STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185461	A. BUILDING **01 - GLEN RIDGE HEALTH CAMPUS** B. WING _____	R **04/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN RIDGE HEALTH CAMPUS	**6415 CALM RIVER WAY** **LOUISVILLE, KY 40299**

(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) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable plan of correction and the revisit conducted on 04/25/2024, deficiencies were determined to be corrected effective 04/14/2024 as alleged, for the survey completed on 03/13/2024.	{K 000}		

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

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.

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	185461	A. BUILDING **01 - GLEN RIDGE HEALTH CAMPUS** B. WING _____	**03/13/2024**

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K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2006 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story, (2006), Type V (111), protected combustible construction with eight (8) smoke compartments and a complete automatic wet sprinkler system. A Life Safety Recertification Survey was initiated on 03/13/2024 and concluded on 03/13/2024, in accordance with 42 Code of Federal Regulations, Part 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Glen Ridge Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.90 (a) et seq. (Life Safety from Fire).	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		4/14/24

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

Electronically Signed | 04/15/2024

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.

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K 353	Continued From page 1 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to inspect, test, and maintain the automatic sprinkler system. The deficient practice affected eight (8) of eight (8) smoke compartments, staff, and all residents. The facility had the capacity for 70 beds with a census of 64 on the day of survey. The findings include: Record review, during the building inspection tour, on 03/13/2024 at 3:12 PM, revealed the facility failed to provide documentation, by the end of the survey, for the sprinkler inspection for the first (1st) and third (3rd) quarter of 2023. Interview, on 03/13/2024 at 3:13 PM, with the Director of Plant Operations revealed the facility was not aware the sprinkler inspection had not been performed. The finding was verified by the Director of Plant Operations at the time of record review and the Administrator at the exit conference on 03/13/2024.	K 353	Compliance Date_4_/_14_/_2024_ Immediate Intervention See photo labeled K353 The Director of Plant Operations has contacted "AI Integrated Systems" to conduct a one-time inspection 4/26/24 of the sprinkler inspection to reset the frequency of the quarterly inspections. The Director of Plant Operations was educated by the Executive Director on Actual NFPA Standard: NFPA 101 (2012), 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 101, 9.7.7 Documentation. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at	

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K 353	Continued From page 2 Actual NFPA Standard: NFPA 101 (2012), 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Actual NFPA Standard: NFPA 101, 9.7.7 Documentation. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. Actual NFPA Standard: NFPA 101, 9.7.8 Record Keeping. Testing and maintenance records required by NFPA25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location. Actual NFPA Standard: NFPA 25 (2011), 5.1 General. 5.1.1 Minimum Requirements. 5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. 5.1.1.2 Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. 5.1.2 Valves and Connections. Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. 5.1.3 Obstruction Investigations. The procedures outlined in Chapter 14 shall be followed where	K 353	an approved, secured location for the life of the fire protection system. NFPA 101, 9.7.8 Record Keeping. Testing and maintenance records required by NFPA25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location. The Director of Plant Operations, as an audit will review all required documentation NFPA25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location 1 x per month x 3 months. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice affected eight (8) of eight (8} smoke compartments, staff, and all residents.	

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K 353	Continued From page 3 there is a need to conduct an obstruction investigation. Table 5.1.1.2 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Frequency Reference Inspection Gauges (dry, preaction, and deluge systems) Weekly/monthly 5.2.4.2, 5.2.4.3, 5.2.4.4 Control valves Table 13.1 Waterflow alarm devices Quarterly 5.2.5 Valve supervisory alarm devices Quarterly 5.2.5 Supervisory signal devices (except valve supervisory switches) Quarterly 5.2.5 Gauges (wet pipe systems) Monthly 5.2.4.1 Hydraulic nameplate Quarterly 5.2.6 Buildings Annually (prior to freezing weather) 4.1.1.1 Hanger/seismic bracing Annually 5.2.3 Pipe and fittings Annually 5.2.2 Sprinklers Annually 5.2.1 Spare sprinklers Annually 5.2.1.4 Information sign Annually 5.2.6.1 Fire department connections Table 13.1 Valves (all types) Table 13.1 Obstruction, internal inspection of piping 5 years 14.2 Test Waterflow alarm devices Mechanical devices Quarterly 5.3.3.1 Vane and pressure switch type devices Semiannually 5.3.3.2 Valves supervisory alarm devices Table 13.1 Supervisory signal devices (except valve supervisory switches) Table 13.1 Main drain Table 13.1 Antifreeze solution Annually 5.3.4 Gauges 5 years 5.3.2 Sprinklers - extra-high temperature 5 years 5.3.1.1.1.4 Sprinklers - fast-response At 20 years and every	K 353		

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K 353	Continued From page 4 10 years thereafter 5.3.1.1.1.3 Sprinklers At 50 years and every 10 years thereafter 5.3.1.1.1 Sprinklers At 75 years and every 5 years thereafter 5.3.1.1.1.5 Sprinklers - dry At 10 years and every 10 years thereafter 5.3.1.1.1.6 Maintenance Valves (all types) Table 13.1 Low-point drains (dry pipe system) 13.4.4.3.2 Sprinklers and automatic spray nozzles protecting commercial cooking equipment and ventilation systems Annually 5.4.1.9 Investigation Obstruction 14.3	K 353		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke	K 372	Compliance Date_4_/-12_/_2024_ Immediate Intervention See photo labeled	4/12/24

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K 372	Continued From page 5 barriers could restrict the transfer of smoke in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice affected two (2) of eight (8) smoke compartments, staff, and 24 residents. The facility had the capacity of 70 beds with a census of 64 on the day of survey. The findings include: Observation, during the building inspection tour on 03/13/2024 at 11:10 AM, revealed the smoke barrier wall located above the cross-corridor doors by room 400 had an unsealed pipe sleeve and another pipe sleeve filled with unrated expandable foam. Interview, on 03/13/2024 at 11:11 AM with the Director of Plant Operations, revealed the facility was not aware of the penetration of the smoke barrier or the unrated foam in use. The finding was verified by the Director of Plant Operations at the time of record review and the Administrator at the exit conference on 03/13/2024. Actual NFPA Standard: NFPA 101 Life Safety Code (2012), 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c).	K 372	K372 The Director of Plant Operations has removed the unrated expandable foam from the pipe sleeve located above the cross- corridor doors by room 400 with approved Fire Caulking, and another pipe sleeve that was not sealed. The Director of Plant Operations was educated by the Executive Director on NFPA 101 Life Safety Code (2012), 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-2-hour fire resistance rating. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling. assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. The Director of Plant Operations will perform a one-time inspection of penetrations of all smoke barriers in the facility checking for proper seal. Any penetration found deficient will be repaired/sealed. This inspection will be followed by an audit of penetrations at smoke barriers for proper seal 1 x per month x 3 months.	

