordered, monitor, record any complaints of pain, record any nonverbal signs of pain, and use pain relief measures as needed. Review of Resident #1's Physician's Orders revealed an order, dated 08/07/2023, for Morphine Sulfate (an opioid used to relieve moderate to severe pain) 100 milligrams (mg)/5 milliliters (ml) (20 mg/ml), amount five (5) mg (0.25 ml) oral concentration liquid. Resident #1 was to receive 0.25 ml orally every six (6) hours for pain. Review of Resident #1's Medication Administration Record (MAR), dated 08/25/2023 through 08/26/2023, revealed RN #1 administered Resident #1's scheduled Morphine Sulfate on 08/25/2023 at 12:00 AM, with documentation on the Narcotic Record of 0.25 ml of the dose dispensed and 16.25 ml dose present/remaining. Further review of Resident #1's MAR documentation, dated 08/26/2023, revealed no documented evidence of RN #1's administration of Morphine Sulfate to Resident #1 on 08/26/2023 and no assessed pain evaluation. 2. Review of Resident #2's closed medical record revealed the facility admitted the resident, on 08/19/2023, with diagnoses that included Down's Syndrome, Encephalopathy, and Anxiety. Review of Resident #2's admission MDS Assessment, dated 08/26/2023, revealed the facility assessed the resident with a BIMS' score of zero (0) of fifteen (15), indicating severe cognitive impairment. Review of Resident #2's care plan, initiated on 08/21/2023, revealed a problem for chronic pain with a goal that the resident would verbalize or demonstrate relief or reduction of pain within one (1) hour after receiving interventions. Interventions included positioning, report uncontrolled pain to physician and/or hospice nurse and MD, evaluate effectiveness of pain management interventions, observe, and record any complaints of pain. Review of Resident #2's Physician's Orders revealed an order, dated 08/21/2023, to admit Resident #2 to Hospice Services with a diagnosis of Mild Protein-Calorie Malnutrition. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review revealed an order, dated 08/26/2023, for Resident #2 to receive Morphine Sulfate 100 mg/5 ml (20 mg/ml), amount five (5) mg (0.25 ml) oral concentration liquid to administer 0.25 ml orally every four (4) hours as needed (PRN) for pain. Additional review revealed a new order, dated 08/26/2023, for Resident #2 to receive Morphine Sulfate 100 mg/5 ml (20 mg/ml), amount ten (10) mg (0.5 ml) oral concentration liquid, to administer 0.5 ml orally every four (4) hours as needed (PRN) for pain. Review of the facility's Controlled Drug Record revealed on 08/26/2023 at approximately 10:00 PM, pharmacy delivered a thirty (30) ml bottle of Morphine Sulfate 100 mg/5 ml oral concentration liquid for Resident #2. The order stated to administer 0.5 ml orally every four (4) hours as needed (PRN) for pain. Further review revealed Resident #2's Morphine narcotic medication was signed off as received by RN #1 and witnessed by Licensed Practical Nurse (LPN) #3. Review of Resident #2's MAR, dated 08/25/2023, revealed RN #1 administered Resident #2's PRN Morphine Sulfate at 10:17 PM with an assessed pain score of three (3) of ten (10), with no follow-up pain assessment documented. Further review revealed on 08/26/2023 at 5:34 AM, RN #1 administered Resident #2's PRN Morphine Sulfate with an assessed pain score of seven (7) of ten (10), with no follow-up pain assessment documented. In addition, review of Resident #2's Narcotic Record revealed on 08/26/2023 at 10:30 PM, RN #1 signed that she had administered PRN Morphine Sulfate 0.5 ml to Resident #2. However, according to Resident #2's MAR, there was no documented evidence of RN #1's administration of Morphine Sulfate 0.5 ml to Resident #2 on 08/26/2023 at 10:30 PM, and no assessed pain evaluation was documented. Review of Resident #2's Progress Note, dated 08/27/2023 at 4:13 AM, revealed LPN #2 contacted the on-call Nurse Practitioner (NP) to request a new prescription be sent to the pharmacy to replace Resident #2's Morphine that had been confiscated by the police. 3. Review of Resident #3's closed medical record revealed the facility admitted the resident on 11/07/2017, with diagnoses that included Dementia, Chronic Kidney Disease (CKD) III, and Congestive Heart Failure (CHF). Review of Resident #3's Quarterly MDS Assessment, dated 05/28/2023, revealed the facility assessed the resident to have a BIMS' score of five (5) of fifteen (15) which indicated severe cognitive impairment. Review of Resident #3's care plan, dated 02/20/2023, revealed a focus for Hospice/Palliative Care with a goal that the resident would be supported to promote comfort and dignity throughout the dying process. There was an intervention to notify the physician/hospice provider if pain or discomfort was not alleviated by current preventative measures, treatment regimen, or medications provided. Review of Resident #3's Physician's Orders, dated 06/27/2023, revealed an order to admit Resident #3 to Hospice Services with a diagnosis of Mild Protein-Calorie Malnutrition. Further review revealed an order, dated 08/09/2023, for Resident #3 to receive Morphine Sulfate 10 mg/5 ml, (2 mg/ml) oral concentration liquid, to administer one (1) ml orally every two (2) hours as needed (PRN) for pain. Review of Resident #3's MAR dated 08/26/2023, revealed no assessed pain evaluation or PRN pain medication of Morphine had been documented as administered by RN #1. Review of the Narcotic Record for 08/26/2023 revealed the Morphine had not been administered. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #3's Progress Note, dated 08/27/2023 at 4:34 AM, revealed LPN #2 contacted the on-call NP to request a new prescription be sent to the pharmacy to replace Resident #3's bottle of suspected tampered Morphine. The bottle of Morphine had been confiscated by police as evidence to be sent to the Kentucky State Police (KSP) Central Lab for testing. Review of the Long-Term Care Facility-Self-Reported Incident Form/Initial Report, dated 08/27/2023, with no time documented and signed by the Director of Nursing (DON), revealed an Allegation of Misappropriation of resident property occurred on 08/27/2023, involving Residents #1, #2, and #3. Additional review revealed the DON was notified that Agency Nurse/RN #1, had been pulled over by police after her shift ended at 11:00 PM last night', with suspicion of impairment and was noted to have syringes, blue food coloring, and saline in her backpack. Afterwards, the report stated police came to the facility and took Morphine from the medication carts for testing. Review of the Kentucky Incident Based Reporting System (KYIBRS) Report of incident KY 23-212, dated 08/27/2023 at 12:35 AM, revealed police were contacted by the facility's staff, LPN #3, who reported an employee (RN #1) was possibly under the influence was reportedly leaving intoxicated. The report revealed the driver failed to signal when turning into a parking lot. Officer #1 conducted a traffic stop on the vehicle for failure to signal and to conduct a Driving Under the Influence (DUI) investigation at 12:37 AM. At that time, RN #1 advised Officer #1 that the seven (7) syringes with the blue liquid were Morphine, and she had taken them from the facility. Per the report, RN #1 also advised Officer #1 she had taken a dose of Morphine while on shift earlier tonight while caring for twenty-one (21) residents. Further review of the report revealed RN #1 said she had taken the Morphine because she wanted to kill herself, and then RN #1 started to have chest pains. Continued review revealed the Emergency Medical Services (EMS) was called for medical treatment. RN #1 was transported to the hospital by paramedics related to her stating she wanted to commit suicide. Review of the Kentucky Incident Based Reporting System (KYIBRS) Report, while enroute RN #1 informed EMS personnel she had been conducting this unlawful act since January 2023. Per the report, an arrest warrant was issued for RN #1 on 08/27/2023 at 2:36 AM. The report stated RN #1 was implicated on eight (8) counts for the charge of Theft of a Legend Drug (a drug approved by the Food and Drug Administration (FDA) that could be dispensed to the public only with a prescription); twenty-one (21) counts of Wanton Endangerment in the First Degree; seven (7) counts of Possession of Controlled Substance; seven (7) counts of Theft by Unlawful Taking or Disposition; three (3) counts of Knowingly Abuse or Neglect of an Adult by Stealing; three (3) counts of Tampering with Physical Evidence; and one (1) count of Drug Paraphernalia. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Administrator's Witness Statement, dated 08/28/2023 and signed by the Administrator, revealed on 08/26/2023 at 11:30 PM, he was called by the DON and was informed staff members were saying RN #1 was acting weird, walking around the nurse's station, had been to the bathroom several times, and was wearing her backpack. Per the statement, the DON told the Administrator, It's not a big deal; RN #1 was being budgeted at 11:00 PM anyway; she had spoken with RN #1; and RN #1 was going to finish up some charting and go home. The Administrator stated he asked the DON about RN #1's backpack, and the DON responded that RN #1 usually had one with her and in the bathroom. The Administrator stated the DON told him she had worked with RN #1 and that RN #1 went to the bathroom with the backpack. Further review revealed the Administrator stated the DON informed him that RN #1 had gastrointestinal (GI) issues. Per the statement, the DON told the Administrator that it had just been a crazy evening, and she had instructed the staff to call her for any issues with the medication cart count or if they needed anything else. The Administrator stated he told the DON to let him know if she heard anything more; however, he did not hear from the DON again until 7:30 AM on 08/27/2023. Review of State Registered Nurse Aide (SRNA) #2's telephone Witness Statement, dated 08/31/2023, signed by the [NAME] President of Clinical Operations (VPCO), revealed during her shift on 08/26/2023, she observed RN #1 looking in the narcotic box for a long period of time. SRNA #2 stated it appeared that RN #1 was flipping through the narcotics. SRNA #2 stated she had seen other nurses get in the narcotic box, but they did not look for a long time like RN #1 did. SRNA #2 also stated, while RN #1 was looking through the narcotic box, she kept looking around and over her shoulder. SRNA #2 stated RN #1 saw her watching, and RN #1 then shut the narcotic box quickly, put her backpack on, and went to the bathroom. SRNA #2 stated she immediately informed Licensed Practical Nurse (LPN) #2, LPN #3, and LPN #4 of RN #1's suspicious behavior. Review of LPN #2's telephone Witness Statement, dated 08/31/2023, signed by Unit Manager UM/LPN #10, revealed on 08/26/2023 at approximately 8:00 PM, SRNA #2 alerted LPN #2 that RN #1 had been going through the narcotic drawer with her backpack on. The statement revealed RN #1 continued to go to the bathroom frequently with her backpack on and stayed in the bathroom for forty (40) minutes. LPN #2 stated when RN #1 came out of the bathroom, LPN #3 met RN #1 to count the carts with her, and RN #1 then took Morphine out of her pocket and returned it to the medication cart. Further, LPN #2 stated, while counting the medication, the new bottle of Morphine was marked exactly at thirty (30) ml in the bottle. Per the statement, RN #1's face was flushed, and she was talking slowly while counting with LPN #3. Review of LPN #1's telephone Witness Statement, signed by the DON, undated, revealed the DON and Administrator spoke with LPN #1 via telephone on 08/28/2023. LPN #1 stated that RN #1 was witnessed by LPN #3, after RN #1 returned from the bathroom, to remove a Morphine bottle from her pants pocket and return the bottle to the medication cart (no date or time given). LPN #1 stated that was when she called the DON. Per the statement, RN #1 counted the medication cart with LPN #3, walked down the hallway three (3) times, and then went into the bathroom with her backpack and came out with her backpack. After this occurred, LPN #1 stated RN #1 continued to finish her charting, swaying at the medication cart, and then left through the laundry room door with her backpack on. Per the statement, RN #1 then came back inside without her backpack on, stopped at the medication cart to sign herself out, and walked out of the facility without her backpack. Further, LPN #1 stated she directly went out the laundry room door and saw RN #1's backpack lying by the facility dumpster with needles and syringes inside. Per the statement, RN #1 was observed driving from the facility, and she almost hit a fence. At that time, LPN #1 stated the police were called at 12:45 AM (no date given), and police were in and out of the facility and retrieved Morphine bottles for evidence. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the DON's typed Witness Statement, dated 08/31/2023 and signed by the DON, revealed she received a call from LPN #1, an agency nurse, around 10:45 PM on 08/26/2023, stating that RN #1 was in the building, had not taken her backpack off the entire time, and was using the bathroom frequently. Per the statement, LPN #1 told the DON that RN #1 appeared like she was doing drugs because RN #1 was walking around the nurses station, going to the bathroom frequently, and would not take the backpack off. The DON stated, at that point, the decision was made to remove RN #1 from the schedule, and staff needed to arrange how to cover the assignments while she called RN #1 to tell her that her shift was ending. The DON stated she called RN #1 and informed her that she was being cut, and RN #1 explained to the DON that she needed to complete some charting before she went home. The DON stated that she had spoken to RN #1 twice on the phone during her shift, once when RN #1 called her about some items to follow-up on clinically on Monday, and the other was when the DON called RN #1 about the need to end her shift. The DON stated during her contact with RN #1 on 08/26/2023, there were no signs of impairment, slurred speech, or altered cognition. Continued review of the statement revealed the DON stated LPN #1 called her back and notified her that there was a medication bottle wrapper in the trash can. The DON stated LPN #1 told her that she needed to call the police department, but no behavior changes had been relayed to her at that time, and she did not call the police. The DON stated she notified the Administrator of LPN #1's statements, and then she called the facility and told staff to call her back if they noticed any changes of behaviors, signs of impairment, or if the narcotic count was incorrect. The DON stated, they never called me back. Further, the DON stated she woke up on 08/27/2023 to see text messages from LPN #1 stating staff had found RN #1's backpack out by the dumpster, and police had confiscated it. The DON stated she was informed that the backpack contained needles and syringes filled with a blue substance, and the police officers had taken the Morphine in the building for evidence, along with RN #1's backpack. The DON stated she received additional text messages that RN #1 had been arrested, and she notified the Administrator immediately. Review of the Long-Term Care Facility-Self-Reported Incident Form/Final Report, dated 09/01/2023, signed by the facility's Administrator, revealed an allegation of misappropriation of resident property occurred on 08/27/2023, which involved Residents #1, #2, and #3. Review of the Final Report revealed the facility's Determination of Findings as documented: After a thorough investigation and interviews with staff and residents, at this time we are unable to substantiate that the alleged (RN #1) took the resident's medication due to the ongoing investigation still in process with the Local Police Department. According to the investigating officer, the results of the medication testing could take up to thirty (30) days to complete. Once the finalized results were complete, the facility would follow up with an addendum. The facility does substantiate that RN #1 was observed to be impaired at the end of her shift, was wearing a backpack that was later found to have syringes filled with a blue liquid solution, and was detained and taken to the Emergency Department (ED) due to impairment and voicing suicidal ideations to the officer. Review of the facility's Addendum dated 08/31/2023, revealed after additional information was available that was not available at the time when the five (5) day report was due, the nurse in question, RN #1, confessed to the arresting police officers that she had stolen Morphine from the places she worked. The facility substantiated neglect against RN #1. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of LPN #3's telephone Witness Statement, dated 09/07/2023, no witness signature documented, revealed on 08/26/2023, she witnessed RN #1 go into the bathroom for forty (40) minutes and heard two (2) other nurses call the DON for help. LPN #3 stated she then witnessed RN #1 take a bottle of Morphine out of her pocket and placed it back into the medication cart. LPN #3 stated she went into the bathroom and found the seal from the new Morphine bottle, took a picture, and provided it to the police. In addition, LPN #3 stated she counted the narcotics with RN #1 and noted the new Morphine bottle only had thirty (30) ml and not the thirty-four (34) ml as was in new bottles. LPN #3 stated she asked RN #1 about it, and RN #1 told LPN #3 that she did not know about the missing medication. During an interview on 09/13/2023 at 1:50 PM with SRNA #1, she stated she worked night shift and had worked with RN #1 about a month ago. She stated RN #1 appeared under the influence of something. She stated that on the night shift about a month ago, RN #1 was mean to her and was yelling at her. SRNA #1 stated that both RN #1 and another agency nurse that night looked intoxicated, but she did not remember the other nurse's name. SRNA #1 stated they were both running around and were very unfocused. The SRNA stated that she reported it first to LPN #2, and LPN #2 called the DON about the incident. SRNA #1 stated the other nurse left the building sometime around midnight and did not come back into the building until about 3:00 AM. During continued interview with SRNA #1, on 09/13/2023 at 1:50 PM, she stated the DON got to the facility around 3:30 AM, but before the DON got to the building the other nurse had already left due to personal issues. The SRNA stated, that on that night a few residents came to the nursing station with complaints of not getting their medications. SRNA #1 stated she was scheduled to work with RN #1 a week later. She stated RN #1 refused to work with her; RN #1 was moved to another hallway. Further, SRNA #1 stated, she thought RN #1 used that as an excuse to get onto another hallway. The SRNA stated on that night, RN #1 looked high and could not focus that night either, before she moved to another hallway. In addition, SRNA #1 stated she reported it to the other night shift nurses, and the DON had been notified on multiple occasions about RN #1. However, she stated the DON kept defending RN #1, and she and other staff did not know why. SRNA #1 stated RN #1 always kept a backpack on her, except when she was sitting down, she went to the bathroom about ten (10) times a shift, and she would stay in the bathroom for over forty (40) minutes at the most. During an interview with LPN #4 on 09/13/2023 at 8:17 PM, she stated she reported on 08/26/2023 at 7:30 PM that SRNA #2 went to LPN #3, and informed her that RN #1 was acting oddly and was going through the medication carts but not passing medications. LPN #4 stated around 10:00 PM, RN #1 was talking belligerently, slurring words, and her pupils were pinpoint. At approximately 10:46 PM, LPN #4 stated she called the DON and told her RN #1 was higher than an f-in kite. LPN #4 also stated RN #1 went into the bathroom right after that and was in there for quite some time. The LPN stated that the pharmacy brought in a new vial of Morphine, and RN #1 signed it off and went into the bathroom afterwards with her backpack on and did not come out of the bathroom until 11:26 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Heritage Hall Rehab & Well	331 South Main Street Lawrenceburg, KY 40342

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In continued interview with LPN #4, on 09/13/2023 at 8;17 PM, she stated she called the DON again and informed her that she and other staff wanted to call the cops because they felt RN #1 had taken the Morphine. LPN #4 stated she also informed the DON when RN #1 came out of the bathroom, LPN #3 had witnessed RN #1 pull a Morphine bottle out of the side pocket of her pants and put the vial back in the medication cart on the Tulip Hall. In addition, she stated LPN #3 showed LPN #2 and LPN #4 a picture of RN #1 putting the Morphine bottle back into the medication cart. LPN #4 stated they wanted to call the cops, but the DON said not to call the cops that it was speculation. LPN #4 stated the DON told her that she wanted to call the Administrator, and the DON called them back in about five (5) minutes and said they would send RN #1 home, it was speculation, and they would deal with RN #1 at a later time. During the continued interview with LPN #4 on 09/13/2023 at 8:17 PM, LPN #4 stated SRNA #2 and LPN #3 went to the bathroom and obtained the seal for the Morphine bottle in the bathroom. LPN #4 stated RN #1 ditched her backpack out the service door and could not focus on clocking out. LPN #4 stated she walked RN #1 to the time clock after about an hour. Afterwards, LPN #4 stated she and other staff went to check on what happened to RN #1's backpack, and they found it next to the dumpsters. LPN #4 stated she observed seven (7) syringes filled with a blue liquid substance, Scopolamine transdermal patches (prevent nausea and vomiting), and needles in RN #1's backpack. LPN #4 stated she took a picture of the contents with her cell phone and sent it to the DON. LPN #4 stated, at that time, LPN #3 called 911 Police Department (PD) but waited until RN #1 was in the vehicle. LPN #4 stated the PD was just a few blocks down the road, and police stopped RN #1 down the street and came back to the facility and picked up the backpack. LPN #4 stated during interview, on 09/13/2023 at 8:17 PM, that all nurses performed visual pain assessments on all the residents and did pain assessments on the two (2) Hospice residents, Residents #2 and #3, as well as Resident #1 since he/she was on Morphine. LPN #4 stated the night of the incident with RN #1, after she exited the facility, Resident #1 started to demonstrate behaviors and did not sleep. LPN #4 stated Resident #1 was very vocal even though the resident did not talk, and this was not typical behavior when Resident #1 was on his/her Morphine. LPN #4 stated she did visual assessments on those twenty-one (21) residents that RN #1 took care of, and no pain was noted other than the two (2) Hospice residents (Residents #2 and #3), who were hollering out in pain, looked strained, and clinched fists. The LPN stated the staff tried to reposition them and talked to them, but LPN #4 stated she and other nurses were scared to do anything else, not knowing for sure what the residents had received or not. She stated the PD had confiscated the Morphine earlier when they came back to the facility. In addition, LPN #4 stated it took an hour and one-half (1.5) to get the Nurse Practitioner to send new prescriptions for the residents. She stated two (2) residents were sent to the ED for abdominal pain, and one (1) resident had a fall. During the interview, on 09/13/2023 at 1:50 PM, LPN #4 stated she and other staff made sure all the residents were alive, not out of it, and SRNAs were put on high alert. LPN #4 stated she called the DON twice and texted her the rest of the time. LPN #4 stated she called the DON again and informed her nursing did not feel comfortable taking over RN #1's medication cart keys. She stated th[TRUNCATED]

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's investigation, and review of the facility's policies, and the Kentucky Incident Based Reporting System (KYIBRS) Report it was determined the facility failed to ensure an thorough investigation was conducted timely; and failed to protect the safety of the residents after they were informed of an allegation of misappropriation related to narcotic (Morphine) drug diversion for three (3) of sixty-one (61) sampled residents (Residents #1, #2, and #3). Residents #1, #2, and #3 were prescribed Morphine (an opioid given to relieve moderate to severe pain). The Administrator and the Director of Nursing (DON) became aware of an allegation of misappropriation that Registered Nurse (RN) #1 had diverted narcotic medications on 08/26/2023. However, an investigation was not initiated until 08/27/2023. In addition, the Administrator, who was the Abuse Coordinator, did not come to the facility until 08/28/2023. The facility's Ad Hoc meeting to address the diversion was not held until 08/29/2023. The facility's failure to take immediate action to prevent drug diversion and have a system in place to ensure the residents were protected is likely to cause serious injury, impairment, or death. Immediate Jeopardy (IJ) and Substandard Quality of Care were identified on 09/21/2023 and determined to exist on 08/26/2023 in the area of 42 CFR 483.12 Freedom from Abuse and Neglect, F602 and F610 with a Scope and Severity of a J. The facility was notified of the Immediate Jeopardy on 09/21/2023. The IJ is ongoing. The findings include: Review of the facility's policy, Abuse, Neglect, and Misappropriation of Property, revised 10/17/2022, revealed the Administrator would investigate all allegations and provide complete and thorough documentation of the investigation of abuse/misappropriation. The Administrator would also determine the root cause; take steps to eliminate the ongoing danger to residents; and notify the Medical Director. Review of the facility's policy,Controlled Medication and Drug Diversion Policy revision date 07/07/2022, revealed the facility was to investigate and make every reasonable effort to reconcile reported narcotic discrepancies. The policy stated if a major discrepancy or a pattern of discrepancies occurred or if there was apparent criminal activity, the DON would notify the Chief Executive Officer (CEO), Nurse Care Consultant (NCC), Regional Vice-President (RVP), and pharmacy immediately. 