STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Richwood Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 Richwood Way LA Grange, KY 40031	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and facility policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 33 sampled residents (Resident (R)16). Observation on 03/11/2025, 03/12/2025, and 03/13/2025 revealed multiple wheelchairs, wheelchair leg extenders and boxes observed on the other side of room from R16's bed. The findings include: Review of the facility policy, Homelike Environment, revised February 2021, revealed facility staff and management maximized, to the extent possible, the characteristics of the facility that reflected a personalized, homelike setting which included personalized furniture and room arrangements. Review of the facility policy, Resident Rights, revised February 2021, revealed the facility assessed each resident to have the right to privacy, and retain and use personal possessions to the maximum extent that space and safety permit. Review of R16's admission Record and medical record revealed the facility admitted the resident on 02/14/2015, with diagnoses which included abnormal posture, muscle weakness, and epilepsy. Observation on 03/11/2025 at 11:10 AM, revealed R16 lying on her bed on the A side of the room. Per observation, there were multiple personal items stacked on R16's dresser. Further observation revealed the B side of the room contained the following items stored there: four wheelchairs, multiple wheelchair leg extenders, and a large box. Observation on 03/12/2025 at 1:39 PM, revealed R16 sitting up in a wheelchair receiving a breathing treatment from the nurse. Per observation, the B side of the room contained the following: two wheelchairs, multiple leg extenders, and the large box. Continued observation revealed the nurse had to walk close to those items to get to R16's bathroom and wash his hands. Observation on 03/13/2025 at 9:07 AM, revealed R16 lying on her bed on the A side of the room. Continued observation revealed the B side of the room contained three wheelchairs, multiple leg extenders, and the large box. During interview on 03/11/2025 at 11:10 AM, R16 stated the facility used the other side of her room for storage. The resident said staff came and got the wheelchairs or other items when they needed them and then returned the items to her room. (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: 185438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 03/13/2025 at 9:18 AM, the Social Services Director (SSD) stated the facility encouraged residents to make their rooms have a homelike environment and to be comfortable. She said she was unsure why equipment was being stored in R16's room, but equipment should not be stored in the resident's room as it did not make the room homelike for her. During interview on 03/13/2025 at 12:02 PM, the Director of Nursing (DON) stated she was unsure who stored equipment in R16's room. She reported however, that could cause R16 to have a loss of privacy and dignity with staff going in and out of the resident's room to get the equipment and then return it. During interview on 03/13/2025 at 4:55 PM, the Administrator stated equipment should be stored in the facility's basement. He said it was sometimes a little hard for therapy however, to go downstairs to get the equipment. The Administrator reported the facility was getting two storage sheds because it was a hodge podge of trying to get equipment stored in different areas of the facility. He stated it was not appropriate to store equipment in a resident's area as that was not a homelike environment, and he would not like having equipment stored in his bedroom. Additionally, he stated R16's room needed to be a clean space in which the resident lived.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facility policy, the facility failed to send a copy of the notice of transfer to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 sampled residents investigated for hospitalizations out of a total sample of 33 residents, (Resident (R)69 and R43). Review of R69's and R43's medical records revealed no documented evidence the facility provided notice of the residents' transfer to the hospital to the Office of the State Long-Term Care Ombudsman as required. The findings include: Review of the facility's policy titled, Bed Hold Transfer and Discharge Policy, undated, revealed under the Receipt of Notice heading, the facility was to notify the resident, and if known, family and a legal representative of the resident before the resident was transferred or discharged . Per review, that notification was to be made in writing. Continued review of the policy revealed the facility was to contact the resident, and if known, the resident's family and legal representative at the time of discharge, and notification was to also be sent by mail. Further review revealed if in an emergency situation, the facility was to notify the family and legal representative of the resident's (transfer) as soon as practicable. 1. Review of R69's admission Record revealed the facility admitted the resident on 09/17/2024, with diagnoses of displaced fractures of the lateral malleolus of the left and right fibulas, displaced fracture of the medial malleolus of the right tibia, unspecified fracture of shaft of right fibula, mild protein-calorie malnutrition, and chronic obstructive pulmonary disease (COPD). Review of R69's Progress Notes in the resident's Electronic Medical Record (EMR) revealed on 03/10/2025 at 6:44 PM, the resident had new orders to be transferred out to the hospital due to an unstoppable nosebleed. Per review of the Progress Notes, R69 returned to the facility 03/10/2025 at 10:05 PM with his daughter and son-in-law. Further review of R69's Progress Notes revealed however, no documentation of notification of the resident's transfer to the hospital made to the Ombudsman. 2. Review of R43's admission Record revealed the facility admitted the resident on 12/04/2024, with diagnoses of: chronic diastolic (congestive) heart failure, cognitive communication deficit, presence of cardiac pacemaker, complete atrioventricular block, and chronic respiratory failure with hypoxia. Review of R43's, Notice of Proposed Transfer/Discharge V2.0, dated 12/18/2024, revealed the facility discharged the resident to a local hospital on [DATE], due to the transfer being necessary for the resident. Continued review of the Notice of Proposed Transfer/Discharge V2.0 under II.A. Ombudsman Services, it was noted, Social Services to notify. Review of R43's Progress Notes in the EMR revealed the resident had been transferred to the hospital on [DATE]. Further review revealed however, there was no documentation of notification to the Ombudsman of R43's transfer to the hospital. In interview on 03/13/2025 at 12:40 PM, the Social Services Director (SSD) stated she sent a (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monthly log via email to the Ombudsman of residents who were transferred to a hospital that was unplanned, or a facility initiated transfer. When the State Survey Agency (SSA) Surveyor asked the SSD for the emails, the SSD stated she would work on getting that information together. In interview on 03/13/2025 at 2:49 PM, the SSD she said she had the information for R69 and R43. The SSD provided the SSA Surveyor with two pieces of paper, one for R69 and the other for R43. Per review of the papers, on the top, it read, Monthly Ombudsman Report, and under that was the residents' names, the month, date, and year. Further review of the papers provided revealed at the bottom it read, sent to: To: nhoa@ombuddy.org. In interview on 03/13/2025 at 3:22 PM, the SSD said she had additional information and provided the SSA Surveyor with two different papers which resembled an email; however, had no date or time, and was not a message or body of the email. The SSA Surveyor then asked the SSD for copies of her sent emails, as proof of having sent the notification of transfer to the Ombudsman. The SSD expressed understanding of what the SSA Surveyor was asking her for. However, in additional interview on 03/13/2025 at 4:08 PM, the SSD reported she had not emailed the Ombudsman the monthly log since November 2024. She further stated she would immediately start sending the logs again and would send the Ombudsman the backlogs of the months she had missed. In interview with the Director of Nursing (DON) on 03/13/2025 at 4:31 PM, she stated the SDD was responsible for notifying the Ombudsman of any transfers out to the hospital. She stated that was done to let the Ombudsman know when the residents were in and out of the building. The DON reported if the notification to the Ombudsman was not being completed, it was a possibility the residents would not be allowed to come back to the facility, or the Ombudsman would not know where the residents were located. In interview with the Administrator on 03/13/2025 at 4:50 PM, he stated Social Services took care of the notifications to the Ombudsman. He stated, She does a good job, I don't know how often, (she notifies the Ombudsman) I guess it's every time (a resident is transferred to the hospital). The Administrator said the reason for the notification to the Ombudsman was to make sure residents' rights were being followed. He further stated, We value our relationship with the Ombudsman. The Administrator additionally reported if the notification to the Ombudsman was not being done, it was possible the resident won't have a voice.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, record review, and review of facility policy, the facility failed to implement the comprehensive person-centered care plan for 2 of 33 sampled residents (Resident (R)28 and R259).

