Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING _____ B. WING _____	R-C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments An unannounced on-site Revisit Survey was initiated on 06/07/2024 and concluded on 06/07/2024. It was determined the facility had achieved substantial compliance on 05/14/2024 as alleged. Survey Dates: 06/07/2024 Survey Census: 66 Sample Size: 2 However, an Abbreviated survey was conducted on 06/07/2024. The facility was found to not to be in substantial compliance with 902 KAR 20:036 4(1)(g)1-7. A deficiency was related to KY00042487 at P0215.	{P 000}		

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

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P 000	Initial Comments AMENDED An unannounced on-site Complaint survey and relicensure was concluded on 04/17/2024. The facility was found not to be in substantial compliance with 902 KAR 20:036 4(1)(a)1-4, and 902 KAR 20:036 4(3)(c)4a-m (P0330). Survey Dates: 04/11/2024-04/17/2024 Survey Census: 77 Sample Size: 12 Supplemental Residents: zero No deficiencies were issued related to KY00039377. No deficiencies were issued related to KY00039494. No deficiencies were issued related to KY00042270. A deficiency was related to KY00038467 at P0185.	P 000		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility.	P 185	All residents have the potential to be affected by the cited deficiency. Resident R4 no longer resides at the facility. The Director of Health Services and/or designee conducted an audit of current residents existing assessments and updated their service plans as needed to include the necessary provisions of nursing services to meet the residents individualized basic health care needs in accordance with P 185 902 KAR 20:036 4 (1) (a) 1-4 Section 4. Provision of Services.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 04/29/24

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P 185	Continued From page 1 This requirement is not met as evidenced by: The facility failed to provide basic health and health related services that included supervision and monitoring of the resident to assure that the resident's health care needs were met for one of 12 sampled residents, Resident (R4). The findings include: Review of "Resident Face Sheet" revealed the facility admitted Resident (R4) on 01/12/2022 with diagnoses that included psychophysiologic insomnia, vascular dementia with behavioral disturbance and generalized anxiety order. Review of "Resident Progress Notes" for R4 revealed the note, dated 01/12/2022 at 7:54 PM, read: "rsd [Resident] arrived at facility at 11:07 AM with [family member (F2) and F3]. Rsd [Resident] was transported by car. Rsd [Resident] came from home. rsd [Resident] has been diagnosed with memory loss, heart failure, and injury rib d/t [due to] fall ...rsd [Resident] very anxious and exit seeking since F2 left." Further review of the "Observation Detail List Report: Resident Rights" revealed "Planning and implementing care. The resident has the right to be informed of, and participate in, his or her	P 185	Going forward, residents will be assessed utilizing the newly implemented Kentucky Functional Needs Assessment and Service Plans for all newly admitted residents, residents experiencing a change of condition/hospitalization. Every resident will be assessed no less than every six months as indicated within the Kentucky regulation referencing the Functional Needs Assessment. The Clinical Campus Support provided re-education to the Director of Health Services regarding our policy and procedure regarding utilization of our Functional Needs Assessment and Service plan to determine eligibility for admission and continued stay and development of Service Planning based on the residents individualized basic health care needs. The Director of Health Services and/or designated individual will perform random audits of five resident records, four times per week, for a period of 5 weeks, then 5 resident records, three times per week, for 5 weeks, then five resident records, 2 times per week, for a period of 5 weeks. The above-mentioned audits will be reviewed by the campus' interdisciplinary team during their monthly QAPI meeting to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. Completion date of 05/14/2024.	05/14/2024

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P 185	Continued From page 2	P 185		

treatment, including: The right to be informed, in advance, of changes to the plan of care, the right to receive the services and/or items included in the plan of care, and the right to see the care plan, including the right to sign after changes to the plan of care." Additional "Resident Rights" of the facility's residents were "Safe environment. The resident has a right to a safe, clean, comfortable, and Homelike environment, including but not limited to receiving treatment and supports for daily living safely."

