STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin County Health Care Facility	62 Maude Road Inez, KY 41224

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document policy review, it was determined the facility failed to maintain an environment which protected residents from physical abuse by another resident for one (1) out of three (3) residents, Resident #32. Resident #49, who had a history of wandering and aggressive behaviors, wandered into Resident #32's room and hit the resident on the right arm with a grabber (a grabber or a reacher is an assistive device used to pick up items from the floor/shelves, turn off lights, etc.). Resident #32 experienced a red, dime-sized area to his/her right arm, as a result of being hit with the grabber. The findings include: Review of the facility's policy titled, Reporting Abuse to Facility Management, dated 11/02/2017, revealed it was the facility's policy for each resident to have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Continued review revealed the facility did not condone resident abuse by anyone, including staff members, other residents, friends, or other individuals. The policy further revealed the facility's abuse prevention/intervention program included, but was not limited to: assessing, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. In addition, review also revealed abuse prevention/intervention program included: assessing residents with signs and symptoms of behavior problems, and developing and implementing care plans which assisted in resolving behavioral issues. Review of the Long Term Care Facility-Self-Reported Incident Form dated 04/27/2022, revealed Resident #49 entered Resident #32's room and struck Resident #32 on the right arm with a grabber that belonged to Resident #32. Continued review of the Form revealed Resident #49 was removed from Resident #32's room and placed on one-on-one (1:1) supervision. Review further revealed Resident #32 had a small red area on his/her right arm; however, the resident stated he/she was not hurt. Review of the Facility Investigation-5 Day Final Report dated 05/02/2022, revealed the facility substantiated that a resident-to-resident altercation occurred. Continued review revealed Resident #32's left palm was a tiny bit sore but not really. Further review revealed Resident #32 stated he/she was not afraid of Resident #49 anymore and was just anxious when the incident occurred. 1. Review of Resident #49's admission Record revealed the facility admitted the resident on 06/24/2020, with diagnoses that included Dementia with Behavioral Disturbance, Mood Disorder, Anxiety Disorder, and late onset Alzheimer's Disease. Continued review of Resident #49's medical record revealed the facility discharged the resident on 10/26/2022. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2023
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #49 to have a Brief Interview for Mental Status (BIMS) score of four (4), indicating the resident was severely cognitively impaired. Further review revealed the facility also assessed Resident #49 as dependent on staff for his/here Activities of Daily Living (ADLs) and to have behaviors of wandering. Review of Resident #49's Care Plan dated 07/06/2020, revealed the facility care planned the resident with cognitive thought process impairment related to Dementia. Per review of the care plan, on 01/21/2022, documentation on the care plan revealed the resident had behavior problems related to wandering. Further review of the care plan revealed the facility developed interventions which included: anticipating and meeting the resident's needs; providing a program of activities that were of interest and supplying a personal busy box; and redirecting and offering to assist the resident to bed if he/she was tired. Review of Resident #49's Progress Note dated 04/27/2022 at 4:18 PM, revealed the nurse had spoken with the resident's Physician regarding an incident of him/her wandering into another resident's room and hitting that resident with a grabber. Review of the Note further revealed the Physician ordered Resident #49 to be transferred to the emergency room (ER) for a psychiatric evaluation. 