1. On 12/09/2024 and 12/17/2024, R28 experienced a fall without injury, and the facility updated the resident's care plan with an intervention to educate staff to place dycem (a nonslip material used to stabilize objects) in the resident's wheelchair.

2. Additionally, the facility care planned R259 for one person assist with eating on 03/07/2025. Observation on 03/11/2025, 03/12/2025, and 03/13/2025 revealed however, R259 eating meals in her room without staff present to provide assistance.

The findings include:

Review of the facility policy, Falls and Fall Risk, Managing revised March 2018 revealed staff were to try to prevent the resident from falling and identify interventions related to the resident's specific risks and causes. Per review, risk factors included heart failure and cognitive impairment. Continued review revealed staff were to implement a resident-centered plan for fall prevention to reduce specific risk factors of falls for each resident with a history of falls or at risk for falls. Policy review further revealed staff were to continue the interventions if interventions had been successful in preventing falling.

The facility did not provide a policy for care plans.

1. Review of R28's clinical record revealed the facility admitted the resident on 10/22/2021 and re-admitted the resident on 11/15/2021. Continued review revealed R28's diagnoses included immobility syndrome, congestive heart failure, and weakness.

Review of the facility's Comprehensive Care Plan (CCP) for R28 dated 11/03/2021, revealed the facility identified the resident as at risk for falls with an intervention for dycem to the wheelchair (w/c) dated 11/08/2023. Continued review of the CCP revealed on 08/14/2024, an intervention for staff education to place dycem in R28's w/c, which was revised on 12/09/2024. Further review of R28's care plan for risk of falls, revealed an intervention for staff education for dycem to the resident's w/c dated 12/17/2024.

Review of a progress note dated 12/09/2024, revealed the facility noted R28 sat on the ground in the resident's bathroom beside the w/c. Review of a progress note dated 12/16/2024, revealed R28 had been found on the floor beside the bed and an intervention to evaluate chair and add dycem was documented.

Review of the Speech Therapy Medicare SLP Evaluation and Plan of Treatment dated 12/09/2024, revealed R28 had been assessed as at risk for falls. Further review revealed R28 had been assessed to have a St. Louis University Mental Status. (SLUMS) Examination score of one out of 30, indicating her level of cognition was severe.

Review of the facility's, Record of In-Service Training dated 08/14, revealed the Infection