Review of "Resident Progress Notes" for R4 revealed the note, dated 03/15/2022 at 9:30 PM, written by Licensed Practical Nurse (LPN3) was "Recorded as Late Entry on 03/16/2022 4:05 AM" and read: "Nurse knocked, walked into residents [sic] room to give night medications. Resident laying in bed, eyes open. Resident tells nurse to get out. Nurse exits the room, resident follows behind. The aide and another resident was [sic] in the hallway. Resident begins to yell, swinging arms. Resident continued to yell, multiple residents began to come out of their rooms. Resident started yelling at another resident, aide got into them. Both residents went back in their room. A couple minutes later, resident walks back into the hallway. The aide and current resident was [sic] still in hallway at this time, and resident became combative and physical. Resident did go back to room afterward. Will continue to monitor."

Review of "Physician Order Report" revealed all of the medications prescribed by R4's providers for administration on 03/15/2022 were ordered to be given before or at 7:00 PM each day; melatonin for insomnia, trazadone for anxiety, quetiapine, and buspirone for anxiety.

Review of "Medications Administration History:

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P 185	Continued From page 3 03/13/2022 - 03/30/2022" revealed the following medications were ordered to be administered given at 7:00 PM but were not given by LPN 3. Attempt to interview LPN 3 on 04/17/2024 at 11:16 AM revealed the telephone number the facility provided for LPN 3 was no longer in service. Review of "Resident Progress Notes" for R4 revealed the note, dated 03/29/2022 at 8:10 AM, was written by Registered Nurse (RN1) and read: "At approximately 0740 [F2] called the campus stating [R4] was reporting that he was having difficulty breathing. [F2] requested this writer check on resident. Upon entering resident's room blood was noted throughout the apartment and resident [R4 was] sitting on [his] couch with blood on clothing, shoes, and head. A large swollen area was noted to left forehead with a small amount of blood oozing from an apparent laceration. Resident's glasses noted to have lens missing on left side. Lens found intact on the floor. This writer instructed [Resident Care Associate] RCA and [Certified Medication Technician] CMT to call 911. Light pressure was applied to swelling and laceration. Resident was alert to self. He responded to his name being called and was able to state his last name. Without verbal stimuli resident would close his eyes. His respirations were even and unlabored. He responded quickly to his name being called. [Emergency Medical Services] EMS arrived at approximately 0750 and assisted resident to stretcher. Resident's clothing was cut by EMS and this writer noted a large skin tear to left arm near elbow. Resident transported to [Emergency Room] ER for further evaluation. [F2 and F3] notified of the event and resident being sent to ER. Resident departed campus with EMS at	P 185		

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P 185	Continued From page 4 approximately 0803." Further review of "Resident Progress Notes" for R4 revealed the note, dated 03/31/2022 at 3:21 PM, was written by the former Director of Health Services [DHS] and read: "IDT [Interdisciplinary Team] reviewed notes of recent unwitnessed fall that resulted in lacerations to head, arm, and broken ribs. Resident was transferred out via EMS and admitted to [acute care] ...Interviews performed with staff to assess how this can be prevented in future. Plan to assist in preventing future occurrences on [the memory care unit] include: 2 hour rounding at night when residents in room, Check off sheet to be performed when rounding. Walking rounds [periodic checks on residents by staff] with oncoming shifts to ensure that all residents are safe prior to leaving shift. Staff to immediately begin performing 2 hour rounding/check off sheet. Staff to immediately begin walking rounds. Staff educated by ED [Executive Director] to perform these on 03/30/2022." During an interview, on 04/16/2024 at 10:50 AM, Certified Resident Medication Assistant (CRMA1) stated during walking rounds she expected aides to look at each resident and offer assistance. CRMA1 stated she did not do walking rounds and "typically the aides do that." During an interview, on 04/16/2024 at 11:00 AM, CRMA2 stated she recalled R4 and stated "he paced non-stop. It was an all-day thing." CMRA2 stated R4 could get agitated at night, but she was able to redirect him. During an interview, on 04/16/2023 at 11:13 AM, LPN4 stated when she came on shift at the facility she would get report from the nurse and	P 185		