1. Review of Resident #1's admission record revealed the facility admitted Resident #1 on 08/10/2021 with diagnoses that included Cerebral Palsy, Scoliosis, and Severe Intellectual Disabilities. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 06/14/2023, revealed the facility could not assess the resident with a Brief Interview for Mental Status (BIMS) score due to Resident #1 being never or rarely understood. Review of Resident #1's Physician's Orders revealed an order, dated 08/07/2023, for Morphine Sulfate 100 milligrams (mg)/5 milliliters (ml) (20 mg/ml), amount five (5) mg (0.25 ml) oral concentration liquid to administer 0.25 ml orally every six (6) hours for pain. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of Resident #2's admission record revealed the facility admitted Resident #2 on 08/19/2023 with diagnoses of Down's Syndrome, Encephalopathy, and Anxiety. Further review revealed Resident #2 was a Hospice/Palliative care resident. Review of Resident #2's admission MDS Assessment, dated 08/26/2023, revealed the facility could not assess the resident with a Brief Interview for Mental Status (BIMS) score due to Resident #2 being never or rarely understood. Review of Resident #2's Physician's Orders revealed an order, dated 08/26/2023, for Resident #2 to receive Morphine Sulfate 100 milligrams (mg)/5 milliliters (ml) (20 mg/ml), amount five (5) mg (0.25 ml) oral concentration liquid to administer 0.25 ml orally every four (4) hours as needed (PRN) for pain. Additional review revealed a new order, dated 08/26/2023, for Resident #2 to receive Morphine Sulfate 100 mg/5 ml (20 mg/ml), amount ten (10) mg (0.5 ml) oral concentration liquid, to administer 0.5 ml orally every four (4) hours as needed (PRN) for pain. Review of Resident #2's Medication Administration Record (MAR) revealed the resident received a dose of Morphine 5 mg on 08/26/2023 at 12:33 PM with effective results. No further documentation was noted on the MAR for 08/26/2023. Review of the facility's Controlled Drug Record revealed on 08/26/2023 at approximately 10:00 PM, pharmacy delivered a thirty (30) ml bottle of Morphine Sulfate 100 mg/5 ml oral concentration liquid for Resident #2, with an order to administer 0.5 ml orally every four (4) hours as needed (PRN) for pain. Further review revealed Resident #2's Morphine narcotic medication was signed off as received by Registered Nurse (RN) #1 and witnessed by Licensed Practical Nurse (LPN) #3. 3. Review of Resident #3's admission record revealed the facility admitted Resident #3 on 11/07/2017 with diagnoses of Down's Syndrome, Dementia, Epilepsy, and Anxiety. Further review revealed Resident #3 was a Hospice/Palliative care resident. Review of Resident #3's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility could not assess the resident with a Brief Interview for Mental Status (BIMS) score due to Resident #3 being never or rarely understood. Review of Resident #3's Physician's Orders, dated 06/27/2023, revealed an order, dated 08/09/2023, for Resident#3 to receive Morphine Sulfate 10 mg/5 ml, (2 mg/ml) oral concentration liquid, to administer one (1) ml orally every two (2) hours as needed (PRN) for pain. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Kentucky Incident Based Reporting System (KYIBRS) Report of incident KY 23-212, dated 08/27/2023 at 12:35 AM, revealed the police stopped RN #1 for her vehicle's failure to signal and to conduct a Driving Under the Influence (DUI) investigation at 12:37 AM. At that time, RN #1 advised Officer #1 that the seven (7) syringes with the blue liquid were Morphine, and she had taken them from the facility. Per the report, RN #1 also advised Officer #1 she had taken a dose of Morphine while on shift earlier tonight while caring for twenty-one (21) residents. Per the report, while enroute to the hospital, RN #1 informed Emergency Medical Services (EMS) personnel (called because RN #1 was expressing suicidal ideation) she had been conducting this unlawful act since January 2023. Per the report, a warrant of arrest was issued for RN #1 on 08/27/2023 at 2:36 AM, which included eight (8) counts for the charge of Theft of a Legend Drug (a drug approved by the Food and Drug Administration (FDA) that could be dispensed to the public only with a prescription); twenty-one (21) counts of Wanton Endangerment in the First Degree; seven (7) counts of Possession of Controlled Substance; seven (7) counts of Theft by Unlawful Taking or Disposition; three (3) counts of Knowingly Abuse or Neglect of an Adult by Stealing; three (3) counts of Tampering with Physical Evidence; and one (1) count of Drug Paraphernalia. Review of the Long-Term Care Facility-Self-Reported Incident Form/Initial Report, dated 08/27/2023, revealed the Director of Nursing (DON) was notified on 08/27/2023 at 7:30 AM that Registered Nurse (RN) #1 was pulled over by the police after her shift ended at 11:00 PM on 08/26/2023. The RN was pulled over for suspicion of impairment and was noted to have syringes, blue food coloring, and saline in her backpack. Further review revealed the police came to the facility and took Morphine from the medication carts for testing, and stated they would follow up. Per the investigation, Residents #1, #2, and #3's responsible parties, Hospice, and the Medical Director were notified; pain assessments were completed; pharmacy was notified and the medication (Morphine) was sent immediately (stat); all narcotic counts were completed and were accurate; and the investigation was started immediately. However, during an interview on 09/13/2023 at 8:17 PM with Licensed Practical Nurse (LPN) #4 she stated she had observed RN #1, on 08/26/2023 at approximately 10:00 PM, talking belligerently, with slurred speech and pinpoint pupils. LPN #4 stated she contacted the DON at approximately 10:46 PM and informed her that RN #1 was higher than a f**king kite. LPN #4 stated the DON was made aware that LPN #3 had observed RN #1 take a Morphine bottle from her pocket and place it in the medication cart after RN #1 came out of the bathroom around 11:26 PM. LPN #4 stated she informed the DON that she felt the police should be contacted due to staff's suspicion that RN #1 had taken the Morphine that was delivered at approximately 10:00 PM for Resident #2. LPN #4 stated that she was informed not to call the police, but to let the DON contact the Administrator, and she would call her back. LPN #4 stated, on the return phone call from the DON around 11:30 PM, the DON instructed her to send RN #1 home, and they would deal with RN #1 later. LPN #4 stated she was informed by the DON that the Administrator stated that it was only speculation that RN #1 had misappropriated narcotics. LPN #4 stated she spoke with the DON two (2) different times and conversed by text message all the other times. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of LPN #2's telephone Witness Statement, dated 08/31/2023, signed by the Unit Manager (UM/LPN) #10, revealed on 08/26/2023 at approximately 8:00 PM, State Registered Nurse Aide (SRNA) #2 alerted LPN #2 that RN #1 had been going through the narcotic drawer with her backpack on. The statement revealed RN #1 continued to go to the bathroom frequently with her backpack on and stayed in the bathroom for forty (40) minutes. LPN #2 stated when RN #1 came out of the bathroom, LPN #3 met RN #1 to count the carts with her, and RN #1 then took Morphine out of her pocket and returned it to the medication cart. Further, LPN #2 stated, while counting the medications, the new bottle of Morphine was marked exactly at thirty (30) ml in the bottle. Per the statement, RN #1's face was flushed, and she was talking slowly while counting with LPN #3. Review of the Long-Term Care Facility-Self-Reported Incident Form/Final Report, Addendum, dated 08/31/2023, revealed after additional information was available that was not available at the time when the five (5) day report was due, the nurse in question, RN #1, confessed to the arresting police officers that she had stolen Morphine from the places she worked, and the facility substantiated neglect against RN #1. Review of LPN #3's telephone Witness Statement, dated 09/07/2023, no witness signature documented, revealed on 08/26/2023, she witnessed RN #1 go into the bathroom for forty (40) minutes and heard two (2) other nurses call the DON for help. LPN #3 stated she then witnessed that RN #1 took a bottle of Morphine out of her pocket and placed it back into the medication cart. LPN #3 stated she went into the bathroom and found the seal from the new Morphine bottle, took a picture, and provided it to the police. In addition, LPN #3 stated she counted off the narcotics with RN #1 and noted the new Morphine bottle only had thirty (30) ml and not the thirty-four (34) ml as was in new bottles. LPN #3 stated she asked RN #1 about it, and RN #1 told LPN #3 that she did not know about the missing medication. During an interview on 09/19/2023 at 3:31 PM with the Medical Director (MD), he stated he had been the MD since 2019. He stated the Administrator made him aware of the unfortunate incident on Tuesday 08/29/2023. He stated he had been informed that RN #1 was arrested outside the building, and had been suspended. The Medical Director stated they had discussed how RN #1 had replaced Morphine with water and blue food coloring and ways to prevent this in the future. The MD stated that everybody was in crisis mode and trying to figure out how to deal with it. He further stated that nobody had notified him about the incident prior to 08/29/2023, and he did not get any phone calls about residents being in pain. The Medical Director stated he recommended switching residents from liquid form to tablet form of Morphine. He stated at the Ad-Hoc meeting participants were just brainstorming. He stated he was not sure if pharmacy had come up with anything yet to prevent this from happening again. The MD stated he should have been notified immediately for something that was this major. He said his expectation of administration would be for them to go to the facility immediately after being made aware of the situation. The Medical Director stated the risk with residents not receiving their ordered Morphine would be they could have opiate withdrawal, and it could potentially be fatal. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/15/2023 at 6:03 PM with the Administrator, he stated he was the designated person for completing the investigation as the Abuse Coordinator. He stated that he received a phone call on 08/26/2023 at approximately 11:30 PM from the DON reporting that she had been contacted by LPN #4. The DON stated LPN #4 informed her that RN #1 was acting weird, wearing a backpack, and going into the bathroom frequently. The Administrator stated he and the DON decided to send RN #1 home. He stated he was made aware of the situation involving suspected narcotic diversion involving RN #1 by the DON on 08/27/2023 at 7:30 AM. He further stated he did not come into the facility until 08/28/2022, and an Ad-HOC meeting was not completed until 08/29/2023. During an interview on 09/19/2023 at 2:07 PM with the [NAME] President of Clinical Operations (VPCO), she stated that she was informed by the Administrator and DON of an alleged incident of misappropriation of narcotics on 08/26/2023. She further stated that the Administrator and DON did not come into the facility until Monday morning, on 08/28/2023, but they should have come to the facility to address the situation on 08/26/2023.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to accurately assess and reflect the resident's current status for one (1) of sixty-one (61) sampled residents (Resident #66). Review of Resident #66's Annual Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident as setup help only for functional status when eating. However, review of Resident #66's Speech Therapy (ST) Notes, dated 06/11/2023, revealed impulsivity continued, and the resident required minimal to moderate verbal cues to slow the food intake rate and consume appropriate bolus (bite) size. The findings include: Review of the facility's policy titled, Comprehensive Care Plans (CCP) effective 04/06/2015, revealed the CCP was based on a thorough assessment which included but was not limited to RAI (Resident Assessment Instrument) and MDS assessments. Continued review revealed care plan interventions were implemented for residents' problem areas, and the causes. Further review revealed the CCPs were prepared by the Interdisciplinary Team (IDT) and were ongoing, and the CCPs were to be revised as information about the resident and the resident's condition changed. Review of the MDS Registered Nurse (RN) Job Description dated 03/2021, revealed duties to oversee the coordination and participate in the completion of the Resident Assessment Instrument (RAI), MDS, Care Area Assessment (CAA) and Care Plan. Further review revealed duties to assist in completion of the RAI with the Interdisciplinary Team (IDT), and to complete the MDS using the medical record, bedside assessment, and staff, resident and/or family interviews. Review of Resident #66's medical record revealed the facility admitted the resident on 12/27/2019, with diagnoses that included Dysphagia, Oropharyngeal Phase, Dementia and Anxiety. Review of Resident #66's Annual MDS assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) which indicated he/she was cognitively intact. Further review revealed the facility assessed Resident #66 to require setup help only under functional status when eating. Review of the Physician's Order, dated 11/28/2022, revealed Resident #66 had orders for nectar thickened liquids and a pureed diet related to Dysphagia (swallowing problem). In addition, the resident was to receive double portions at supper. Review of Resident #66's CCP dated 07/15/2022 and revised on 04/27/2023, revealed the facility care planned the resident as at risk for aspiration and to have a mechanically altered diet. Further review revealed no documented evidence of specific person-centered interventions for Resident #66 to have assistance with meals, or to monitor the resident for swallowing problems. Review of the Speech Therapist (ST) Notes, dated 06/11/2023 and 06/12/2023, revealed Resident #66 was able to verbalize safe swallowing. However, the resident did not always carry this out independently and needed supervision due to continued impulsiveness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medical Nutrition Therapy (MNT) Evaluation Form, dated 06/12/2023, revealed supervision was needed for Resident #66's eating ability; Dysphagia was referenced under swallowing ability; and the need of a Speech Language Pathologist (SLP) was also referenced. During an interview with the MDS Coordinator, on 09/27/2023 at 8:20 AM, she stated it was her responsibility to ensure the MDS and CCP were developed and person-centered to meet the assessed needs of residents. She stated Resident #66's Annual MDS dated [DATE], documented the resident was independent with set up instead of supervision for meals. She stated after review of the ST Notes, Resident #66 required supervision at mealtime and not set up only. She further stated that Resident #66's need for supervision at mealtime was not discussed in the clinical meetings. During an interview with the Assistant Director of Nursing (ADON), on 09/27/2023 at 9:13 AM, she stated that she along with the MDS Coordinator and Director of Nursing (DON) ensured the MDS and CCP were completed and updated. During an interview with the Regional Clinical Dietitian, on 09/27/2023 at 3:55 PM, she stated after review of the MNT Evaluation Form dated 06/12/2023, Resident #66 required supervision at meals. During an interview with the Administrator, on 09/27/2023 at 5:06 PM, he stated the MDS Coordinator and the IDT were responsible for the accuracy of the MDS and CCP.