2. Review of Resident #32's admission Record revealed the facility admitted the resident on 04/23/2021, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, and Morbid Obesity. Review of the Annual MDS assessment dated [DATE], revealed the facility assessed Resident #32 as having a BIMS score of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility additionally assessed Resident #32 as dependent on staff for care with his/her ADLs, and not to have displayed any behaviors. Review of Resident #32's Weekly Nursing Assessment, dated 04/27/2022, revealed the resident had been assessed to have a dime-sized red area to his/her right posterior forearm midway between the wrist and elbow. Review further revealed no bruising was noted. Interview on 01/03/2023 at 11:40 AM, with Resident #32 revealed the resident recalled the incident when Resident #49 entered his/her room. Per interview, when Resident #49 entered his/her room he/she saw the grabber, picked it up, and began hitting Resident #32 on the arm with it. Continued interview revealed Resident #32 started yelling and staff came into his/her room and removed Resident #49 from the room. Resident #32 stated he/she did not believe Resident #49 realized what he/she had been doing and did not think Resident #49 had been trying to intentionally hurt him/her. Further interview revealed Resident #32 stated his/her arm stung from the blows incurred from Resident #49 striking him/her with the grabber. In addition, Resident #32 stated the facility placed a stop sign on his/her room door after the incident, and no further incidents had occurred. Interview on 01/05/2023 at 10:34 AM, with State Registered Nurse Aide (SRNA) #5 revealed she was working the day of the incident but had not witnessed Resident #49 striking Resident #32. SRNA #5 stated it was common for Resident #49 to go into other residents' rooms and take those residents' stuff. Further interview revealed when staff attempted to redirect Resident #49 and take back other residents' items, Resident #49 would become aggressive. Interview on 01/05/2023 at 2:30 PM, with Assistant Director of Nursing (ADON) revealed Resident #49 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Martin County Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 62 Maude Road Inez, KY 41224	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wandered into other residents' rooms not realizing he/she was in the wrong room. The ADON stated she removed Resident #49 from Resident #32's room following the incident. Further interview revealed Resident #49 had opened the bathroom door and could not get out of Resident #32's room because the bathroom door blocked the bedroom door exit. The ADON further stated Resident #49 had not realized what he/she had done when the incident occurred. Interview on 01/06/2023 at 9:41 AM, with Social Services Director (SSD) revealed Resident #49 had Dementia and his/her mental condition had declined. The SSD stated there were numerous interventions in place to help with Resident #49's behaviors, which included having a family member try to calm the resident down when he/she was agitated. She further stated other interventions additionally included: a referral for a psychiatric consultation; one-on-one (1:1) supervision; stop signs were placed on residents' doors; and activities were to be provided which Resident #49 enjoyed. According to the SSD, Resident #49 pretty much required staff to sit with him/her 1:1 in order to manage the resident's behaviors. Further interview revealed Resident #49's behaviors were difficult to manage, and other residents complained of Resident #49 going into their room. Interview on 01/06/2023 at 11:07 AM, with the Director of Nursing (DON) revealed Resident #49 had Dementia with behaviors. The DON stated numerous interventions were in place to help reduce Resident #49's wandering and aggressive behaviors. According to the DON, Resident #49 had a urinary tract infection (UTI) at the time of the incident involving him/her hitting Resident #32 with the grabber. Further interview revealed Resident #49's aggression increased when he/she had a UTI. Interview on 01/06/2023 at 11:34 AM, with the Administrator revealed interventions had been in place to reduce Resident #49's behavior. The Administrator stated Resident #49 roamed and wandered off; however, no other residents had complained about Resident #49's going into their rooms. Further interview revealed the Administrator stated she had never witnessed Resident #49 being physically abusive toward other residents.