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preventionist (IP), who was also the facility's Quality Assurance (QA) person, trained staff to ensure (R28's) dycem was in the w/c (as care planned). Review of the facility's, Class Attendance Record dated 12/17, revealed staff signatures documented for an attached Google search printout for dycem info for wheelchairs, which noted dycem was non-clip and ideal for adhering cushions and inserts to wheelchairs. Observation of R28 on 03/11/2025 at 10:42 AM, revealed the resident sitting up in a w/c near the nurse's station. In interview on 03/13/2025 at 11:59 AM, the Director of Nursing (DON) stated she participated in the facility's morning meetings where they discussed root cause analysis when a resident fell. She reported the meeting reviewed residents' care plan (CP) interventions to determine if they did or did not work, and new interventions were added if needed. The DON said residents' CP's were for each individual resident and she expected staff to follow anything on the resident's CP. She further stated the CP was a plan for each individual resident, which allowed for more person-centered care and was important for a resident's safety. In an additional interview with the DON on 03/13/2025 at 2:23 PM, she stated when the morning meeting reviewed R28's fall on 11/14/2024 (after the resident sustained a fall on 11/13/2024) they looked at previous interventions, which included the dycem to the w/c. She reported on 12/17/2024, the staff present in the morning meeting reviewed R28's fall on 12/16/2024 and referred the resident to therapy to evaluate the w/c. The DON further stated therapy added dycem to R28's w/c, between the w/c seat and the w/c cushion. In further interview on 03/13/2025 at 3:49 PM, the DON stated R28 threw the dycem out of the w/c. She said the dycem kept things from sliding and she was unsure when the resident had thrown it away. The DON reported that had been discovered during the (fall) investigation. She further stated the IP audited residents' safety interventions to ensure they were in place. In interview on 03/13/2025 at 3:58 PM and at 4:07 PM, the IP stated during the morning meeting they reviewed residents' interventions to ensure they matched the orders, and she updated the CP as necessary. She reported she completed weekly visual audits of care plan interventions; however, she did not document her visual audits. The IP said at one point R28 had thrown away the dycem in the w/c, but she (the IP) never identified the dycem as missing during her visual audits. She further stated she educated staff on ensuring R28's dycem was in place in the w/c. In further interview on 03/13/2025 at 4:44 PM, the IP stated she could not find the documentation where staff were educated to place the dycem in R28's w/c after the resident fell on [DATE]. She said she should not have to educate staff more than once to ensure R28's dycem was in place. The IP further stated the purpose of the intervention for educating staff to place the dycem (on R28's CP) was to ensure the dycem was placed where it needed to be at all times, or the resident could fall again. In interview on 03/13/2025 at 4:49 PM, the Administrator stated he expected residents' falls interventions be in place; however, said he could not recall discussion regarding R28's dycem not being in the w/c. The Administrator reported he did not know the reason staff were educated multiple times on ensuring the dycem was in R28's w/c. He further stated he expected residents' falls interventions be in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R259's admission Record revealed the facility admitted the resident on 03/03/2025, with diagnoses which included metabolic encephalopathy, muscle weakness, dysphagia, cognitive communication deficit, and diabetes. Review of the Occupational Therapy (OT) Evaluation for R259 dated 03/03/2025, revealed the OT assessed the resident as requiring moderate assistance with self-feeding. Review of R259's CCP revealed on 03/07/2025, the facility identified R259 as at risk for further Activities of Daily Living (ADL) decline and as requiring assistance related to acute illness, weakness, impaired mobility, and impaired cognition. Further review of the CCP revealed an intervention that R259 required assistance of one staff for eating. Observation on 03/11/2025 at 8:50 AM, revealed R259 sitting in a wheelchair eating breakfast with no staff present in her room. Per observation, R259 had consumed 25% of her meal and had milk spilled, covering her dining tray. Continued observation revealed R259 had a slight tremor to her hand and was having difficulty lifting her glass to her mouth. Additionally, observation revealed R259 had food spilled on her shirt. Observation on 03/12/2025 at 1:18 PM, revealed R259 sitting in a wheelchair, eating her lunch meal with no staff present in her room to provide assistance as per the care plan. Per observation, lids were on two of the bowls on R259's meal tray. Continued observation revealed R259 removed the lid from the pudding with her hand shaking which caused the bowl to shake while opening the resident was removing the lid. Observation on 03/13/2025 at 8:50 AM, revealed R259 sitting in her wheelchair in her room eating breakfast with no staff present to assist the resident as per the care plan intervention. During interview on 03/11/2025 at 8:50 AM, R259 stated she was new to the facility and said she hated to ask for help. During interview on 03/13/2025 at 10:36 AM, the MDS Nurse stated she had written R259's care plan based upon the therapy evaluation performed on the resident's admission. She said R259 required assistance with eating, and it was important for staff to follow the resident's care plan to make sure the resident's needs were met. The MDS Nurse reported if a care plan change was needed, staff could discuss it with the nursing managers or the MDS nurse. She further stated and any needed changes could be discussed in the facility's morning interdisciplinary meeting. During interview on 03/13/2025 at 12:02 PM, the DON stated she did not usually write residents' care plans. She reported however, she expected staff to follow the residents' care plans because it was important to ensure the residents received proper care. In interview on 03/13/2025 at 4:49 PM, the Administrator stated he participated in the facility's morning meetings and discussed any root causes of incidents. He further stated he expected residents' falls interventions be in place.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to provide sufficient and timely activities of daily living (ADL) for 2 of 33 sampled residents who were unable to perform their ADLs (Resident (R)25 and R259). 