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K 372	Continued From page 6 (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke.	K 372	Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice affected two (2) of eight (8) smoke compartments, staff, and 24 residents.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		3/28/24

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K 712	Continued From page 7 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly for each shift in accordance with National Fire Protection Association (NFPA) standards. The deficient practice affected eight (8) of eight (8) smoke compartments, staff, and all residents. The facility had the capacity for 70 beds with a census of 64 on the day of survey. The findings include: Record review, of the facility's fire drill records for the 12-month period prior to the survey on 03/13/2024 at 2:45 PM, revealed the facility failed to conduct a fire drill during the third (3rd) shift, in the third (3rd) quarter of 2023. Interview, on 03/13/2024 at 2:45 PM with the Director of Plant Operations, revealed he had been off work for medical that quarter and the facility was not aware the drill was missed. The finding was verified by the Director of Plant Operations at the time of record review and the Administrator at the exit conference on 03/13/2024. Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712	Compliance Date _3_/_28_/_2024_ Immediate Intervention See photo labeled K712 The Director of Plant Operations conducted a third (3) shift Fire Drill with the facility on 3/28/24 at 1:00 am. The Director of Plant Operations was educated by the Executive Director on NFPA 101 Life Safety Code (2012) 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel. (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. The Director of Plant Operations will audit/review each Fire Drill monthly with Executive Director x 3 months. Results of this audit/review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice affected eight (8) of eight (8) smoke compartments, staff, and all residents.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		4/11/24

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K 918	Continued From page 8 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to perform testing for	K 918	Compliance Date_4_/_11_/_2024_ Immediate Intervention (1) See photo	

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K 918	Continued From page 9 the emergency generator in accordance with National Fire Protection Association (NFPA) standards. The deficient practice affected eight (8) of eight (8) smoke compartments, staff, and all residents. The facility had the capacity for 70 beds with a census of 64 on the day of survey. Findings include: 1. Observation, during the building inspection tour on 03/13/2024 at 11:40 AM, revealed the emergency generator was not equipped with an emergency stop button on the outside of the generator housing. Interview, on 03/13/2024 at 11:41 AM with the Director of Plant Operations, stated the facility was not aware of the requirements for an emergency stop button. 2. Emergency generator maintenance record review, for the 12 months prior to the survey on 03/13/2024 at 1:50 PM with the Director of Plant Operations, revealed the facility was unable to provide documentation for weekly generator inspections between 09/20/2023 and 10/11/2023. Interview, on 03/13/2024 at 1:51 PM with the Maintenance Director, revealed he was out with a medical emergency and the test was missed. 3. Emergency generator maintenance record review, for the 12 months prior to the survey on 03/13/2024 at 2:00 PM with the Director of Plant Operations, revealed the emergency generator for the facility had not been exercised under load during the month of May in 2023. Interview on 03/13/2024 at 2:01 PM with the Director of Plant Operations revealed the facility was unaware the exercise had been missed. The finding was verified by the Director of Plant Operations at the time of observation/record review, and the Administrator, at the exit	K 918	labeled K918(1) The Director of Plant Operations has contacted Evapar (generator contractor) to install the generator emergency stop button to the outside of the generator housing. Installation of the emergency button was completed on-_4_/_11_/_2024_. The Director of Plant Operations was educated by the Executive Director on NFPA 110, Standard for Emergency and Standby Power Systems (2010), 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. Immediate Intervention (2) See photo labeled K918(2) The Director of Plant Operations has performed the weekly inspection of the generator with exercise. This exercise was completed_4_/_10_/_2024_ The Director of Plant Operations was educated by the Executive Director on Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems (2010), 8.3 Maintenance and Operational Testing. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1The permanent record	

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K 918	Continued From page 10 conference on 03/13/2024. Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012) 6.5.4 Administration (Type 2 EES). 6.5.4.1 Maintenance and Testing of Essential Electrical System. 6.5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. 6.5.4.1.1.2 Inspection and Testing. Generator sets shall be inspected and tested in accordance with 6.4.4.1.1.3. 6.4.4.1.1.3 Maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, Chapter 8. Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems (2010), 8.3 Maintenance and Operational Testing. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 The permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of	K 918	shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. Immediate Intervention (3) See photo labeled K918(3} The Director of Plant Operations has performed a monthly exercise of the generator, under load on _3_/_29_/_2024_ The Director of Plant Operation has been educated by the Executive Director on NFPA 110 Standard for Emergency and Standby Power Systems (2010), 8.3 Maintenance and Operational Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. The Director of Plant Operations will conduct weekly inspection of the generator for all components and its operation. This will include weekly exercise of the generator and a monthly load test. Documentation of the inspection will be reviewed with the Executive Director 1 x per week x 6 weeks.	

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	185461	A. BUILDING **01 - GLEN RIDGE HEALTH CAMPUS** B. WING _____	**03/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN RIDGE HEALTH CAMPUS	**6415 CALM RIVER WAY LOUISVILLE, KY 40299**

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K 918	Continued From page 11 electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.1.1 If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.2.1 The date and time of day for required testing shall be decided by the owner, based on facility operations. 8.4.2.2 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.	K 918	Results of this audit/review will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. The deficient practice affected eight (8) of eight (8) smoke compartments, staff, and all residents.	