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	185379	A. Building B. Wing	01/06/2023

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview, and facility document and policy review, it was determined the facility failed to ensure a criminal background check was completed prior to employment for one (1) of five (5) sampled employees whose files were reviewed for background checks, State Registered Nurse Aide (SRNA) #11. The findings include: Review of the facility policy titled, Background Screening Investigations, dated 11/02/2017, revealed, It was the policy of this facility to conduct employment background screening checks, reference checks, screening and criminal conviction investigation checks on individuals who applied for employment with the facility. Continued review revealed the Personnel Director/Human Resources Director, or other designee, was to conduct employment background checks on staff to include: employees, Medical Director, and volunteers where appropriate. Review further revealed the employment background checks to be performed included reference checks, drug screening and criminal conviction checks (which might require fingerprinting as required by state law) on all persons making application for employment with the facility. Review of the facility's, Employee Handbook, revised December 2022, revealed, A criminal record check was required for all employees of the facility. Continued review revealed the facility would not knowingly employ a person in a position which involved providing direct services to a nursing facility resident if that person had been convicted of a felony: related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or sexual crime. Review further revealed the facility would not knowingly employ a person convicted of a misdemeanor including abuse, neglect, or exploitation of an adult. In addition, if an employee was charged, arrested, indicted, or convicted of crime while employed at the facility, the employee was required to immediately inform the Administrator of such action, which might result in disciplinary action up to and including termination. Review of State Registered Nurse Aide (SRNA) #11's employee file revealed an application for employment was submitted on 04/15/2020, and documentation noting the SRNA was hired by the facility on 05/15/2020. Further review of SRNA #11's employee's file revealed no documented evidence a criminal background check had been completed as per facility policy and its Employee Handbook. Interview on 01/06/2023 at 8:50 AM, with the Administrator revealed she had contacted the Administrative Office of the Courts, who reported a criminal background check for SRNA #11 had not been completed upon hire at the facility. Interview on 01/06/2023 at 10:50 AM, with the Human Resources (HR) Manager revealed she completed all new employee paperwork and completed a checklist, which included obtaining a background check. She stated she was responsible for obtaining the criminal background checks for employees which included SRNA #11's. Further interview revealed however, the paperwork for the background check for SRNA #11 was not sent out to be completed prior to employment, but should have. Continued interview on 01/06/2023 at 10:39 AM, with the Administrator revealed she was required to sign off on the new-hire check list to ensure all required background checks and paperwork were completed. The Administrator stated however, the facility failed to complete a checklist for SRNA #11 which included criminal background checks. Further interview revealed the facility's process was for HR to complete a background check on all new hires prior to employment and for the Administrator to (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review the check list to ensure all items had been obtained prior to employment. A follow-up interview with the Administrator on 01/06/2023 at 11:10 AM, revealed it was the facility's expectation for background checks to be completed on all new employees prior to working in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure nebulizer equipment was sanitized after each use to prevent the possible spread of infection for one (1) of three (3) residents, Resident #50. Observation on 01/03/2023 at 2:25 PM, revealed Registered Nurse (RN) #1 opened the nebulizer cup, which contained drops of an unknown liquid around the inner wall of the cup. The RN opened the Ipratropium (an inhalation medication used to treat breathing problems) solution vial and emptied the contents of the vial into the nebulizer cup and turned the nebulizer machine on. At 2:52 PM, RN #1 stated the treatment had been completed and removed the nebulizer mask and placed the nebulizer apparatus inside a clear plastic bag and put it back on the resident's bedside table without sanitizing the equipment. The findings include: Review of the facility's policy titled, Specific Medication Administration Procedures, dated November 2021, revealed after a nebulizer treatment was complete, staff should rinse and disinfect the nebulizer equipment according to the manufacturer's recommendations or wash the pieces, except the tubing, with warm, soapy water daily. Rinse with hot water, and allow pieces to air dry completely on paper towel. Further review of the policy revealed when the equipment was completely dry, it should be stored in a plastic bag with the resident's name and the date on it. Review of the manufacturer guidelines for the nebulizer machine titled, User Manual - Sunset Compressor Nebulizer, undated, revealed after each use, the T-piece kit should be disassembled into three (3) sections. Continued review revealed the equipment should be washed in warm soapy water and rinsed well, then wiped with paper towels and allowed to air dry. Review of Resident #50's admission Record revealed the facility re-admitted the resident on 07/30/2021, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and Hypoxemia (low oxygen level in blood). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #50 to have a Brief Interview for Mental Status (BIMS) score of fourteen (14), indicating the resident was cognitively intact. Review of Resident #50's Care Plan, initiated on 10/29/2021, revealed the resident had a care plan for breathing pattern risk related to his/her diagnosis of COPD. Continued review of the care plan revealed the facility developed interventions which included daily care of the nebulizer equipment. Per review of the care plan, the exterior of the nebulizer machine was to be wiped down with mild soap and water, and noted to never use alcohol on the nebulizer mask or nasal pillows. Further review of the care plan revealed the nebulizer face masks and cushions were to be submerged in warm soapy water (mild soap) for approximately five (5) minutes, and then rinsed thoroughly with warm water. Review further revealed any excess water should be shook from the mask and the mask allowed to air dry on a clean surface every day shift and as needed. Review of Resident #50's Order Listing Report revealed a Physician's Order with a start date of 01/01/2023, for the resident to have DuoNeb (brand name for the ipratropium inhalation solution) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Solution 0.5-2.5 (3) milligrams (mg) per three (3) milliliters (mL) to be given every six (6) hours as needed for chest congestion. Observation on 01/03/2023 at 11:04 AM, revealed Resident #50 lying on his/her bed with the head of the bed elevated approximately thirty (30) degrees. Interview with Resident #50, at the time of observation, revealed he/she was not feeling well because the resident had Pneumonia. Resident #50 stated the nebulizer machine sitting on his/her bedside table was used to give his/her treatments. The resident further stated it had been a few days since the nebulizer machine had been used. Further observation of the nebulizer inhalation apparatus revealed the mouthpiece, tubing, and T-piece, were lying on top of the nebulizer machine and not stored in a clean plastic bag for protection. Observation on 01/04/2022 at 2:15 PM, revealed Resident #50's nebulizer inhalation apparatus was stored in an undated plastic bag sitting on top of the resident's bedside table. Resident #50 stated he/she would like to have a nebulizer treatment administered which Licensed Practical Nurse (LPN #2) was notified of the resident's request at 2:19 PM. Interview with LPN #2, at the time of notification, revealed the LPN was still in training and was shadowing Registered Nurse (RN) #1. Continued observation at 2:25 PM, revealed RN #1 opened the nebulizer cup of Resident #50's inhalation apparatus, which had drops of an unknown liquid on the inner wall of the cup. The RN was observed to open the Ipratropium solution vial and empty the contents of the vial into the nebulizer cup of Resident #50's apparatus and turned the nebulizer machine on. Interview at 2:52 PM, revealed RN #1 stated Resident #50's treatment had been completed and the RN was observed to place the nebulizer apparatus inside the unlabeled clear plastic bag and placed it back on the resident's bedside table. Further observation revealed RN #1 and LPN #2 (her trainee) left Resident #50's room. Further interview at 2:55 PM, revealed RN #1 stated after administering Resident #50's nebulizer treatment, she should have cleaned the apparatus before placing it back in the clear bag. RN #1 stated she had not cleaned the apparatus because she had forgotten to take the bleach wipes in the resident's room with her. RN #1 further stated she only cleaned the areas of the apparatus where residents touched and stated she did not clean inside of their nebulizer canister/cup. Interview on 01/05/2023 at 5:50 AM, with RN #26 revealed once a nebulizer treatment had been completed staff should rinse out the canister/cup, turn the cup over, and make sure it was dry before placing it back in a storage bag. Interview on 01/05/2023 at 9:20 AM, with the Director of Nursing (DON) revealed after a nebulizer treatment had been completed staff should put the nebulizer apparatus inside a storage bag. Interview on 01/05/2023 at 9:21 AM with the Assistant Director of Nursing (ADON) revealed staff should take apart the apparatus, clean the inside of the canister/cup and let it air dry before placing it back inside the bag after a treatment. Interview on 01/05/2023 at 11:47 AM, with the Administrator revealed once a nebulizer treatment had been completed, staff should put the apparatus inside a bag. According to the Administrator, facility policy was that staff were to clean the apparatus once a day, not after each treatment. However, review of the facility's policy revealed staff should rinse and disinfect the nebulizer equipment according to the manufacturer's recommendations and review of the manufacturer's guidelines for the nebulizer machine revealed that, after each use, the T-piece kit should be disassembled into three (3) sections and the equipment should be washed in warm soapy water and rinsed well.