1. The facility failed to assist R25 in maintaining his personal hygiene and comfort related to incontinence. R25 reported calling out for assistance for incontinence assistance; however, not receiving the assistance in a timely manner. He expressed feeling miserable after being left wet for as much as two hours at night and occasionally during the day. 2. Additionally, the facility assessed and care planned R259 for one person assist with eating on 03/07/2025. However, observation on 03/11/2025, 03/12/2025, and 03/13/2025 revealed no staff present in R259's room to assist the resident while she was eating her meals. The findings include: Review of the facility policy, Activities of Daily Living, (ADL), Supporting, revised March 2018, revealed residents were to be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out their ADL's. Continued review revealed appropriate care and services were to be provided for residents who were unable to carry out their ADL's independently with the consent of the resident and in accordance with their plan of care, including appropriate support and assistance with elimination (toileting). 1. Review of the facility policy, Urinary Continence and Incontinence - Assessment and Management, revised in July 2022, revealed relevant information related to urinary incontinence included observations, such as a wet bed or clothing and/or (the resident's) use of diuretics. Per review, staff were to define each individual's level of continence, referring to the criteria in the Minimum Data Set (MDS) Assessment as follows: continent indicating the resident had been continent of urine for at least seven days with no episodes of incontinence; occasionally incontinent defined as the resident having had less than seven bladder incontinence episodes in the past week. Continued review revealed the level of continence definitions also included: frequently incontinent defined as the resident having had at least seven episodes of bladder incontinence in the previous seven days; however, the resident had at least one continent void; or always incontinent defined as the resident having had no continent voids in the past seven days. Further review revealed an incontinent episode defined as any amount of urine sufficient to dampen undergarments, briefs or pads. Additionally, review revealed nursing staff and the physician were to identify (a resident's) risk factors for becoming incontinent or for worsening of recurrent incontinence, including. urinary tract infections (UTI's), and environmental factors including immobility or lack of access to toilet. Review of R25's medical record revealed the facility admitted the resident on 06/10/2022, with diagnoses including acute on chronic combined systolic and diastolic congestive heart failure (CHF); chronic kidney disease, stage 3; and hemiplegia and hemiparesis following cerebral infarction affecting the resident's left non-dominant side. Review of R25's Annual MDS assessment dated [DATE], revealed the facility assessed him with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Continued MDS review revealed under Section H, Bowel and Bladder, the facility assessed R25 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as frequently incontinent of both bladder and bowel. Further review of the MDS Assessments revealed no documented evidence the facility assessed R25 for his toileting hygiene under Section GG. Review of R25's Kardex (the nursing assistants' care plan) revealed information noting the resident as incontinent of bowel and bladder. Further Kardex review revealed the expected intervention included to check and change R25 on rounds, upon request and as needed. Review of R25's clinical Physician's orders revealed an order for R25 to receive furosemide (a diuretic) 80 milligrams (mgs) daily for his CHF. Observation of R25 on 03/12/2025 at 9:42 AM revealed the resident was wearing a watch which he referenced for telling time. Continued observation revealed R25 also had a clock in sight from of the head of his bed. During interview with R25 on 03/12/2025 at 8:33 AM, he stated he was concerned about the quality of the agency staff used at the facility. R25 said he felt agency staff did not really do their job, at night mostly. He reported last night it took two hours to get somebody in here after he called out that he was wet, and that happened two different times. R25 stated he called out for assistance at about 10:00 PM and she (the aide) did not respond until nearly midnight. He said he called out again at around 2:00 AM; however, no staff responded until about 4:00 AM. R25 reported in both instances he was aware of the time because there was a clock on the wall straight ahead of him and he also looked at his watch. He explained he was forced to lay in bed wet during those hours and it made him feel miserable. R25 stated staff knew he took diuretic medication and therefore he emptied his bladder more frequently. He stated he felt agency staff just did not care as much because they would not be back at work the next day. The resident said night staff were more a problem than during the day, although sometimes it was on days also. R25 stated there were some days when people called off and the facility just had to use agency staff. He reported he estimated he saw agency aides at least four nights per week on average. R25 stated the Administrator and Director of Nursing (DON) had told him they were trying to get regular staff hired. During interview with Certified Nursing Assistant (CNA) 8 he stated staff should round on residents every two hours. He stated some residents called out, others might not be able to, so the expectation was to round every two hours. The CNA said there should not be a reason for staff to delay a resident's incontinence care unless an emergency was happening elsewhere. He reported the reason not delaying a resident's incontinence care was because that was less time spent wet or soiled, and less chance of skin breakdown or urinary tract infection (UTI). CNA 8 stated he usually cared for 12 to 15 residents on a shift at the facility and was able to get his work done with that ratio. He said most staffing agencies wanted seasoned nursing assistants, so the expectation was that agency staff could walk in and be ready to work. The CNA further stated he had not received a specific orientation to the workings of the facility; however, could rely on staff employed there. He additionally stated he based the residents' care on the Kardex which were consistently up to date at the facility. During interview with CNA 10 on 03/12/2025 at 2:34 PM, she stated she was responsible for six resident rooms, and that could be providing care for as many as 12 residents. She stated for incontinence care, the expectation was to check and change residents every two hours. The CNA said some residents should be checked more often if they were known to void more frequently, for example, if they were on Lasix (a diuretic medication). She reported staff went by the residents' Kardex which were kept on the inside of each closet door to know what each resident's care needs were. CNA 10 explained staff should be able to keep residents clean and dry, and the residents should not have to wait two (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Richwood Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 Richwood Way LA Grange, KY 40031	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours to receive care if they needed it. She stated if she was having to work alone to care for all 12 rooms, she would not be able to keep up the way she did now. The CNA said however, she would still prioritize keeping her residents clean and dry. She further stated that was important to protect the residents' skin and prevent breakdown or UTI. During interview with CNA 7 on 03/13/2025 at 12:13 PM, she stated some agency staff were good, but some were not. She further stated some did not complete all the necessary care for residents and she had found residents wet when starting her shift. During telephone interview with CNA 11 on 03/12/2025 at 10:25 PM, she stated she worked for an agency and started coming to the facility a lot since December, and usually picked up a lot every week. She stated she floated all over the facility and said there were usually only three aides working on the three halls after 11:00 PM. The CNA reported the expectation was to check and change residents every two hours; however, some residents required extra checks as they voided more often, and so they were rounded on more often. CNA 11 explained she made extra checks as told, such as for a resident on every 15-minute checks. She stated other than emergencies, for the most part one aide on each hall was enough even with getting some residents up in the morning before day shift arrived. The CNA said it might depend on how fast you work, but you should be able to get the resident checks and changes done and keep residents dry with just one aide on each hall. She explained if you check the residents regularly, then most of the time they might be a little wet but not flooded, unless they were just prone to void more often and if so, they should be checked on more often. She reported there was no reason outside of an emergency that anybody should be soaked. The CNA stated if she was in a resident's room and saw a call light on, she would go answer the light, as it was sometimes about getting changed anyway. She said she tried to answer residents' call lights as soon as she could. CNA 11 further stated it was important to keep the residents clean and dry so they did not have skin breakdown, UTI's, yeast infections or even infections of a surgical wound. She additionally stated it would be upsetting to have to sit in feces or urine. During telephone interview with CNA 12 on 03/13/2025 at 1:37 AM, she stated had been a nursing assistant for 36 years, and currently worked for an agency. She stated she had not been to the facility for two to three years, and that day was only her second day on the assignment. The SRNA said the previous night she had been in one resident's room, and there had been no other call lights on when she entered that room. She reported however, when she exited that room, the call light was on in the next room and so she went in there. CNA 12 stated she thought it had been no more than 15 minutes from the time she entered the other resident's room. The CNA further stated they were expected to round on residents every two hours for continence care or more often if a resident put on their call light. During telephone interview with Licensed Practical Nurse (LPN) 11 on 03/12/2025 at 8:04 PM, she stated the expectation was for staff to round for toileting and check/change every two hours. She stated they usually had two aides on day shift, who had 11 residents each. The LPN said that was a good number and it was possible to keep up with that workload. She explained they passed on in shift report any changes in a resident's diuretic use to ensure staff were checking those residents more frequently. She stated there were fewer aides at night, and at 11:00 PM, they picked up more residents which be more like 15 or 16 residents. LPN 11 stated while there were fewer aides, there were fewer tasks to accomplish besides the checking and changing. She said there was no reason for a resident to be left wet for two hours, and there should not be a reason for a resident's call light to remain unanswered for two hours. The LPN reported it was important to keep residents clean and dry to protect their skin, that it was uncomfortable for a resident to be wet or soiled, and would also be a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignity issue. She stated she could tell the difference when working with or following agency staff. LPN 11 explained agency staff did not know the residents or their routines, so some tasks did not get done. She further stated she could tell the difference when following agency staff; however, said she could not say anything about residents being left wet because the day shift aides just take care of it and go on to the next task. During telephone interview with LPN 10 on 03/12/2025 at 9:38 PM, he stated he usually had three aides for the three wings on his unit. He stated on some nights that was doable, though some nights it was harder and just three aides was not enough. The LPN said the facility used agency staff now, although was working to hire their own staff. He reported keeping the residents dry could be challenging with more agency staff being used; however, the house supervisor was really good to help on the unit. He stated having more facility staff, rather than agency, would be a good thing. LPN 10 reported sometimes agency staff seemed unprepared for the work that was necessary, but there was no reason for a resident to be left wet for two hours after the called out. He stated it was important to keep residents clean and dry for their dignity, because nobody wanted to sit in urine and feces. The LPN said it was important to keep the residents dry to prevent skin breakdown, and with diabetic patients, skin integrity was even more important. He reported he tried to keep eye on the nursing assistants to ensure care was completed as required, looking at such things as how much trash was coming out of the residents' rooms and how much linen was being used. LPN 10 stated he followed up with the aides about whether residents had not voided, and to ensure they were reporting that. During interview with Unit Manager (UM) 1 on 03/13/2025 at 9:50 AM, she stated they did use agency staff, but had recently hired quite a few nurses and aides. She stated they used less agency now than even a month ago. UM 1 reported agency staff received an orientation packet, and she showed them around the unit, connected them with a peer for resource, and showed them the resident Kardexes that were kept in the closets. She said the Kardexes were updated daily or as needed. The UM stated the expectation was for staff to be at least checking residents who were prone to incontinence every two hours. She further stated there was no reason for a resident to ever be left wet, and the aides and nurses should pass