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Signature Healthcare at Heritage Hall Rehab & Well	331 South Main Street Lawrenceburg, KY 40342

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop and/or implement a Comprehensive Care Plan (CCP) to ensure it met the residents' medical, nursing, mental, and psychosocial needs as identified on his/her comprehensive assessment and other assessments for one (1) of sixty-one (61) sampled residents (Residents #66). The facility assessed Resident #66 as requiring a pureed, nectar thick diet and needing supervision with meals. The resident had a diagnosis of Dysphagia. Resident #66 had a Physician's Order for nectar thickened liquids, and a pureed diet with double portions at dinner. Review of Resident #66's CCP, dated [DATE], revealed the facility care planned the resident as at risk for dehydration related to his/her risk of aspiration, and a mechanically altered diet. However, record review revealed no documented evidence of specific interventions for assisting Resident #66 with performing safe swallowing techniques or monitoring the resident during meals. Therefore, Resident #66 was found with a partially eaten cheeseburger, unresponsive and slumped over the dining room table after lunch. Emergency Medical Services (EMS) arrived and it was determined Resident #66 was deceased upon EMS' arrival. Review of Resident #66's Comprehensive Care Plan (CCP) dated [DATE] and revised on [DATE], revealed the resident was at risk for aspiration and had a mechanically altered diet. However, there was no evidence of interventions to assist or monitor Resident #66 while eating. Immediate Jeopardy (IJ) was identified on [DATE] and determined to exist on [DATE] in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656 and 42 CFR 483.25 Quality of Care, F684 at a S/S of a J. The facility was notified of the IJ on [DATE] and the IJ is ongoing. The findings include: Review of the facility's policy titled, Accidents and Incidents effective [DATE], revealed the facility's intent was to provide an environment free from accidents and incidents that were avoidable. Further policy review revealed the facility investigated occurrences with applicable documentation and appropriate reporting. Review of the facility's policy titled, Comprehensive Care Plans effective [DATE], revealed the CCP was based on a thorough assessment which included but not limited to the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) assessments. Continued review revealed care plan interventions were implemented for residents' problem areas, and the causes. Further review revealed the CCPs were prepared by the Interdisciplinary Team (IDT), and were ongoing. In addition, the CCP's were to be revised as information about the resident and the resident's condition changed. 1. Review of Resident #66's medical record revealed the facility admitted the resident on [DATE], with diagnoses that included Dementia; Dysphagia, Oropharyngeal Phase, and Anxiety. Review of Resident #66's Annual MDS assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating he/she was cognitively intact. Further review revealed the facility assessed Resident #66 to require setup help only, when eating. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physician's Order dated [DATE], revealed Resident #66 had orders for nectar thickened liquids and a pureed diet related to Dysphagia (swallowing problem). Further review revealed Resident #66 was to receive double portions with dinner. Review of Resident #66's CCP dated [DATE] and revised on [DATE], revealed the facility care planned the resident as at risk for aspiration and to have a mechanically altered diet. However, further review revealed no documented evidence of specific person-centered interventions for Resident #66 to have assistance with meals, or to monitor him/her related to the resident's swallowing problems. Review of the Speech Therapist (ST) Note dated [DATE], revealed Resident #66's impulsivity continued, and the resident required minimal to moderate verbal cues to slow the rate of eating, and consume appropriate bolus (bite) size. Review of the ST Note dated [DATE], revealed Resident #66 was able to verbalize safe swallowing techniques; however, the resident did not always carry out those techniques independently. Review of Resident #66's Medical Nutrition Therapy (MNT) Evaluation Form dated [DATE], revealed supervision of Resident #66 was needed for his/her eating ability; Dysphagia referenced under swallowing ability; and the need for a Speech Language Pathologist (SLP) was also referenced. During interview on [DATE] at 10:17 AM, State Registered Nurse Aide (SRNA) #6 stated Resident #66 choked once before when eating a pork chop. The SRNA further stated Resident #66 did not eat his/her cheeseburgers and hid them in his/her shirt to take to his/her room. In interview on [DATE] at 1:01 PM, Licensed Practical Nurse (LPN) #9 stated Resident #66 had a prior incident of choking on a pork chop. LPN #9 stated Resident #66's roommate, Resident #10 often ordered two (2) cheeseburgers as a substitute for lunch and dinner and sometimes kept cheeseburgers in the room, which Resident #66 had access to. The LPN further stated a partially eaten cheeseburger was found on the table beside Resident #66 when the resident was found unresponsive and slumped over the table. During an interview on [DATE] at 3:55 PM, the Regional Clinical Dietitian, stated as she was the Regional RD she did not know Resident #66. She stated after review of the MNT Evaluation Form dated [DATE], Resident #66 was to have supervision at all meals. During an interview on [DATE] at 8:20 AM, the MDS Coordinator stated it was her responsibility to ensure the CCP was developed and person-centered to meet the assessed needs of the residents. She stated Resident #66's Annual MDS dated [DATE], documented the resident was independent with set up and supervision for meals. The MDS Coordinator further stated, after she reviewed the ST Notes, Resident #66 required supervision at mealtime; however, that was not reflected on the resident's CCP. In addition, she stated Resident #66's need for supervision at mealtime was not discussed in the clinical meetings. During an interview on [DATE] at 8:30 AM, the Rehabilitation Therapy Director (RTD) stated therapy staff held a weekly meeting for review of residents' CCPs and then reported to the IDT to ensure the CCPs were resident specific. The RTD stated Resident #66's CCP did not reflect the resident's specific care needs for swallowing interventions and monitoring during meals. The RTD further stated she was not able to explain why she had not received the information regarding Resident #66's need for monitoring and swallowing interventions from the ST. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:06 PM, the Administrator stated he was not aware of Resident #66's need for supervision.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the residents received quality of care based on the facility's identified care and treatment needs, and failed to ensure professional standards of practice were provided that would meet the residents' physical, mental, and psychosocial needs for one (1) of sixty-one (61) sampled residents (Resident #66). The facility assessed Resident #66, on 11/28/2022, as needing a pureed, nectar thick diet and supervision with meals. Resident #66 was found unresponsive, slumped over at the dining room table after lunch, with a partially eaten cheeseburger on the table. Staff called the Emergency Medical Services (EMS). Prior to EMS' arrival Resident #66 was moved to the floor. Upon arrival EMS found Resident #66 laying on his/back with a blanket underneath his/her head in the dinning hall area of the nursing home. Resident #66 had no pulse. The resident's face was pale with a bluish color, the resident was rolled over and had mottled skin on the back of his/her arms and back. Resident #66 was pronounced dead at 3:55 PM. Immediate Jeopardy (IJ) was identified on 09/29/2023 and determined to exist on 06/24/2023 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F 656 and 42 CFR 483.25 Quality of Care, F 684 at a S/S of a J. The facility was notified of the IJ on 09/29/2023. The IJ is ongoing. The findings include: Review of the facility's policy titled, Accidents and Incidents, effective 06/01/2015, revealed it was the intent of the facility to provide an environment free from accidents and incidents that were avoidable, and to investigate occurrences with applicable documentation and appropriate reporting. 1. Review of Resident #66's closed medical record revealed the facility admitted the resident on 12/27/2019, with diagnoses that included Anxiety, Dementia, Dysphagia, and Oropharyngeal Phase (feeding difficulties). Review of Resident #66's Annual Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating he/she was cognitively intact. Further review revealed the facility assessed Resident #66 to require setup help only, when eating. Review of Resident #66's, Medical Orders for Scope of Treatment (MOST), revealed Do Not Attempt Resuscitation (DNAR) orders, dated 04/17/2022. Review of the Physician's Order dated 11/28/2022, revealed Resident #66 had orders for nectar thickened liquids (NTL) and Dysphagia (swallowing problem). Resident #66 was to receive a pureed diet with double portions with dinner. Review of Resident #66's Comprehensive Care Plan (CCP) dated 07/15/2022 and revised on 04/27/2023, revealed the resident was at risk for aspiration and had a mechanically altered diet. However, there was no evidence of interventions to assist or monitor Resident #66 while eating. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Speech Therapist (ST) Notes dated 06/11/2023, revealed Resident #66's impulsivity continued; he/she required minimal to moderate verbal cues to slow the rate while eating, and should consume appropriate bolus (bite) size. Review of the ST Note dated 06/12/2023, revealed Resident #66 was able to verbalize safe swallowing. However, he/she did not always do this independently. Review of the ST Note dated 06/15/2023, revealed after the swallowing evaluation, education was provided to Resident #66 and staff on general safe swallowing. Review of the Medical Nutrition Therapy (MNT) Evaluation Form for Resident #66 dated 06/12/2023, revealed supervision was marked under eating ability; Dysphagia was marked under swallowing ability; under Speech Language Pathologist (SLP) for treatment. Review of the Swallow Consult Form for Resident #66 titled, Fiberoptic Endoscopic Evaluation of Swallowing Report dated 06/14/2023, revealed a safe PO (by mouth) diet was not recommended for Resident #66 due to the penetration/aspiration of thin liquids and nectar thick liquids (NTL), and the inability for full clearance of puree solids with risk for penetration/aspiration. If the resident continued with PO intake despite the risks for aspiration, it was recommended to continue a puree diet with NTL and after swallowing bites of puree, followed with two (2) to three (3) teaspoons (tsp.) of NTL before the next puree bite. Further review revealed the recommendation for the need of a gastrointestinal (GI) consult for further evaluation of an esophageal component, affecting the pharyngeal swallow. Review of the Emergency Medical Services (EMS) Run Sheet dated 06/24/2023, revealed EMS was dispatched to the facility on [DATE] at 3:23 PM, and arrived to the facility at 3:25 PM and made contact with Resident #66 at 3:26 PM. Further review revealed EMS was dispatched to the facility for a resident that was unresponsive and not breathing. The resident was found laying on his/her back with a blanket underneath his/her head in the dining hall area of the nursing home. Prior to EMS' arrival, staff stated Resident #66 was moved to the floor and was found to have a faint pulse;.after being placed on the floor, Resident #66 lost his/her pulse. Further review revealed Resident #66's face was pale and bluish in color, and the resident had mottled skin on the back of his/her arms and back when EMS rolled him/her over. Continue review revealed Resident #66 was not allowed to have solid food and only puree food, but a piece of a hamburger was sitting on the table in the dining area close to the resident. None of the staff knew what really had happened to Resident #66, but stated the resident looked like he/she was falling asleep before the incident happened. Resident #66 was pronounced dead upon EMS arrival to the facility. 2. Review of Resident #10's medical record revealed the facility admitted the resident on 04/06/2023, with diagnoses that included Diabetes Mellitus, Anxiety, Depression, and Post-Traumatic Stress Disorder (PTSD). Review of Resident #10's Annual MDS assessment dated [DATE], revealed the facility assessed the resident as having a BIMS score of fifteen (15) out of fifteen (15), indicating he/she was cognitively intact. During an interview with Resident #10, roommate of Resident #66, on 09/26/2023 at 7:49 AM, the resident stated he/she did not share a hamburger with Resident #66. Resident #10 stated he/she ordered two (2) hamburgers at lunch and supper every day. He/she further stated Resident #66 was on a processed diet and appeared to cough or choke a lot at lunch. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nursing Progress Note, dated 05/11/2023 at 6:17 AM, revealed Registered Nurse (RN) #3 documented that Resident 66's roommate, Resident #10, gave Resident #66 a bag of goldfish crackers. Further review revealed RN #3 explained to both residents that Resident #66 could not have crackers, because it went against his/her diet order. During an interview with State Registered Nurse Aide (SRNA)//Restorative Aide #12 on 09/28/2023 at 12:30 PM, she stated Resident #66's roommate (Resident #10) took cheeseburgers back to his/her room and she often had to remind Resident #10 not to give Resident #66 any food. During an interview with SRNA #6 on 09/26/2023 at 10:17 AM, she stated Resident #66's roommate kept cheeseburgers wrapped up in the room. SRNA #6 stated during the same week (did not say which day prior to 09/24/2023) Resident #10 had given Resident #66 a cheeseburger and she had instructed Resident #10 not to give Resident #66 a cheeseburger. During an interview with ST #1, on 09/20/2023 at 8:48 AM, she stated Resident #66's diet order was puree with NTL. She provided Resident #66 with strategies for a safe swallow, and even with cues. She stated the resident could not safely swallow and required supervision with a pureed diet. During an interview with the Dietary Manager, on 09/25/2023 at 9:10 AM and 4:46 PM, and on 09/27/2023 at 12:10 PM, he stated Resident #66 was not on the assisted at meals list. He stated Resident #66 often sat in the dining room after a meal and asked for a drink, and Resident #66 did not have supervision with thickened drinks. He further stated Resident #66 would ask for regular food, but he had to explain to the resident that he/she could not be offered regular food due to his/her diet. He stated Resident #66's roommate (Resident #10), ordered two (2) cheeseburgers at lunch and supper. He stated the resident took the cheeseburgers and other food back to his/her room often hidden in his/her jacket. During an interview with Licensed Practical Nurse (LPN) #9, on 09/26/2023 at 1:01 PM, she stated she went to the dining room with Registered Nurse (RN) #6 and found Resident #66 laying over the table. She stated she left RN #6 to find Resident #66's code status and called EMS. She stated she then returned to the dining room to find RN #6 had Resident #66 on the floor. She stated she observed a cheeseburger with three (3) to four (4) bites sitting on the table where Resident #66 was found. She further stated Resident #66's roommate liked to keep cheeseburgers in his/her room. However, she had not seen Resident #10 give Resident #66 a cheeseburger. During an interview with the Assistant Director of Nursing (ADON), on 09/27/2023 at 9:13 AM, she stated she did not recall if it was discussed in the morning meeting or clinical meeting that Resident #66 had requested regular food. The ADON stated staff were not assigned to the dining room after mealtime. However, they passed through' the dining room to observe residents who gathered on their own to watch television and listen to music. During an interview with the Director of Nursing (DON), on 09/28/2023 at 8:18 AM, she stated staff did not observe Resident #66 choke. She stated the staff's supervision in the dining room during mealtime was supposed to be two (2) State Registered Nursing Assistants (SRNA) and one (1) Nurse. She stated the Interdisciplinary Team (IDT) had not discussed the incident and the facility had not completed an investigation of the incident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator, on 09/27/2023 at 5:06 PM, he stated the incident was isolated with Resident #66 and the facility did not investigate it. During an interview with the Medical Director, on 09/26/2023 at 12:26 PM, he stated he was not informed of Resident #66's death on 06/24/2023 until he attended the Ad-Hoc meeting on 06/29/2023. He stated he should have been made aware of Resident #66's death and if the resident was eating regular food. The Medical Director stated if on a regular diet, Resident #66 could have choked, causing aspiration pneumonia and/or death.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy and the Administrator's job description it was determined, the facility failed to be administered in a manner which enabled its' effective use of resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to immediately conduct an investigation of an allegation of misappropriation residents' narcotic medications. Licensed Practical Nurse (LPN) #4 reported to the Director of Nursing (DON) that Registered Nurse (RN) #1 was exhibiting suspicious behaviors of wearing a backpack at work; being in the bathroom for long periods of time, and acting weird. While the DON was in the facility, on 08/11/2023 at 3:00 AM, RN #1 stayed in the bathroom for extended periods and walked around with a backpack. However, the DON reported there were no concerns, and staff members' reports were just speculation. In an interview with LPN #3, she stated on 08/26/2023 she observed Registered Nurse RN #1 take a bottle of Morphine out of her pocket and placed it into the medication cart at approximately 11:30 PM. LPN #4, stated she observed RN #1 on 08/26/2023 at approximately 10:00 PM talking belligerently, slurring her words, and her pupils were pinpoint. LPN #4 stated at 10:46 PM, she observed RN #1 enter the bathroom, and she did not exit until 11:26 PM. LPN #4 stated she called the DON at 10:46 PM initially and told her that RN #1 was higher than a f .ing [NAME]. LPN #4 stated she informed the DON that she wanted to call the police because she thought RN #1 had taken the Morphine that was delivered from the pharmacy at approximately 10:00 PM for Resident #2; however, the DON told her not to call the police. In an interview with the Administrator, he stated on 08/27/2023 at 7:30 AM, he was made aware by the DON that the police had been called on 08/26/2023. The Administrator stated staff had texted the DON on 08/26/2023. However, she was not aware of the text until the next morning on 08/27/2023. He