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F 0888

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure staff are vaccinated for COVID-19

Based on interview, and facility document and policy review, it was determined the facility failed to ensure staff members received a COVID-19 vaccination or an exemption for two (2) of seventy-eight (78) employees, Dietary Aide (DA) #20 and Maintenance Assistant (MA) #21.

The facility failed to ensure DA #20 and MA #21 received the second dose of their two (2) dose series of the COVID-19 vaccination.

The findings include:

Review of the facility's policy titled, COVID-19 Policy and Procedures, undated, revealed where COVID-19 vaccination required multiple doses, the staff member should be provided with current information regarding those additional does, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine to that individual as soon as possible. Continued review revealed the facility would require as a condition of employment that all individuals who provided care, treatments, and services for residents including employees, trainees, and contractors were to be fully vaccinated by March 15th, 2022. Further review revealed if the staff member declined to partake in the facility's vaccination requirement, they would be subject to termination. The policy further revealed the facility was required to track and document staff vaccinations, as well as document staff who had been granted exemptions and those whose vaccine were temporarily delayed. In addition, the policy revealed documentation of each staff member's vaccination status was expected to be performed (which should include the specific vaccine received, the dates of each dose received, or the date of the next scheduled dose for multi-dose vaccine).

Interview with the Administrator, during the entrance conference, on 01/03/2023 at 9:00 AM, revealed the Director of Nursing (DON) was the facility's Infection Preventionist and the Assistant Director of Nursing (ADON) was responsible for the facility's vaccination efforts.

Review of the facility's COVID-19 Staff Vaccination Status for Providers form revealed two (2) staff members, DA #20 and MA #21, were only partially vaccinated.

Interview on 01/05/2023 at 9:25 AM, with the Administrator revealed the partially vaccinated employees (MA #21 and DA #20) were newly hired employees. The Administrator stated Human Resources (HR) was responsible for ensuring employees received the second dose of the COVID-19 vaccine, and the employees knew they needed to have the second dose.

Interview on 01/05/2023 at 10:34 AM, with Maintenance Assistant (MA) #21 revealed he had been hired in September 2022 and received the 1st dose of his COVID-19 vaccination before he started. MA #21 further stated he had received a Moderna vaccine; however, did not know he needed a second dose until the Administrator notified him of that earlier in the day.

Interview on 01/06/2023 at 10:49 AM, with the Dietary Manager revealed DA #20 was on the schedule to work later that day. The DM stated however, DA #20 would need to have a Physician's note when she came to work indicating a vaccine exemption, or was to be fully vaccinated in order to work her shift.

Interview on 01/05/2023 at 2:25 PM, with the HR Manager revealed DA #20's hire date was 05/31/2022, and DA #20 received the first dose of her two (2) part COVID-19 vaccination on 05/31/2022.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview revealed MA #21's hire date had been 09/20/2022 and MA #21 received the first dose of his two (2) part COVID-19 vaccination on 09/07/2022. Further interview revealed there was no documentation of a second dose vaccination which could be located for either of those employees. The HR Manager further stated she had not monitored employees' COVID-19 vaccination status in over a year, as the Administrator now monitored staffs' vaccinations. Interview on 01/05/2023 at 2:30 PM, with the DON/Infection Preventionist revealed the ADON provided staffs' vaccinations and would be the person who knew how staff were monitored to ensure they received their second dose of the COVID-19 vaccine. The DON stated the expectation was that somebody was assigned to make sure staff received the second dose of the two (2) part series of their vaccinations within a month. Further interview revealed unless an employee had an exemption for the COVID-19 vaccinations, employees were required to obtain both doses of the COVID-19 vaccine as a condition of their employment. Interview on 01/05/2023 at 2:37 PM, with the ADON revealed she did not track staffs' vaccinations because HR tracked staffs' vaccination status. The ADON stated however, the staff members (DA #20 and MA #21) should have received their second dose of their two (2) part vaccination one (1) month after the first dose was administered. Interview on 01/06/2023 at 8:33 AM, with the Administrator revealed the expectation was for the facility to track employees' vaccination status. The Administrator stated employees were expected to either be fully vaccinated or have an exemption documented on file.