along in report any changes to a resident's toileting needs. During interview with Nurse Practitioner (NP) 1 on 03/13/2025 at 11:51 AM, she stated patients told her they could not wait for regular staff to get back, that they loved their own people. She stated she noticed everywhere she worked that having to use agency staff had the good point of having staff available in the building; however, those staff did not know the residents like the facility staff did. During interview with the DON on 03/13/2025 at 4:06 PM, she stated her expectation was for the checking and changing of residents to occur every two hours around the clock. She said some residents who needed checking and changing were cognitively intact, and staff must still check those residents who retained the option to refuse that care. The DON stated the aide should report any refusals to the nurse who should document that information. She reported she expected staff to respond to residents' call lights in a timely manner, for example, if going to a room and the next door light came on, she expected staff to communicate to the resident with your aide is already next door and will be here as soon as she is done. In continued interview on 03/13/2025 at 4:06 PM, the DON stated they strived to have two aides on the memory care unit and three on each of the other units from 11:00 PM to 7:00 AM. The DON said in her experience you could have three people on the hall, and the less you had the better the work gets done. She stated the only reasons for a resident being left wet would be if they refused or staff (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were not doing their job. The DON explained resident care should take precedence over other tasks, the residents should be fed, clean and comfortable. She further stated continence care was important for the residents' comfort and it was especially a huge dignity issue, as the residents had been continent since they were small children. The DON additionally said continence care was also important for protecting the residents' skin integrity. During interview with the Administrator on 03/13/2025 at 4:53 PM, he stated prior to coming to the facility he had not dealt with agency staff. The Administrator stated he depended on the DON for assessing and alerting him of staffing needs. He reported having a ton of agency staff made continuity of care for residents difficult, while their own staff got to know the residents and had a personal relationship with the residents. The Administrator said it was more effective to hold your own staff accountable; and he was about coaching staff to be the best they can be. He stated he could not do that as well with people who were only there for a day or two. The Administrator reported he deferred to the DON regarding staffing and felt her assessment of staff was that the numbers were sufficient, and he felt residents should be able to get the care they needed. He further stated resident care was important in residents having good quality of life and a homelike environment and that continence care was important to prevent infections, thus failing to do that could create harm. The Administrator additionally said continence care was also important for maintaining the residents' dignity. 2. Review of R259's admission Record revealed the facility admitted the resident on 03/03/2025, with diagnoses which included metabolic encephalopathy, muscle weakness, dysphagia, cognitive communication deficit, and diabetes. Review of the Comprehensive Care Plan (CCP) for R259 revealed on 03/07/2025, the facility identified a care plan for the resident as at risk for further Activities of Daily Living (ADL) decline. Per review of the ADL care plan, the facility also assessed R259 to require assistance related to impaired cognition, weakness, acute illness, and impaired mobility. Review of the CCP further revealed the facility assessed R259 as requiring assistance of one (1) with eating. Review of the Occupational Therapy (OT) Evaluation dated 03/03/2025, for R259 revealed OT assessed the resident as requiring moderate assistance with self-feeding. Review of R259's Speech Therapy (ST) Evaluation dated 03/04/2025, revealed ST assessed the resident as having a severe cognitive communication impairment characterized by difficulty with memory, problem solving, and executive functioning. Review of R259's Eating Task revealed the facility provided set up assistance for the resident for all three (3) meals on 03/07/2025, 03/09/2025, 03/10/2025, and 03/12/2025. Further review revealed the facility assessed R259 as independent with meals on 03/08/2025 at lunch (and set up assistance with the other two (2) meals on 03/08/2025), and as independent on 03/11/2025 with all three (3) meals. Review of R259's Meal Intake documentation revealed the facility noted the resident to have eaten 0-25% of her meal on 03/04/2025 at lunch and 26%-50% of her breakfast and dinner meals on 03/04/2025 and 03/11/2025 for all meals. Observation on 03/11/2025 at 8:50 AM, revealed R259 sitting in a wheelchair eating breakfast alone in her room. Further observation revealed 25% of meal eaten and milk spilled, covering dining tray. Continued observation revealed R259 had a slight tremor to her hand and had difficulty getting the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	glass to her mouth. Additionally, food was noted to be spilled on R259 ' s shirt. Observation, on 03/12/2025 at 1:18 PM, revealed R259 sitting in a wheelchair alone in her room eating lunch. Further observation revealed lids on two (2) bowls on tray. Continued observation revealed R259 removed the lid from the pudding with a shaky hand causing the bowl to shake while opening the lid. Observation, on 03/13/2025 at 8:50 AM, revealed R259 sitting in her wheelchair in her room eating breakfast alone. During an interview, on 03/11/2025 at 8:50 AM, R259 stated she was new to the facility and stated she hated to ask for help. During an interview, on 03/13/2025 at 10:36 AM, the Minimum Data Set (MDS) nurse stated she wrote R259 ' s care plan based upon the therapy evaluation (eval) on admission, and R259 did require assistance with eating. She further stated it was important to follow the care plan to make sure the resident ' s needs were met and the CNA could not alter the care plan. She continued to state if a care plan change was needed, staff could discuss it with the nursing managers or the MDS nurse and the needed change could be discussed in the morning interdisciplinary meeting. During an interview, on 03/13/2025 at 12:02 PM, the Director of Nursing (DON) stated she does not usually write care plans but she expected staff to follow care plans because it was important to ensure residents received proper care.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, record review, and review of facility policy, the facility failed to ensure residents were free from accidents as possible for 1 of 33 sampled residents, (Resident (R)28).