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P 185	Continued From page 5 count the [controlled medication substances in the] cart. LPN4 stated the facility aides got report and did walking rounds, which meant going in and putting eyes on all the residents to ensure the residents were "clean, dry and safe." During an interview, on 04/12/2024 at 2:42 PM, LPN6 stated she worked at the facility about six months, and she left employment at the facility because she would be the sole nurse on the floor at night. LPN6 stated she felt like the facility had unsafe working conditions because of the way they were admitting residents who needed a higher level of care than the facility provided. During further interview LPN6 stated she recalled R4, and that he had issues with the Resident Care Associates (RCAs) when they would take his blood pressure. LPN6 stated on time she saw R4 throw the blood pressure device at the RCA. LPN6 stated family would tell staff to just put R4 in his room and "do not check on him on night shift if he does not come out because they try to keep him calm." During an interview, on 04/12/2024 at 3:33 PM, LPN5 stated she worked night shift at the facility, had been there about three years, and when she began working at the facility there were no two-hour checks on the memory care residents. LPN5 stated two-hour checks on residents came into effect after R4 fell. LPN5 stated staff had to start writing down their two-hour checks after R4 fell in the facility. LPN5 stated R4's family did not say to her, but it was passed on in report, to not go in R4's room once he was asleep in his bed and to leave him alone until he came out. LPN5 stated whenever staff would go in R4's room at night he would scream and say "you woke my [spouse]." R4 would ask staff what they were doing in his room and tell staff to "get out of	P 185		

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P 185	Continued From page 6 here." LPN5 stated she did not believe the memory care unit was the right type of setting for R4, and thought he needed a higher level of care. LPN5 stated R4 would be fine one minute and agitated another. She stated R4 ran another nurse off the unit after he smacked her phone out of her hand and had her backed up in the corner. LPN5 stated there were lots of instances when R4 would go up to another resident and get physical and she would separate the residents. During further interview, LPN5 stated on the morning of R4's fall she left the facility after finishing her night shift around 7:30 AM, and then around 8:00 AM the former Director of Health Services (fDHS) called her to follow up on what time she had checked on R4. LPN5 stated she told the fDHS the last time she had seen him was at 11:00 PM when he went to bed. During an interview, on 04/13/2024 at 12:45 PM, CRMA3 stated she came to work on the day of R4's injury and had heard from RN1 that F2 had called the facility because F2 had heard R4 making weird sounds over the "speaker box" in R4's room. CRMA3 recalled seeing R4 sitting on the couch that morning, and stated she saw blood "everywhere" in R4's room. CRMA3 stated EMS came quickly to the facility to transport R4 to the hospital ER. During an interview, on 04/14/2024 at 3:30 PM, Certified Registered Care Associate (CRCA) 2 stated she worked the night R4 was injured at the facility and recalled he got his medications around 9:30 PM that evening. CRCA2 stated she had helped him to his room at bedtime and that was the last she saw of him that night. CRCA2 stated she had come to work at the facility with a long-term care background where two-hour	P 185		

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checks were routinely done on residents. When CRCA2 asked the fDHS about two-hour checks, CRCA2 stated the fDHS stated "we do not do rounds like that. We are not a nursing home." CRCA2 stated she was told by the fDHS, and she would get in report from other CRCA's, that R4 was not to be bothered during the night and the family had a camera in the room. CRCA2 stated she asked the fDHS for documentation of this and that she wanted "to see it in writing." CRCA2 stated there were no instructions for when staff were allowed to go into R4's room once morning came. CRCA2 stated she did not agree with this practice and would put her ear to R4's door and listen. CRCA2 stated there were no walking rounds until R4's accident, and afterwards staff had to do two-hour rounding on residents and had to sign off that they were completed. CRCA2 stated she would have wanted someone checking on her mom or dad during the night, but not to "beat the door down and yell." CRCA2 stated "you have got to check on them and put eyes on them."