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K 918	Continued From page 12 Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012) 6.5.4 Administration (Type 2 EES). 6.5.4.1 Maintenance and Testing of Essential Electrical System. 6.5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. 6.5.4.1.1.2 Inspection and Testing. Generator sets shall be inspected and tested in accordance with 6.4.4.1.1.3. 6.4.4.1.1.3 Maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, Chapter 8. Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010), 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.	K 918		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185461	A. BUILDING _____ B. WING _____	R-C 04/25/2024

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{F 000}	INITIAL COMMENTS A desk review of the Plan of Correction was completed on (PoC) 04/25/2024, and based on the findings, it is recommended the facility be placed in compliance as of April 19, 2024, as alleged in the plan of correction.	{F 000}		

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

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.

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	185461	A. BUILDING _____ B. WING _____	C 03/15/2024

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F 000	INITIAL COMMENTS A Recertification, COVID-19 Focused Infection Control, and Abbreviated Survey investigating KY34268, KY34554, KY34878, KY36372, KY37371, KY37756, KY38643, KY41426, KY41842, KY41861, and KY41915 were initiated on 03/11/2024, and concluded on 03/15/2024. Deficiencies were cited at the highest Scope and Severity of a "D." Total census was 57. KY34268, KY41426, and KY4186 were noncompliant with the regulatory requirements and deficiencies were cited. KY36372, KY37371, KY37756 , KY34554, KY34878, KY38643, KY41842, and KY41915 were compliant with the regulatory requirements and no deficiencies were cited. The facility was found was found to be in compliance with 42 CFR 483.80 infection control regulations and had implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 677	F677 ADL Care Provided for Dependent	4/19/24

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

Electronically Signed | 04/05/2024

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.

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F 677	Continued From page 1 and facility policy review, it was determined the facility failed to assist one (1) of seven (7) residents sampled for review of activities of daily living (ADL) care, (Resident #3). Observation revealed Resident #3's feet were dry with a buildup of black, dry, and flaky skin between and under the toes. Additionally, the skin on the resident's heels was also observed as dry and flaky with a buildup of callused skin on the right heel. The findings include: Review of the facility policy titled, "Guidelines for Pressure Prevention," last reviewed on 12/31/2023, revealed to moisturize residents' skin "with lotion or cream (if applicable) to keep skin soft and pliable." Continued review of the policy revealed to "pay special attention to bony" prominences and "Keep skin clean, dry and free of body wastes, perspiration, and wound drainage." Review of Resident #3's "Resident Face Sheet" revealed the facility originally admitted the resident on 12/24/2022, and most recently readmitted him/her on 03/25/2022, with diagnoses that included chronic kidney disease with heart failure, chronic respiratory failure with hypoxia (inadequate oxygen supply at the tissue level), chronic obstructive pulmonary disease (COPD), and unspecified dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/21/2023, revealed the facility completed a Staff Assessment for Mental Status (SAMS) for Resident #3 which	F 677	Residents 1. Resident #3 was affected by the alleged deficient practice. Resident #3 was provided foot care. Resident is scheduled to see the podiatrist on 4/12/24. Resident has new physician's orders for a treatment for the right heel; protective, moisturizing and healing ointment for bilateral feet; and an emollient for bilateral lower legs. 2. All residents who require assistance with foot care had the potential to be affected and had their feet observed by the Director of Health Services on 3/27/24 to ensure foot care was provided. Nursing staff were provided education on foot care and Guidelines for Pressure Prevention by the Director of Health Services (DHS) with real time discussion and questions to ensure competency on 3/28/24. Any newly hired nursing staff will have education provided during new hire orientation by their assigned preceptor/mentor. The campus does not use agency staff. 3. As a measure of ongoing compliance, DHS or other designated nurse leader will observe 3 random residents who require assistance with foot care weekly for 1 month, every other week for 2 months, and monthly for 3 months to ensure feet are clean and treatment is being provided for any skin conditions. 4. As a quality measure, the DHS will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality	

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F 677	Continued From page 2 indicated the resident had short- and long-term memory impairment with moderately impaired cognitive skills for daily decision-making. Continued review of the MDS Assessment revealed Resident #3 had expressed no rejection of care, and was dependent on staff to put on and take off his/her footwear. Further review revealed Resident #3 was also dependent on staff for showering/bathing and required substantial to maximal assistance from staff for completion of personal hygiene. Review of Resident #3's "Care Plan" revealed the facility identified a problem area that indicated the resident had impairment in his/her ADL functional status in regards to bed mobility, transfers, toileting, and eating. Per review, the problem start date was noted as 12/10/2021, and a date of last edit of 02/26/2024. Continued review revealed the interventions were for staff to encourage the resident to be as independent as safely possible. Further review revealed however, there was no evidence of an intervention that addressed Resident #3's bathing or hygiene. In addition, review further revealed an additional problem with a last edit date of 02/26/2024, which identified Resident #3 as at risk for skin breakdown related to reduced mobility, with an interventions directing staff to keep the resident as clean and dry as possible. During a concurrent observation and interview on 03/13/2024 at 11:00 AM, of Certified Resident Care Assistant (CRCA) #14 and CRCA #16 in the resident's room to provide care to Resident #3, who was lying on his/her bed. CRCA #14 and #16 both stated they were not assigned to care for Resident #3 that day; however, had been asked by the Director of Health Services (DHS) to	F 677	Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date of compliance 4/19/24.	

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F 677	Continued From page 3	F 677		

provide any needed care for the resident at that time. Per observation, Resident #3's feet were observed to be dry with a buildup of black, flaky skin between and under the toes. Further observation revealed the skin on Resident #3's heels was observed as dry and flaky with a buildup of callused skin on the right heel.

During a concurrent observation and interview on 03/13/2024 at 11:25 AM, Registered Nurse (RN) #10 entered Resident #3's room and stated the resident's feet were dry and flaky. RN #10 was observed to take a warm, wet washcloth and passed the washcloth between Resident #3's toes and underneath the resident's toes. Continued observation revealed the RN removed black-brown, dry skin that was approximately 0.5 inches in diameter from the resident's feet. In interview, after providing care of Resident #3's feet, RN #10 stated the resident's feet did not appear to have been washed

During a follow-up interview on 03/13/2024 at 12:38 PM, RN #10 stated she did not think Resident #3's feet had been washed due to how "dirty" the resident's feet appeared.