The facility developed a care plan for R28's risk for falls which included an intervention for dycem (a nonstick material used to stabilize objects) to the resident's wheelchair on 11/08/2023. On 12/09/2024, R28 sustained a noninjury fall and the facility updated the resident's fall risk care plan on 12/09/2024, for staff to be educated to place dycem in her wheelchair. On 12/16/2024, R28 experienced another noninjury fall, and the facility updated R28's fall risk care plan on 12/17/2024, again with the intervention for staff to be educated on ensuring the dycem was in the resident's wheelchair.

The findings include:

Review of the facility's policy, Falls and Fall Risk, Managing revised March 2018, revealed staff were to identify interventions related to the resident's specific risks to try to prevent the resident from falling. Per review, risk factors included cognitive impairment and heart failure. Continued policy review revealed staff were to implement a resident-centered fall prevention plan to reduce specific risk factors of falls for each resident at risk or who had a history of falls. Further review of the policy revealed if interventions were successful in preventing falling, staff were to continue those interventions.

Review of the clinical record for R28 revealed the facility admitted the resident on 10/22/2021 and re-admitted the resident on 11/15/2021. Per review, R28's diagnoses included congestive heart failure, immobility syndrome, and weakness.

Review of R28's care plan dated 11/03/2021, revealed the facility identified the resident as at risk for falls and developed the care plan with an intervention for dycem to the wheelchair (w/c) on 11/08/2023. Per care plan review, staff were educated to place dycem in R28's w/c on 08/14/2024 and the care plan was revised on 12/09/2024 and 12/17/2024, with the intervention for staff education regarding placing dycem to the resident's w/c.

Review of the progress note dated 12/09/2024, revealed R28 sat on the ground beside her w/c in her bathroom. Review of the progress note dated 12/16/2024, revealed staff found R28 on the floor beside her bed and an intervention was noted to evaluate chair and add dycem.

Review of the Speech Therapy Medicare SLP Evaluation and Plan of Treatment for R28 dated 12/09/2024, revealed the therapist assessed the resident to have a St. Louis University Mental Status (SLUMS examination score of one out of 30, indicating the resident's level of cognition was severe .and (the resident was) at risk for falls.

Review of the facility's, Record of In-Service Training dated 08/14 (no year noted) revealed the Infection Preventionist (IP), also the facility's Quality Assurance (QA) staff person, trained staff to ensure the dycem was in (R28's) w/c. Review of the facility Class Attendance Record dated 12/17 (no year noted) revealed staff signatures documented. Continued review of the Class Attendance Record revealed an attached Google search printout for dycem info for wheelchairs which noted it was ideal