During an interview, on 04/12/2024 at 4:29 PM, the fDHS stated she recalled R4 and had been familiar with his care. The fDHS stated R4's risk factors for having an accident were that he was mobile, and he moved around really well. The fDHS stated R4 had to be monitored for where he went and what he was doing and watched because R4 would get agitated with other staff or residents. Her expectation of the facility's staff for supervision of the residents at night was for staff to "round on patients every two hours" which meant a staff member was "popping their head in the resident's room to make sure the resident was ok" stated the fDHS. She recalled R4 had two different instances when he was especially confused at night, and R4 would get agitated and

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P 185	Continued From page 8 upset. During further interview, the fDHS stated there were conversations between her and F3 after one of R4's agitated events. The fDHS stated F3 told her "do not mess with R4" and stated F3 told her she wanted the facility staff to leave R4 alone once he went to bed until he emerged from his room, but she "did not put a note [about this in R4's electronic health record] right away." The fDHS stated "in that type of situation you try to keep the resident as safe as you can." The fDHS stated when R4 first came to the facility she thought he was in the appropriate level of care, but then there were meetings with the family and conversations with the psych APRN about different interventions for R4 like geripsych. The fDHS stated in the future, if anyone would ask that residents not be disturbed during the night, she would deny the family their request because she realized to not check on residents every two hours during the night was not appropriate for resident safety. During interview, on 04/12/2024 at 2:59 PM, RN1 stated on the morning of 03/29/2022 she answered a phone call to the facility from F2 who voiced concerns about R4, so RN1 went to R4's room. RN1 stated she found R4 in his room seated on his couch with no evidence of any major pain. RN1 stated she talked to him about basketball while she assessed him and tended to his injuries. RN1 stated she did not move him from his couch and got staff to call EMS and F2. RN1 stated there was nothing remarkable about R4 that was given in report the night before R4's fall. RN1 stated she could not remember if "walking rounds" were active at the time R4 fell. RN1 stated she did not remember when walking rounds started, but at the beginning of her	P 185		

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employment with the facility staff did not do walking rounds, and it seemed like walking rounds were started near the end of her employment in August 2022.

Review of the "Investigation Summary," dated 03/29/2022, revealed the "Timeline of event" noted, on 03/29/2022 at 7:40 AM, F2 contacted the facility to ask a staff member to go check on R4 due to them sensing a change in R4's condition "difficulty breathing" via a "drop in" camera in R4's room.

Further review of the "Investigation Summary" revealed the section "Summary of investigation" read: "Investigation consisted of witness statements of all employees who worked the evening and morning of the incident. During the early HS [nighttime sleeping] hours of 03/28/2022, [R4] had significant behaviors and became highly agitated with staff prior to entering his room at approximately 9:30 PM to 'cool down.' Per family request, staff did not enter [R4's] room during the HS hours, but they did make many passes by his closed door throughout the night. Staff members present on the night shift of 03/28/2022 to 03/29/2022 were interviewed and stated they did not hear anything out of the ordinary. Based on an investigation of this event, the best root cause of this falls [sic] the facility can determine is [R4] was completing routine ADL [Activities of Daily Living] evening care when he sustained a fall. [R4] assisted himself from the floor after the fall and continued to ambulate throughout his room through the evening. Family/staff checked on the resident in the morning hours of 03/29/2022 and found him sitting on his couch with the above-mentioned injuries. The resident was immediately transferred to the hospital via EMS for evaluation

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and treatment. Family expressed extreme appreciation to staff for the residents [sic] care during his stay at the facility."

During an interview, on 04/11/2024 at 4:28 PM, F2 stated in R4's room at the facility "there was an echo thing" [remote visual-audio monitoring device] placed where F2 could see R4 and check on him throughout the day. F2 stated the facility "knew we had that echo thing." F2 stated on the morning of 03/29/2022 she checked on R4 at 7:30 AM and she could see R4 in his room. R4 was sitting on the sofa, and she could see his injury, stated F2. She called the facility, and F2 stated she could hear over the "echo thing" that someone had come into R4's room and screamed "what have you done!" F2 stated she could see the staff member "tiptoeing around blood" and then F2 heard the staff member call for help. F2 stated she called the Executive Director, and then she saw him come in R4's room and then turned the "echo machine off." F2 stated she could no longer see or hear R4 and did not know what had happened. F2 stated she then called F3 who went to the facility. F2 stated the facility told F3 staff did not check on R4 during the previous night.