During a concurrent observation and interview on 03/14/2024 at 10:23 AM, CRCA #13 and CRCA #14 were observed providing Resident #3 with showering assistance. Per observation, when CRCA #14 washed Resident #3's feet, CRCA #14 removed a large amount of brown/black dried skin from between the resident's toes. CRCA #14 stated at that time, based on what she had seen the day prior and the amount of black, flaky skin she had just removed during the shower, she would say Resident #3's feet had not been "washed in weeks."

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F 677	Continued From page 4 During an interview on 03/15/2024 at 9:24 AM, the DHS stated she expected Resident #3's feet to be clean. During an interview on 03/14/2024 at 11:53 AM, the Medical Director stated he had nothing to say about the condition of Resident #3's feet since the State Survey Agency (SSA) Surveyor and multiple staff members had seen the resident's feet with the buildup of dried skin. The Medical Director stated he did not expect Resident #3's feet to have been left in that type of condition. During an interview on 03/15/2024 at 1:45 PM, the Executive Director (ED) stated residents should be presentable at all times. The ED further stated he expected all residents' feet to be washed and kept clean.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify and implement appropriate safety interventions for one (1) of six (6) sampled residents (Resident #213) reviewed for accidents/hazards out of the total sample of	F 689	F689 Free of Accidents Hazards/Supervision/Devices 1. Resident #213 discharged home as planned on 2/14/24. The grab bar in the	4/19/24

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F 689	Continued From page 5 twenty (20) residents. The facility failed to identify loose screws in a round metal ring that covered the grab bar in Resident #213's shower which contributed to the resident's fall on 02/09/2024. The findings include: The State Survey Agency (SSA) was not provided a policy related to the prevention of accidents and incidents. However, during an interview with the Executive Director, on 03/15/2024 at 1:50 PM, he stated it was his expectation that maintenance issues would be reported and repaired for the safety of the residents. Review of Resident #213's "Resident Face Sheet" revealed the facility admitted him/her on 01/04/2024, with diagnoses that included dementia and osteoarthritis. Review of Resident #213's Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/05/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating he/she had severe cognitive impairment. Further review of the MDS Assessment revealed the facility additionally assessed Resident #213 as dependent on staff for bathing. Review of Resident #213's "Care Plan," revealed the facility identified a problem with activities of daily living (ADLs) with a start date of 01/12/2024. Continued review revealed the facility assessed the resident to require staff assistance to	F 689	bathroom has been repaired. 2. All residents had the potential to be affected. All resident rooms, bathrooms, and assistive devices were inspected by the Director of Plant Operations (DPO) on 4/4/24 to ensure no repairs were required and no accident hazards were present. On 3/28/24, staff were provided with education on completing work orders for items that need repair by the Executive Director (ED), Director of Health Services, and the DPO. On 3/28/24, nursing staff were provided education by the Director of Health Services (DHS) on Falls Management Program Guidelines with real time discussion and questions to ensure competency. Any newly hired staff will have this education provided to them during new hire orientation by their assigned preceptor/mentor. The campus does not use agency staff. 3. As a measure of ongoing compliance, the Executive Director or Director of Plant operations will observe 5 resident rooms, bathrooms, and assistive devices weekly for 1 month, then every other week for 2 months, then monthly for 3 months to ensure there are no accident hazards or items are in need of repair. 4. As a quality measure, the ED or DPO will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is	

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F 689	Continued From page 6 complete self-care and mobility functional tasks completely and safely. Review of the facility's "Event Report, for Resident #213 revealed on 02/09/2024, the resident sustained a fall in his/her bathroom. Per review of the Event Report, the fall was witnessed by Certified Occupational Therapy Assistant (COTA) #18, who assisted Resident #213 with a transfer from the shower bench to the wheelchair. Continued review revealed during Resident #213's transfer the resident slipped and was lowered to the floor by COTA #18. Review of the Event Report further revealed Resident #213 sustained a skin tear to his/her right and left elbow and a hematoma to the posterior upper arm. During an interview on 03/14/2024 at 2:27 PM, COTA #18 stated she entered Resident #213's room and the resident stated he/she needed to use the bathroom, so she assisted the resident to the bathroom where she lowered the resident's pants. She stated upon lowering the resident's pants she noticed he/she had been incontinent, so she called for assistance to provide incontinence care. COTA #18 stated Certified Resident Care Associate (CRCA) #12 came to assist and stated Resident #213 needed to take a shower. She stated she rolled the resident's wheelchair to the shower area of the bathroom and with her gait belt around the resident, she had Resident #213 stand while holding onto the grab bar. COTA #18 stated while she held onto the gait belt the resident started to pivot to sit in the shower chair and his/her feet slipped, so she and CRCA #12 assisted the resident to slide down the COTA's right leg and right arm. She stated Resident #213 initially placed his/her hand	F 689	met. 5. Date of compliance 4/19/24.	

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F 689	Continued From page 7	F 689		

on the grab bar, but due to his/her dementia, she thought the resident's hand moved and ended up on the loose piece of the grab bar. COTA #18 stated she thought when the round piece of the grab bar moved it startled or frightened Resident #213, and he/she then lost momentum and focus which resulted in the fall. She stated the resident's elbow hit on the spinning part of the loose bar and Resident #213 sustained a skin tear that turned into a hematoma. COTA #18 further stated the slippage of the round "thing" on the grab bar had something to do with Resident #213's fall as the resident had his/her hand on that piece of the bar.

During an interview on 03/14/2024 at 2:00 PM, CRCA #12 stated she responded to the call light turned on by the COTA that needed assistance with Resident #213. CRCA #12 stated COTA #18 had taken Resident #213 to the bathroom and was in the process of transferring him/her to the shower chair. She stated COTA #18 had the resident stand up from the wheelchair and hold onto the grab bar in the shower. CRCA #12 stated as Resident #213 pivoted, the resident's feet started to slip, and his/her hand was on the metal circle part of the grab bar which was loose. She stated as Resident #213 slid down and his/her arm hit the loose part of the metal circle which caused a skin tear. CRCA #12 stated she thought the fall resulted because of a combination of the resident's feet slipping and his/her hand on the loose part of the grab bar and he/she sliding down. She stated she had not noticed the round part of the grab bar being loose before, and after the incident the grab bar having a loose part was reported to Registered Nurse (RN) #19, that same day.