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for adhering cushions and inserts to wheelchairs, and was non-slip. Observation of R28 on 03/11/2025 at 10:42 AM, revealed the resident sitting up in a w/c near the nurse's station. In interview on 03/13/2025 at 9:46 AM, the Physical Therapy Assistant (PTA) stated R28 was able to self-propel in her w/c; however, was not able to stand on her own. She stated R28 had sustained falls trying to take herself to the bathroom. In interview on 03/13/2025 at 11:59 AM and 03/13/2025 at 2:23 PM, the Director of Nursing (DON) stated residents' falls were discussed in the facility's morning meeting the day following the fall, for the root cause analysis (RCA) of the fall. She stated when R28 fell on [DATE], the fall was reviewed in the morning meeting on 11/14/2024. The DON reported during that meeting they reviewed R28's previous interventions, which included dycem to her w/c (however, review of the care plan revealed the current intervention for dycem to the resident's w/c was dated 11/08/2023). She said R28 experienced a fall on 12/16/2024, and the resident was referred to therapy on 12/17/2024. The DON further stated therapy added dycem to the resident's w/c as an intervention on 12/17/2024. In additional interview on 03/13/2024 at 3:49 PM, the DON stated R28 was throwing the dycem (in her w/c) away, which had been discovered during the facility's investigation. She reported the dycem was made of silicone and helped keep things from sliding. The DON further stated the IP checked to ensure residents' safety interventions were in place. In interview on 03/13/2025 at 3:59 PM and 03/13/2025 at 4:07 PM, the IP/QA stated she was responsible for QA at the facility. She stated as part of QA, she conducted weekly visual audits throughout the facility; however, did not record (document) her audits. The IP/QA said her audits included making sure the dycem (for R28) was in her w/c. She reported she had not found R28's dycem missing during her audits, but R28 had thrown the dycem away at one point. The IP/QA further stated she educated staff to place the dycem in R28's w/c when the dycem was missing. She additionally stated she conducted that education once; however, could not recall when she conducted the education. In an additional interview on 03/13/2025 at 4:44 PM, The IP/QA stated she could not find her training logs for the staff education provided on 12/09/2024, regarding placing R28's dycem in her w/c. She reported she should not have had to educate staff more than once on that subject (to place the dycem in the w/c). The IP/QA further stated the purpose of the staff education was to ensure the dycem was where it needed to be at all times, because if the dycem was not in place, R28 could fall again. In interview on 03/13/2025 at 4:49 PM, the Administrator stated he participated in the facility's morning meetings where they discussed incidents and any root causes. He stated his role was to find the nurses the resources they needed to take care of the residents the best they can. The Administrator said he did not recall any discussions related to R28's falls or regarding if the dycem was not in her w/c. He reported he did not know the reason staff were educated for the dycem to be in R28's w/c on three different occasions. The Administrator stated he deferred to the nursing department to deal with that. He further stated he was not familiar with dycem and could not say what could be a potential issue if the dycem was not in place. The Administrator additionally stated he expected residents' falls interventions be in place as required.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents requiring respiratory care were provided such care consistent with professional standards of practice. Observation on 03/11/2025 and 03/12/2025 revealed R13's nasal cannula was not bagged while not in use. The findings include: Review of the facility's policy, Receipt and Storage of Supplies and Equipment, revised November 2009, revealed all supplies and equipment must be stored in accordance with the manufacturer's recommendations. Review of R13's admission Record revealed the facility admitted the resident on 12/10/2016, with diagnoses which included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and pulmonary hypertension due to left heart disease. Review of R13's Physician Orders revealed an order dated 01/30/2025, for oxygen at two (2) liters per minute (LPM) per nasal cannula to keep the resident's oxygen saturation above 90%. Review of R13's Comprehensive Care Plan (CCP) dated 02/28/2025, revealed the facility care planned the resident as at risk for respiratory complications related to CHF, COPD, and chronic respiratory failure with hypoxia with oxygen per orders. Further review revealed the facility developed interventions for R13's oxygen therapy and for staff to follow (the facility's) infection control protocol for universal/standard precautions. Observation on 03/11/2025 at 8:35 AM, revealed R13 eating breakfast while wearing her oxygen per nasal cannula which was attached to an oxygen concentrator. Further observation revealed a nasal cannula attached to the portable oxygen tank on R13's wheelchair which was not bagged and was hanging off the wheelchair. Observation on 03/12/2025 at 1:20 PM, revealed R13 lying on her bed with eyes closed with oxygen on per nasal cannula that was attached to the concentrator. Further observation revealed the nasal cannula attached to R13's portable oxygen tank on her wheelchair was wrapped around the wheelchair handle and was not stored in a bag. During an interview on 03/11/2025 at 8:35 AM, R13 stated she used oxygen all the time and had pneumonia last month. During an interview on 03/13/2025 at 10:05 AM, with the Infection Preventionist (IP), she stated the floor nurse or respiratory nurse should change the resident's oxygen tubing (nasal cannula) weekly. She reported the oxygen tubing (nasal cannula) should always be stored in a bag when not in use to prevent infection and keep it from getting germs. The IP said the facility placed bags in all rooms where residents had oxygen for the purpose of staff storing their nasal cannula's in when not in use. She further stated if nasal cannula's were left unbagged, germs could get on the tubing and get into the resident's lungs which was very unsanitary.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on observation, interview, record review, and facility policy review, the facility failed to ensure performance review evaluations were completed for every Certified Nursing Assistant (CNA) at least once every 12 months for 4 out of 4 CNA's personnel records reviewed, CNA 21, CNA 22, CNA 23, and CNA 24. The findings include: Review of the facility policy titled, Staffing, Sufficient and Competent Nursing, revised August 2022, revealed Competency was defined as, a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Continued review revealed the policy stated, Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that gaps in education are identified and addressed. Further policy review revealed tracking or mechanisms are in place to evaluate effectiveness of training. Review of the facility policy titled, Performance Evaluations undated, revealed, The job performance of each employee shall be reviewed and evaluated at least annually. Review of CNA 21's personnel file revealed a hire date of 08/17/2022. Continued review revealed CNA 21 completed 8.25 hours of annual online Relias training for healthcare organizations and eight hours in person classroom training with skill assessments/checkoffs for the timeframe of 08/17/2023 through 08/17/2024. Further review revealed however, no documented evidence of a performance evaluation during that 12-month period. Review of CNA 22's personnel file revealed a hire date of 08/03/2023. Continued review revealed CNA 22 completed 9.75 hours of annual online Relias training for healthcare organizations and eight hours in person classroom training with skill assessments/checkoffs for the timeframe of 08/03/2023 through 08/03/2024. Review further revealed however, no documented evidence of a performance evaluation during that 12-month period. Review of CNA 23's personnel file revealed a hire date of 12/04/2023. Continued review revealed CNA 23 completed 6.5 hours of annual online Relias training for healthcare organizations and eight hours in person classroom training with skill assessments/checkoffs during the timeframe of 12/04/2023 through 12/4/2024. Further review revealed however, there was no documented evidence of a performance evaluation during that 12-month period. Review of CNA 24's personnel file revealed a hire date of 01/20/2021. Continued review revealed CNA 24 completed 14.25 hours of annual online Relias training for healthcare organizations for the timeframe of 01/20/2024 through 01/20/2025. Additional review revealed however, no documented evidence of a performance evaluation during that 12-month period. In interview with the Director of Nursing (DON) on 03/13/2025 at 4:31 PM stated, Every department director is responsible for annual staff performance reviews, I am responsible for nurses and CNA reviews. She said the purpose of the performance evaluation was to look at how staff want to grow and what their goals were. The DON explained previous overall job satisfaction could be assessed through the performance evaluations. She stated a potential outcome (if performance evaluations) were not performed could be morale might be affected and staff members might not get a raise. The DON reported, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185438	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richwood Nursing & Rehab	1012 Richwood Way LA Grange, KY 40031

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA training is determined by regulation, that is 12 hours annually that results and assists in staff performance. She said corporate could add training as necessary. The DON stated possible additions could be situational, for example, customer assistance which could assist in growth. She said, We also provide competency skills checkoffs. We look at needs or complaints for training opportunities. The DON stated she was aware of regulation regarding performance evaluation; however, would have to ask Human Resources (HR) for the specifics. She reported last year, sometime, the facility switched to Workday an electronic system for evaluations and stopped doing handwritten performance evaluations for staff. The DON stated, Typically, the date of hire is used for the staff annual performance date, but in October, it will not be the date of hire anymore. She explained all annual evaluations would be completed every October afterwards. The DON stated was not aware CNA evaluations had not been completed. She further stated when she was completing performance evaluations handwritten, she would have HR provide a monthly list of nurses and CNA's. In interview with the Administrator on 03/13/2025 at 4:50 PM stated, The department heads are responsible for annual staff performance reviews. He said the purpose of performance evaluations for staff was for equal parts to assess their role and make sure proper training had occurred. The Administrator reported the purpose was also to reward those who deserved it with a pay raise. He stated a potential outcome if performance reviews were not done in a timely manner was not catching training needs that should be done. The Administrator further stated, leadership and the individual need to be on the same page. If staff is not on the same page, it could cause dysfunction.