stated he was told by the DON that RN #1 had been arrested, and Morphine was found in RN #1's backpack. The facility's Administrator and DON failed to immediately take action to investigate and report, implement corrective action consistent with the investigation's findings, and failed to take steps to eliminate any ongoing danger to the resident(s) in a timely manner. Immediate Jeopardy (IJ) and Substandard Quality of Care were identified on 09/21/2023 and determined to exist on 08/26/2023 in the area of 42 CFR 483.12 Freedom from Abuse and Neglect, F602 and F610 with a Scope and Severity of a J. The facility was notified of the Immediate Jeopardy on 09/21/2023. The IJ is ongoing. The findings include: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy, Facility Administration revised 09/05/2018, revealed the facility was operated under the direction of a Chief Executive Officer (CEO) in accordance with Federal and State laws and professional standards. Continued review revealed the CE0 or Administrator was to report unusual occurrences to appropriate agencies in accordance with specific state and/or federal guidelines. Per review, the facility had a governing body consisting of the CEO, Director of Nursing (DON) and Medical Director that was legally responsible for establishing and implementing policies regarding the management and operation of the facility. Further review revealed the facility's policies and procedures were maintained and updated periodically to reflect current professional standards and practice through annual review. Review of the job description for the Administrator dated 03/2021, revealed the Administrator reported to the Regional [NAME] President of Operations and was to lead and direct the overall operations of the facility in accordance with residents' needs, government regulations and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. Per review, the Administrator was to monitor Data Points and address issues that affected the performance of the facility. Continued review revealed the Administrator was also to monitor each department's activities; communicate policies; evaluate performance; provide feedback and assist, observe, coach, and discipline as needed. Further review revealed the Administrator was to oversee via regular rounds the monitoring of delivery of nursing care, operation of support departments, cleanliness and the appearance of the facility; morale of the staff, and ensure resident needs were being addressed. In addition, the Administrator was to utilize survey information to address areas of importance as defined by the residents and he/she was responsible for the facility's Quality Assurance (QA) program. Review of the job description for the Director or Nursing (DON) dated 03/2021, revealed the DON reported to the Administrator and was to manage the overall operations of the facility's Nursing Department in accordance with company policies and standards of nursing practices and governmental regulations, so as to maintain excellent care for all residents' needs. Continued review revealed in the role of the DON, he/she was to plan, develop, organize, implement, evaluate and direct the Nursing services department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines given the long-term care facility. Further review revealed the DON was responsible for informing the State of any reportable incidents within the appropriate time frames and complete the investigative analysis as required. In addition, the DON was to regularly inspect the facility and nursing practices for compliance with federal, state, and local standards and regulations. On 08/11/2023 at 3:00 AM, the DON was in the facility working due to the facility requiring staff coverage and to observe Registered Nurse (RN) #1's behaviors which had been reported as suspicious. While the DON was in the facility on 08/11/2023, RN #1 stayed in the bathroom for long periods and walked around with a backpack on as reported by staff. However, the DON reported the staff members' reports as just speculation and there were no concerns regarding RN #1. On 08/26/2023, Licensed Practical Nurse (LPN) #4 reported to the DON that Registered Nurse (RN) #1 had suspicious behaviors of acting weird, being in the bathroom for long periods of time, and wearing a backpack at work. During an interview with LPN #3, she stated on 08/26/2023, at approximately 11:30 PM she saw RN #1 remove a bottle of Morphine from her pocket and place it in the medication cart. (continued on next page)

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Signature Healthcare at Heritage Hall Rehab & Well	331 South Main Street Lawrenceburg, KY 40342

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LPN #4 on 09/13/2023 at 8:17 PM, she stated on 08/26/2023 at approximately 10:00 PM, she saw RN #1 slurring her words, speaking belligerently, and observed the RN's pupils as pinpoint. LPN #4 stated she saw RN #1 at 10:46 PM, enter the bathroom, and not come out of the bathroom until 11:26 PM. LPN #4 stated she called the DON initially at 10:46 PM, to tell the DON that RN #1 was higher than a f .ing [NAME]. LPN #4 stated she told the DON she wanted to call the police because she thought RN #1 had taken Morphine meant for Resident #2 from the medication cart which had delivered from the pharmacy at approximately 10:00 PM. The Administrator stated in interview on 08/27/2023 at 7:30 AM, that the DON made him aware the police had been called on 08/26/2023. He stated staff had texted the DON on 08/26/2023. However, he was not aware of the text messages until the morning of 08/27/2023. He stated the DON told him RN #1 had been arrested, and Morphine was found in the RN's backpack. In interview on 09/15/2023 at 6:03 PM, the Administrator stated he and the DON decided to send RN #1 home. The Administrator stated he was made aware of the situation involving suspected narcotic diversion by RN #1 by the DON on 08/27/2023 at 7:30 AM. However, he stated he did not go to the facility until 08/28/2022, and an Ad-HOC meeting was not completed until 08/29/2023. The Administrator stated he was the designated person for completing the investigation as the Abuse Coordinator. In interview on 09/15/2023 at 2:20 PM, the DON stated her attorney wanted to be present during any interviews, therefore no interview was obtained from the DON. In an interview on 09/19/2023 at 3:31 PM, the Medical Director stated he had been the facility's Medical Director since 2019. He stated, when he was asked about the recent drug diversion in the facility, he stated he had not been notified immediately. The Medical Director stated he had talked with the Administrative Team, and they were currently working on a process so the diversion did not happen again. He stated the Administrator notified him of the unfortunate incident on Tuesday, 08/29/2023. The Medical Director stated no one had notified him about the incident prior to 08/29/2023, and he did not get any phone calls about residents being in pain. He stated he set up a Quality Assurance (QA) meeting to deal with the incident, and he attended an Ad- Hoc Quality Assurance over the phone but no full blown' Quality Assurance and Prevention Improvement (QAPI) meeting. The facility had a QAPI meeting scheduled 09/19/2023 to discuss the incident going forward. He stated he had not heard of anyone having increased pain in the facility. The Medical Director stated the facility was in the process of decreasing the Morphine dose for Resident #1 and the plan was to either discontinue it or switch to pill form. He stated we had several Ad Hoc meetings over the phone about the incident, and his recommendation had been for getting the resident a new supply of morphine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185277	A. Building B. Wing	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In continued interview on 09/19/2023 at 3:31 PM, the Medical Director stated he was not aware of how quickly medications were replaced at the facility; however, he thought it was within twenty-four (24) hours. He stated reporting needed to be immediately, was to go up the chain of command, and he should have been notified immediately for something that major. The Medical Director stated if he had been notified immediately after the incident, he would have switched the narcotic pain medication to a pill form from the liquid form. He stated he would have started brainstorming quicker with the facility's administration on how to prevent the incident from happening again. Per the Medical Director, Everyone here is my patient, he would have made sure the morphine was replaced quicker and a pain assessment completed on everyone. He stated for Something that big I would have thought they would have called me. The Medical Director stated, We were going to discuss what the plan in place was at today's QAPI meeting. He stated his expectation for the administration role going forward, after an incident like that one was for them to go into the facility, and he also stated, I was shocked, and I didn't ask why they didn't come into the building. when notified. The Medical Director stated he thought it would show leadership and help staff see things were being taken seriously and issues were being taken care of if administration had come into the building. He further stated the risk for residents not receiving their Morphine was they could have opiate withdrawal and it could potentially be fatal. The Medical Director stated for residents not receiving their Morphine would be they would have increased pain from the withdrawal. In addition, he further stated psychosocial harm would be a result of the pain incurred.