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F 689	Continued From page 8 During an interview on 03/14/2024 at 3:17 PM, RN #19 stated she was made aware of Resident #213's fall by one of the staff members involved; however, was unable to remember if it was CRCA #12 or COTA #18. RN #19 stated however, COTA #18 or CRCA #12 never mentioned the loose metal cover on the grab bar as being the cause of Resident #213's fall and skin tear. She stated when she went into Resident #213's room, the resident was in the bathroom sitting in the wheelchair, and she observed a small amount of blood on the resident's arm. Observation on 03/14/2024 at 2:12 PM, with CRCA #12 of Resident #213's shower area, revealed the round ring covering the screws on the grab bar, on the left wall of the shower, were movable and slid the entire length of the grab bar. During an interview on 03/14/2024 at 4:15 PM, the Director of Plant Operations (DPO) stated he checked for work orders; however, had no work orders to repair any issues for the room where Resident #213 resided while at the facility. He said he also had not been notified of any issues with the grab bar in the shower in Resident #213's room. Observation at the time of interview revealed the DPO looked at the grab bar in the room where Resident #213 resided and found the circular screw cover was loose from the wall and was able to slide up and down the grab bar. The DPO stated the circular screw cover, if properly applied would have been so snug it would not come off or slide up and down the grab bar. He stated since the edges of the screw cover were sharp, it was possible a resident could sustain a skin tear if the circle was away from the wall, and his/her skin encountered the sharp area.	F 689		

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F 689	Continued From page 9 During an interview on 03/15/2024 at 9:53 AM, the Director of Health Services (DHS) stated Resident #213's fall had been reported to her by RN #19. The DHS stated RN #19 reported Resident #213 sustained a fall with a skin tear in the shower; however, had not given any details of how the fall occurred. She stated the nurses were expected to place immediate interventions in place that should relate directly to what caused the resident to fall in order to prevent another fall from occurring. The DHS further stated she had not been informed of the loose fitting on the grab bar that caused the resident's injury. During a concurrent observation and interview on 03/15/2024 at 10:08 AM, the DHS observed the grab bar in the shower where Resident #213 resided while at the facility, and stated no one had informed her the screw cover did not fit properly and slid across the entire grab bar. The DHS stated no one informed her that Resident #213's hand settled on the screw cover and when the cover moved, it startled the resident and that had affected his/her balance and resulted in the fall. She acknowledged the grab bar fitting had not been properly applied, and agreed the edge of the fitting was sharp. The DHS stated the cover should not slide. During an interview on 03/15/2024 at 1:50 PM, the Executive Director (ED) stated he expected maintenance issues to be fixed as soon as identified, and expected staff to report those issues especially if the issue could affect a resident's safety.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		4/19/24

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F 755	Continued From page 10 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to provide pharmaceutical services to meet the needs of one (1) of six (6) sampled residents reviewed for pharmacy services (Resident #209).	F 755	F755 Pharmacy Services 1. Resident #209 was identified as having the potential to be affected by the cited deficiency. Resident #209 is no longer a resident at Glen Ridge Health Campus.	

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F 755	Continued From page 11 The facility admitted Resident #209 on 09/25/2023; however, failed to ensure the resident's medications were ordered from the pharmacy until the following day, on 09/26/2023. Consequently, Resident #209 missed ten (10) doses of his/her routine medications on 09/26/2023, because the medications were not available. The findings include: Review of a facility policy titled, "Provider Pharmacy Requirements," revised in November 2018, revealed "Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies." Continued review of the policy revealed under the procedures area, section D the provider pharmacy agreed to perform the following pharmaceutical services provision of routine and timely pharmacy service as contracted, and emergency pharmacy services twenty-four (24) hours per day, seven (7) days per week. Per policy review, emergency or "stat" (needed urgently) medications were to be available for administration no more than four (4) hour(s) after the order was received by the pharmacy and a STAT request was made via a phone call from a facility representative. Further review revealed if an emergency or "stat" medication could not be provided to the facility within four (4) hours the facility was to be notified with an expected delivery window. Review further revealed all other new medication orders faxed prior to the daily cutoff were received and to be available for administration as soon as possible on the next routine delivery, unless indicated otherwise by facility personnel. In addition,	F 755	2. All residents had the potential to be affected by the alleged deficient practice. The Medication Administration Compliance Report was reviewed on 4/6/24 by the Director of Health Services (DHS) to ensure that any medication not available for administration was reported to the provider and pharmacy for any medications not available. Nurses and CMTs were provided education by DHS or other designated nurse leader on the facility policy for medication administration guidelines regarding medications not available with real time discussions and questions to ensure competency. This was completed 3/28/24. Any newly hired nurse or CMT will have education provided during new hire orientation by their assigned preceptor/mentor. The campus does not use agency staff. 3. As a measure of ongoing compliance, the Director of Health Services or other designated nurse leader will review the Medication Administration Compliance Report 5 times per week for x2 weeks, 3 times per week for 2 weeks, 2 times per month for 1 week, and monthly x 1 month to ensure provider and pharmacy notification if medication is not available for administration. 4. As a quality measure, the Director of Health Services will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond	

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F 755	Continued From page 12 medications were to be delivered by the primary pharmacy or back-up pharmacy, or were to be available from the "emergency medication kit." Review of Resident #209's "Resident Face Sheet" revealed the facility admitted the resident on 09/25/2023 at 5:45 PM, with diagnoses that included pneumonia, acute and chronic respiratory failure with hypoxia, sarcoidosis of the lung (condition which cause small lumps of inflammatory cells in the lungs), acute pulmonary edema, diabetes, hypercholesterolemia, nonrheumatic aortic stenosis, and asthma. Review of Resident #209's Five-Day Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 09/28/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating he/she was intact cognitively. Per review of the MDS, Resident #209 also had active diagnoses that included heart failure, hypertension, and acute pulmonary edema. Review of Resident #209's "Order History," revealed physician orders were started on 09/26/2023, the day after the resident's admission to the facility. Continued review of the "Order History" revealed Resident #209 had orders for the following medications: - atorvastatin (treats high cholesterol) 40 milligram (mg) tablet by mouth ("po") once per day; - furosemide (treats fluid retention) 40 mg tablet po twice a day; - hydrocodone-acetaminophen (narcotic pain medication) 7.5-325 mg tablet po twice per day; - ipratropium-albuterol solution for nebulization	F 755	6 months, if warranted, until 100% compliance is met. 5. Date of compliance 4/19/24.	