During further interview, on 04/13/2024 at 12:12 PM, F2 stated she had told the facility not to go into R4's room at 10:30 PM to give him pills that were late, but that she "absolutely never" told the facility not to check on R4 during the night. F2 stated R4 needed staff to check on him every two hours.

During an interview, on 04/14/2024 at 3:24 PM, F3 stated she had discussed with the facility and had an understanding that staff did rounds to check on patients during the night. F3 stated she

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P 185	Continued From page 11 and F2 did not want R4 woken up at night when he was sleeping because that caused R4 to get angry. F3 stated she did expect staff to check on R4 every two hours, and during the night she expected staff to ensure R4 "was ok" by opening the door and checking on him. During an interview, on 04/15/2024 at 1:10 PM, the psychiatric Advanced Practice Registered Nurse (psych APRN) stated she did not recall R4, but when she read her note about him it looked like one of her biggest concerns about R4 was he seemed to be sedated per her note, and she "was concerned he was fatigued and restless at the same time." The psych APRN stated "per my note I did not want to give too much sedating medication," and at some point she stopped going to the facility because she changed employers. The psych APRN stated she usually only saw facility residents one time per month and had only one visit note on R4 which was dated 02/28/2022. The psych APRN also stated she may have been off work sometime in March of 2022, which could explain why she only had one visit note on R4. During an interview, on 04/17/2024 at 2:49 PM, the Medical Advisor stated he could not recall R4, and he expected staff to take care of the facility's residents. During an interview, on 04/13/2024 at 1:45 PM the Director of Health Services (DHS) stated it was the request of R4's family, that once R4 was in bed for the evening, staff was not to go into R4's room until he emerged. Although her expectation of staff during rounding was to lay "eyes on each resident," the DHS stated if the family or resident was not agreeable to staff entering the resident's room, rounding could be	P 185		

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	101366	A. BUILDING _____ B. WING _____	C 04/17/2024

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done in the hallway by staff listening and smelling at the resident's closed door.

During an interview, on 04/16/2023 at 11:53 AM, the DHS stated supervision of the facility's residents meant meeting their basic health care needs, which included medication administration, vitals taken if that was in their plan of care, and knowing what was going on with each resident day by day. The DHS stated residents were supervised for safety based on their baseline. The DHS stated, regarding communication to families about supervision of the facility's residents, that families were "aware of the setting" and the rooms were their apartments. If the facility knew a resident did not wish for staff to go in his or her room at night, and the facility did not have any reason to believe there was a safety issue, then staff did not go in that resident's room at night, stated the DHS. She also stated there was no set time frame for when staff could go back into a resident's room in the morning after staying out of their room at night, but "at any point if it is outside of someone's normal routine and they are not out of their room then staff would go check on them." The DHS stated rounding on the facility's memory care unit meant at the beginning of each shift staff got report of what occurred shift to shift and staff then went resident to resident to check and change each resident as needed. The DHS stated rounds were done during the night now, and she did not know when rounding on residents every two hours started or why rounding was changed, because she was not the DHS at the time.

During further interview, the DHS stated the facility was not a skilled setting and staff did not want to wake anybody up. When the DHS was asked if it was the facility's responsibility to keep