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(treats chronic obstructive pulmonary disease) 0.5 mg-3 mg (2.5 mg base)/3 milliliters (mL), 1 inhalation twice per day;
- levothyroxine (treats hypothyroidism) 75 microgram (mcg) tablet po daily;
- losartan (treats high blood pressure) 25 mg tablet po daily;
- metformin (treats high blood sugar levels) 500 mg tablet, 2 tablets po in the morning and 1 tablet po in evening; and
- potassium chloride (potassium supplement)10 milliequivalent (mEq) extended release tablet po daily.

Review of Resident #209's "Medications Administration History," dated 09/01/2023 to 09/30/2023, revealed no documented evidence the resident had the following medications administered on 09/26/2023, due to lack of availability of the medications:
- atorvastatin: one (1) dose;
- furosemide: two (2) doses;
- hydrocodone-acetaminophen: one (1) dose;
- ipratropium-albuterol: one (1) dose;
- levothyroxine: one (1) dose;
- losartan: one (1) dose;
- metformin tablet: two (2) doses; and
- potassium chloride: one (1) dose.

Review of Resident #209's "Progress Notes," dated 09/26/2023 at 3:14 PM, revealed Registered Nurse (RN) #10 contacted the provider pharmacy to send the resident's antibiotic order, and the rest of his/her routine medications "stat" (immediately/urgently).

During an interview on 03/13/2024 at 12:49 PM, RN #10 stated details about Resident #209 were unclear, but could recall the resident's name and

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the resident being transferred to the hospital. RN #10 stated when a resident was admitted, the physician orders from any hospital paperwork were entered into the facility's computer system and staff then called the pharmacy to obtain the medications. Per RN #10, if the pharmacy expedited the medications (stat), then the medications were to arrive within four (4) hours of the request. The RN stated staff could also pull "some" medications necessary from the facility's emergency drug kit (e-kit) if the medications were not available from the pharmacy.

During an interview on 03/15/2024 at 9:39 AM, a Pharmacy Customer Care Representative stated the pharmacy received Resident #209's medication orders on 09/26/2023, between 1:00 and 1:40. The Pharmacy Customer Care Representative stated however, as the pharmacy no longer had a "patient profile" for Resident #209, there was no way to tell whether the order time was AM or PM. The Pharmacy Customer Care Representative further stated the pharmacy staff could also see the medications were ordered "stat" at some point on 09/26/2023.

During an interview on 03/13/2023 at 10:08 AM, Licensed Practical Nurse (LPN) #2 stated when a resident was admitted and once the physician orders were verified, facility staff entered the medication orders into the computer system, then called the pharmacy. LPN #2 stated medications generally arrived from the pharmacy in a "couple" of hours. LPN #2 stated if the hospital sent a prescription for a medication, staff could administer the medications from the facility's e-kit. The LPN stated medications could be late due to pharmacy delivery, but she was not aware that a resident missing multiple doses of his/her

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medications. Further interview revealed LPN #2 stated staff could pull medications from the facility's medication storage/dispensing machine; however, not all medications a resident might need were in the machine.

During an interview on 03/13/2024 at 12:20 PM, LPN #3 stated when a resident was admitted, staff entered their medication orders into a computer and called the pharmacy to have the medications sent stat. She stated if medications did not arrive in a timely manner, staff could retrieve the medications from the medication storage/dispensing machine.

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During an interview on 03/13/2024 at 1:07 PM, LPN #4 stated if staff sent a new resident's admission medication orders to the pharmacy before 3:00 PM, the pharmacy would send the medication to the facility that same night. Per LPN #4, if a resident was admitted after 3:00 PM, staff had to call the pharmacy to have the medications sent "stat," which took four (4) to six (6) hours to receive. LPN #4 stated when residents' medications were not available she pulled the medications from the e-kit.

During an interview on 03/13/2024 at 1:53 PM, LPN #5 stated when a resident was admitted to the facility, a nurse was to input the medication orders into the computer and call the pharmacy to have the medications sent "stat" because not all medications were in the facility's e-kit. She stated if a resident was admitted at or after 6:00 PM, the nurse was to call the pharmacy to expedite the resident's medications. LPN #5 stated the medications should arrive between 10:00 PM to 2:00 AM the same night. In continued interview the LPN stated the facility could not enter

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medication orders until the resident was physically present at the facility. She stated night shift staff should have called the pharmacy to ensure Resident #209's medications were at the facility before the morning shift. LPN #5 further stated it was "not good" for a resident to miss that many medication doses.

During an interview on 03/13/2024 at 11:21 AM, the Medical Director stated there could be delays in the facility receiving medications because the correct list of medications might not be available until the resident was physically present in the facility. The Medical Director stated not receiving ordered medications could be detrimental to a resident. The Medical Director reviewed Resident #209's medications that were not administered on 09/26/2023, and stated that missing the medication doses had not caused further respiratory problems or caused the resident's condition to worsen.

During an interview on 03/13/2024 at 2:21 PM, LPN #11 stated when a resident was admitted to the facility, she entered the medication orders in the computer, and said staff could have the pharmacy send the medications "stat," which meant the medications should arrive within four (4) hours. She stated if a resident was admitted after 5:00 PM, and his/her medications were not ordered "stat," the pharmacy would not deliver the medications until the next night. She stated there were medications available in limited supplies in the facility's e-kit. LPN #11 stated she did not remember Resident #209 or the situation with the resident's medications; however, LPN #11 further stated if medications were not available for administration, there should have been a note entered on the MAR, and the medications started

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the next day once they arrived. LPN #11 further stated apparently she did not notify the Director of Health Services (DHS) that some of Resident #209's medications were not available to give.