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P 185	Continued From page 13 residents safe, she stated she did not "think the regulation says that per se." When the DHS was asked if the facility kept R4 safe when he was injured there, she stated "at the time the facility was respecting the family's wishes." During an interview, on 04/16/2024 at 3:18 PM, the Director of Sales (DoS) stated she told families what differentiated this facility from others was that it was a "medical model" with a nurse on staff 24/7 to administer medications, assist residents with ADLs, and complete rounding every one-and-one-half to two hours, which meant someone was going to be checking in on each resident many times throughout day and night to see if residents needed any assistance. The DoS stated the assisted living (AL) side of the facility had apartment doors that could lock which kept others out of the apartments. The DoS stated nursing staff had master keys that would open all those AL doors if necessary. There were some residents who requested staff not come in their room at night and those residents had call lights they could use if needed, stated the DoS. Further interview revealed the DoS stated the memory care unit was different because, for safety reasons, the facility did not want those residents' doors to be locked. She stated a lot of times with residents who have Alzheimer's or dementia diagnoses, staff did not know what was going on behind a closed door. A memory care unit resident may have gotten up in the night, and the facility just wanted staff to "put eyes on those residents every one-and-one-half to two hours. That is what it should be," stated the DoS. When asked what she would tell family members who did not want staff to check on a resident during the night, the DoS stated because of	P 185		

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safety concerns, somebody was going to be checking on the resident during the night in case the resident had to get up and use restroom. She would also encourage family members to keep an open mind and allow nursing to do what they were supposed to do. She stated staff checked on residents for incontinence, especially at nighttime for those who may not wake up. The DoS stated those memory care unit residents needed to be checked on in case they were to get up and "had a wild hair and wanted to transfer from the bed to the recliner. Staff and family would want to know the resident made it to the recliner safely." If a family insisted on no check by staff of a resident during the night, the DoS stated she would have that refusal of nighttime two-hour checks "documented in the resident's care plan." The DoS stated she would also want to know that the facility's executive director, the DHS and the family had come to that agreement and would want that documented in an IDT progress note. Further, the DoS stated she was familiar with families who wanted to set up a camera in a resident's room, and that the facility had "to say no for Health Insurance Portability and Accountability Act (HIPPA) guidelines." She stated if the facility's Executive Director said it was "ok" for a family to set up a camera in a resident's room, "he should have it in writing."

During an interview, on 04/16/2024 at 4:10 PM, F3 stated she could not recall when the "echo" was first placed in R4's room but was certain it was before 03/15/2022 because LPN3 was "heard on the echo after casino night" when LPN3 came into R4's room and woke him up. F3 stated LPN3 was heard "on the monitor yelling to wake up [R4] to give him medications."

Review of the "Observation Detail List Report:

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P 185	Continued From page 15 Move In Agreement," dated 01/11/2022, revealed "Videotaping, photographing, audiotaping, recording, or monitoring of residents, facilities, or campus personnel [was] prohibited without prior written consent of the Executive Director." During an interview, on 04/16/2024 at 4:00 PM, the Executive Director stated he first learned R4's family had placed a monitoring device in R4's room on 03/29/2022 when F2 contacted the facility at 7:40 AM. The Executive Director stated the monitoring device was against facility policy, and if he had known the device was in R4's room, the ED "would have said no." Review of the "Investigation Summary," dated 03/29/2022, revealed the "Description of the incident" was R4 had an unwitnessed fall between 03/28/2022 at 9:30 PM and 03/29/2022 at 7:40 AM in his room. After providing first aid treatment and stabilization, the resident was transported via EMS to the hospital which indicated the fall resulted in nine broken ribs, a skin tear to his forearm, and a forehead laceration. Further review of the "Investigation Summary" revealed "Critical Factors "Key points Campus defense of situation" were "to decrease aggressive behaviors displayed by resident at nighttime, R4's POA [Power of Attorney] and IDT's plan of care was to allow resident to be by himself in his room for the evening. Clinical staff was not to go into R4's room until resident requested their help. This plan of care was followed by staff on the evening of 03/29/2022 into 03/29/2022." Review of "Service Plan 8.9.18" revealed the plan of care was R4 required supervision or escort. R4 needed someone to escort due to way finding, or	P 185		