During an interview on 03/14/2024 at 1:52 PM, the DHS stated she was not aware Resident #209's medications had not been available after admission until the next day. She stated she was also not aware the resident missed doses of his/her routine medications after admission. The DHS stated however, she expected residents to receive their ordered medications. She stated when a resident was admitted, nursing staff could request the medications be delivered "stat," which could take up to four (4) hours or more to arrive at the facility. The DHS further stated some medications were available for administration in the facility's medication storage/dispensing machine.

During an interview on 03/15/2024 at 8:57 AM, the Executive Director (ED) stated when the facility admitted a resident, he expected nursing staff to contact the pharmacy to acquire the medications timely and, if they were ordered "stat," the medications should arrive within four (4) hours. The ED stated if a resident arrived in the evening for admission, the nurse ordering the medications needed to order the medications "stat" so the medications would be at the facility by midnight. The ED further stated he expected nursing staff to communicate with the DHS to determine why a resident's medications were not available for administration and to escalate the order if needed.

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F 000	INITIAL COMMENTS A Recertification, COVID-19 Focused Infection Control, and Abbreviated Survey investigating KY34268, KY34554, KY34878, KY36372, KY37371, KY37756, KY38643, KY41426, KY41842, KY41861, and KY41915 were initiated on 03/11/2024, and concluded on 03/15/2024. Deficiencies were cited at the highest Scope and Severity of a "D." Total census was 57. KY34268, KY41426, and KY4186 were noncompliant with the regulatory requirements and deficiencies were cited. KY36372, KY37371, KY37756 , KY34554, KY34878, KY38643, KY41842, and KY41915 were compliant with the regulatory requirements and no deficiencies were cited. The facility was found was found to be in compliance with 42 CFR 483.80 infection control regulations and had implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and	F 583		4/19/24

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

Electronically Signed | 04/05/2024

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.

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F 583	Continued From page 1 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined, the facility failed to ensure personal privacy for one (1) of six (6) sampled residents reviewed for dignity (Resident #32). Observation revealed staff obtained Resident #32's blood glucose level and administered insulin in the resident's abdomen while he/she was seated at a table in a common area with five (5) other residents.	F 583	F583: Personal Privacy/Confidentiality of Records 1. Resident #32 was affected by the alleged deficient practice. Resident's insulin administration and blood glucose checks are performed in his/her room. 2. All residents who receive insulin and/or blood glucose checks had the potential to be affected. Nurses and CMTs were provided education by Director of Health	

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	185461	A. BUILDING _____ B. WING _____	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 583	Continued From page 2 The findings include: Review of the facility policy titled, "Resident Rights Guidelines," revised 05/11/2017, revealed the purpose of the policy was "To ensure resident rights are respected and provide an environment in which they can be exercised." Further policy review revealed facility residents had the right to be "treated with dignity and respect" and privacy. Review of Resident #32's "Resident Face Sheet" revealed the facility admitted the resident on 10/03/2022 with diagnoses which included type 2 diabetes. Review of Resident #32's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/23/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3), indicating the resident had severe cognitive impairment. Per MDS review, the facility assessed Resident #32 to have medically complex conditions and diabetes. Further review of the MDS revealed the facility assessed Resident #32 to have received insulin injections in the last seven (7) days of the assessment period. Review of Resident #32's "Care Plan," dated 10/10/2022, revealed the facility care planned the resident as at risk for hypo/hyperglycemia related to diabetes mellitus. Further review revealed the facility developed interventions that included staff to administer medication per physician orders. During an observation on 03/12/2024 at 8:33 AM, Resident #32 was seated at a table in a common	F 583	Services (DHS) and Executive Director (ED) on Resident Rights Guidelines with real time discussion and questions to ensure competency. This education was completed on 3/28/24. Any newly hired nurses and CMTs will have education provided during new hire orientation by their assigned nurse preceptor/mentor. The campus does not use agency staff. 3. As a measure of ongoing compliance, the DHS or other designated nurse leader will observe 3 random resident blood glucose checks and/or insulin administrations weekly x1 month, every other week x2 months, then monthly x3 months to ensure privacy was maintained. 4. As a quality measure, the DHS will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date on compliance 4/19/24.	

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F 583	Continued From page 3 area with five (5) other residents. Continued observation revealed Licensed Practical Nurse (LPN) #4 checked Resident #32's blood glucose level and administered the resident's insulin in his/her abdomen. Further observation revealed Resident #32 was not able to answer any questions related to privacy or dignity. In an interview on 03/12/2024 at 8:53 AM and 2:51 PM, LPN #4 stated she should not have obtained Resident #32's blood glucose level and administered his/her insulin in the resident's abdomen at a table where other residents were present. She stated she should have taken Resident #32 to his/her room to perform those procedures in privacy for the resident. In interview on 03/14/2024 at 3:53 PM, the Director of Health Services (DHS) stated she expected staff to treat all the residents with respect. The DHS stated the nurse should have taken Resident #32 to his/her room before checking the resident's blood glucose level or administering an insulin injection. In interview on 03/15/2024 at 1:36 PM, the Executive Director stated he expected staff to provide treatments, such as an insulin injection, in a private area. He further stated he expected staff to provide privacy during medication administration.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F 585		4/19/24

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reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency,

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F 585	Continued From page 5 Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility	F 585		