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P 185	Continued From page 16 for safety or fall risk for mobility. R4's plan of care for transferring himself from one surface to another was staff were to encourage safety precautions. R4 required supervision, cues, and encouragement for hygiene and dressing. R4 needed reminders to get dressed, dress appropriately, and he needed assistance with clothing selection. R4's "service plan" scored R4 at a BIMS level of 9/15, indicating moderate cognitive impairment. Additionally, the "service plan" included an Elopement Risk review of R4 which indicated R4 exhibited periods of pacing, agitation or wandering toward an exit. During an interview, on 04/13/2024 at 1:50 PM the Executive Director stated R4's family was not educated on the risks of staff not checking on the resident from when he went to bed in his room at night until he emerged, and there had been no timeframe established of how long to leave R4 in his room before he emerged. Additionally, the Executive Director stated the health services offered to R4 were food, hygiene, and incontinence care. There were three staff members in the building on 03/29/2022 with one staff member assigned to the memory care unit where R4 resided, and in this situation stated the Executive Director, the facility was addressing R4's basic health needs by keeping R4 on a secured unit. R4 did not have toileting issues, was independent with his ADLs, and his medications would have already been given, so from 10:00 PM until 7:00 AM R4 was not relying on the health care facility to meet his health care needs, stated the Executive Director.	P 185		
P 330	902 KAR 20:036 4(3)(c)4a-m Section 4. Provision of Services	P 330		

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P 330	Continued From page 17 (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (c) Dietary services. 4. Food preparation and storage. a. There shall be at least a three (3) day supply of food to prepare well-balanced, palatable meals. b. Food shall be prepared with consideration for any individual dietary requirement. c. Modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician. d. At least three (3) meals per day shall be served with not more than a fifteen (15) hour span between the evening meal and breakfast. e. Between-meal snacks, including an evening snack before bedtime, shall be offered to all residents. f. Adjustments shall be made if medically contraindicated. g. Food shall be: (i) Prepared by methods that conserve nutritive value, flavor, and appearance; and (ii) Served at the proper temperature and in a form to meet individual needs. h. A file of tested recipes, adjusted to appropriate yield, shall be maintained. i. Food shall be cut, chopped, or ground to meet individual needs. j. If a resident refuses food served, substitutes shall be offered. k. All opened containers or leftover food items shall be covered and dated when refrigerated. l. Ice water shall be readily available to the residents at all times. m. Food services shall be provided in accordance with 902 KAR 45:005.	P 330	Although the campus recognizes that all residents have the potential to be affected by the cited deficiency, there were no identified adverse effects from the finding. The Dining Service Campus Support provided re-education to the kitchen staff regarding our policy and procedure regarding "Food Production Guidelines- Sanitation and Safety," safe and sanitary food handling during food production. The in-service includes serving of food at appropriate temperatures and recording of temperatures of both the food and the cooler temperatures on the "Food Temp and Cooler Log" until the new system called JOLT is installed that will assist with automatically recording both food and cooler temps thereby eliminating the need for physically recording temperatures within the "Food Temp and Cooler Log". Documented temps will be available and easily accessed and readily produceable via the JOLT software. The Executive Director and/or designee will perform random audits of the kitchen to ensure temperatures are recorded for food, refrigerator, freezer, and dishwasher temperature logs 4 times per week for 5 weeks, then 3 times per week for 5 weeks, then 2 times per week for 5 weeks to ensure ongoing compliance. The above-mentioned audits will be reviewed by the campus' interdisciplinary team during the monthly QAPI meeting to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. Completion date of 05/14/2024.	05 05/14/2024

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This requirement is not met as evidenced by:
The facility failed to ensure the residents food was served at the proper temperatures for 77 of 77 sampled residents.

The findings include:

Review of the facility's undated policy titled, "Food Production Guidelines-Sanitation and Safety," indicated safe and sanitary handling of food would be employed during food production. Food was to be served as soon after preparation as possible and was to be held at the following temperature[s]: Hold food - HOT =135 [degrees] Fahrenheit (F) or above. Hold food - COLD = 41 [degrees] F or below. Additionally, the policy indicated food prepared in advance must be heated to 165 [degrees] F or above before placing on the steam table.

Observation of the facility's kitchen, on 04/11/2024 at 10:05 AM, review of the three-ring binder containing the "Food Temp and Cooler Log" sheets revealed the log sheets were not completed for each day in February and April 2024. Of the 70 days during the period from 02/01/2024 through 04/10/2024, there were only 14 "Food Temp and Cooler Log" sheets in the three-ring binder. Of those 14 "Food Temp and Cooler Log" sheets, there were only five days when the "Food Temp and Cooler Log" sheets

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were fully completed, and nine days when the "Food Temp and Cooler Log" sheets were partially completed. On those six days in February 2024, and three days in April 2024 when the "Food Temp and Cooler Log" sheets were only partially completed, food storage and service temperatures were recorded for breakfast and lunch meals, but no food storage or service temperatures were recorded for any of the facility's dinner meals during those nine days in February 2024 and April 2024. There were no "Food Service and Cooler Log" sheets completed for the 61 remaining days in February 2024, March 2024, and April 2024.

Further review of the "Food Temp and Cooler Log" sheets revealed the bottom of each sheet read: ""DO NOT SERVE FOODS AT INAPPROPRIATE TEMPS"NOTIFY DEPT [department] MANAGER IF REGRIGERATOR >40 OR FREEZER >15."

During an interview, on 04/11/2024 at 10:15 AM, Campus Support Dining Services employee (CSDS) stated the "Food Temp and Cooler Log" sheets "were kind of out of order." The CSDS stated the company was in the process of converting to a remoted food and food storage temperature monitoring system. The new system would have sensors in the coolers and alarms if food storage temperatures fell below the acceptable range, and if food temperatures were not taken by a certain preset time, stated the CSDS. He also stated the three-ring binder used for manually recording food and food storage temperatures would no longer be needed once the new system was implemented.

During an interview, on 04/12/2024 at 5:09 PM, the Director of Food Services (DFS) stated the

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P 330	Continued From page 20 "Food Temp and Cooler Log" sheets stated the daily log sheets which were missing for February 2024 and March 2024 "should be in the [three-ring] binder unless they were stuck somewhere else." The DFS stated she had "an old cook who would put [the log sheets] in a folder to give to me later." The DFS stated it was the expectation that the "Food Temp and Cooler Log" sheets were filled out every day. During an interview, on 04/17/2024 at 9:03 AM, the Vice President of Culinary Services (VPCS) stated the new system would automate temperature taking so the facility would not be relying on staff to take and document food storage and food service temperatures. The VCPS also stated daily completion of the "Food Temp and Cooler Log" sheets mattered for safety because the risk of foodborne illness was greater if the food temperature logs were not filled out. During an interview, on 04/12/2024 at 5:00 PM, the CSDS stated it the DFS was on leave from work, and he was the DFS as of 04/01/2024. The CSDS stated it was the cook's responsibility to complete the "Food Temp and Cooler Log" sheets, and it was the DFS's responsibility to ensure the "Food Temp and Cooler Log" sheets were completed. The CSDS could not explain why there was no evidence that food storage or food service temperatures were taken and most of the "Food Temp and Cooler Log" sheets were not completed during March 2024. The CSDS stated the DFS on leave "may have filed" those "Food Temp and Cooler Log" sheets before they went on leave. The CSDS stated if food was not stored at the proper temperature the food could spoil, and if food was not served at the proper temperature foodborne illness could result. The CSDS stated if food was not hot enough when	P 330		

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P 330	Continued From page 21 served, the food was potentially unsafe. During an interview, on 04/16/2024 at 2:17 PM, the Executive Director stated the Director of Food Services (DFS) was on leave and was surprised when he learned from the Campus Support Dining Services employee that some of the "Food Temp and Cooler Log" sheets were not completed for each day in February and April 2024, and there were no "Food Temp and Cooler Log" sheets completed for any days in March 2024. The Executive Director stated he had discussed his expectations with the DFS before she went on leave, that she was not new to the job, and it was his expectation that the facility's policy was being followed. The Executive Director said the company was "forward thinking," and stated the new system planned for measuring food and food storage temperatures was one of the ways to alleviate mistakes in the kitchen. Additionally, the Executive Director stated the taking of food temperatures prior to serving it was part of the process to ensure properly prepared food.	P 330		

Eric Bryant