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F 585	Continued From page 6 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility documents and policy, it was determined the facility failed to ensure resolution of a grievance for one (1) of twenty (20) sampled residents, (Resident #9). Interview with staff revealed they were aware Resident #9 did not sleep well at night due to his/her roommate's yelling/screaming out, and reported everyone knew about that information. However, the facility failed to make prompt efforts to resolve the resident's complaint/grievance and ensure he/she received the care and treatment necessary to achieve adequate rest/sleep at night. The findings include: Review of the facility policy titled, "Resident Concern Process," effective 11/13/2019, revealed, the purpose of the policy was "To provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service." Continued review revealed the facility was to provide an "open and customer friendly atmosphere" for residents and their families/representatives to voice concerns and problems to ensure their	F 585	F585 Grievances 1. Resident #9 was affected by the alleged deficient practice. A room move was offered and accepted. Resident was satisfied with the outcome. 2. All residents with a concern/grievance had the potential to be affected. On 4/6/24, residents with a BIMS of 8 or greater were interviewed by the Director of Health Services (DHS) to ensure that all concerns they had were addressed. The last 30 days of resident concerns were reviewed by the Executive Director, Director of Health Services (DHS), and/or Director of Social Services (DSS) on 4/6/23 to ensure that all concerns have been addressed. The campus Clinical Support provided education to the ED, DHS, and DSS on the Resident Concern Process on 3/26/24. All staff were provided education on the Resident Concern Process by the ED, DHS, or DSS with real time discussion and questions to ensure competency on 3/28/24. Any newly hired nursing staff will have education provided during new hire orientation by the assigned nurse preceptor/mentor. The	

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F 585	Continued From page 7 concerns were heard and acted upon. Per review, the facility was committed to the on-going education of their employees on immediately responding to and resolving "customer" concerns. Further review revealed the facility was to follow its "Resident Concern Process flow chart" when any concern or complaint was voiced. Additionally, policy review revealed the facility staff were to take steps to correct the problem, ensure the problem was resolved, and the Executive Director was to review and manage the follow up of the concerns. Review of Resident #9's "Resident Face Sheet" revealed the facility admitted the resident on 07/05/2022, with diagnoses that included atrial fibrillation, chronic pain syndrome, fatigue, muscle weakness, and a history of falling. Review of Resident #9's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/23/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15), which indicated he/she had moderate cognitive impairment. Review of Resident #9's "Care Plan" revealed a "Problem" statement, last edited on 02/26/2024, that indicated the resident had the potential for experiencing symptoms of fatigue, weakness, and confusion related to anemia. Further review revealed the Care Plan interventions directed staff to encourage Resident #9 to take rest periods during episodes of fatigue. During an interview on 03/11/2024 at 10:52 AM, Resident #9 stated his/her roommate kept him/her up at night screaming and yelling.	F 585	campus does not use agency staff. 3. As a measure of ongoing compliance, the ED or DSS will interview 3 random residents to ensure that any/all concerns have been addressed, weekly x 1 month, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the ED or DSS will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date of compliance 4/19/24.	

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Resident #9 stated he/she had discussed the problem with the Executive Director (ED), who stated he would fix the problem; however, the problem had not been resolved.

Review of the facility's resident complaint log for the timeframe of 03/02/2023 through 02/19/2024, revealed no documentation noting Resident #9's issues of not being able to sleep at night due to his/her roommate's screaming/yelling.

During an interview on 03/13/2024 at 10:12 AM, the Director of Social Services (DSS) described Resident #9 as able to make his/her needs known however, at times, did not accurately recall events. The DSS stated she did not know Resident #9 as well as other residents, and had not received any concerns from staff, or the resident regarding his/her relationship with his/her roommate. The DSS further stated if Resident #9 was having difficulty with his/her roommate, she expected staff to have notified her of that information.

During an interview on 03/13/2024 at 10:53 AM, Registered Nurse (RN) #10 stated Resident #9 had told her and "everyone" else that his/her roommate screamed and yelled at night which kept the resident awake and was unable to sleep. RN #10 stated she had not notified anyone of Resident #9's concern because "everyone" knew about it. She further stated she was not aware of whether a room change had ever been offered to Resident #9, or whether the facility's grievance process had been completed as required.

During an interview on 03/13/2024 at 12:09 PM, Licensed Practical Nurse (LPN) #5 stated Resident #9 had reported his/her inability to sleep

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at night due to his/her roommate's yelling and screaming. LPN #5 stated she had documented that information in Resident #9's medical record and had reported the resident's concerns to the Director of Health Services (DHS). The LPN stated the DHS told her she would report the resident's concerns to the ED. She further stated she had not completed a written grievance regarding Resident #9's concerns, but felt she had done her part by reporting the resident's concerns to the DHS.

During a telephone interview on 03/14/2024 at 1:10 PM, Certified Resident Care Associate (CRCA) #17 stated she worked at the facility on the 6:00 PM to 6:00 AM shift or on the 10:30 PM to 6:30 AM shift. She stated she knew Resident #9 well and confirmed the resident had reported his/her roommate keeping him/her awake at night. The CRCA stated Resident #9's roommate yelled and screamed at night, keeping Resident #9 awake. She stated when staff from the night shift went into Resident #9's room, the resident "begged" the staff to do something about his/her roommate's behaviors. CRCA #17 stated she had not reported that information however, because "everyone knew about it," including the ED, who was also well aware of the issue. She stated the ED changed Resident #9's shower time from 5:00 AM to 7:00 AM, due to the resident not being able to sleep at night. CRCA further stated however, the DHS and the ED changed Resident #9's shower time back to 5:00 AM because the first shift did not consistently assist the resident as he/she needed.

During an interview on 03/14/2024 at 3:13 PM, RN #19 stated Resident #9 complained about his/her roommate yelling and screaming at night,

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keeping Resident #9 awake. RN #19 stated Resident #9's complaints regarding his/her roommate keeping him/her awake at night had been occurring since she was hired in May 2023. She stated she reported Resident #9's concerns to the DHS and knew several other staff members had also reported the resident's concerns to the DHS. RN #19 further stated however, she had not completed a grievance form.

During an interview on 03/15/2024 at 9:13 AM, the DHS stated "sometimes" Resident #9 and his/her roommate got along fine, and sometimes they argued about the heat, and Resident #9's roommate yelled. She stated no one had reported any recent problems occurring between the roommates. The DHS stated staff had offered Resident #9 earplugs. She stated if there was not a record of a written grievance regarding Resident #9's concerns, then a grievance had not been filed. The DHS further stated she had not completed the grievance process because "they" handled the resident's concerns at the time of occurrence.

During an interview on 03/15/2024 at 1:37 PM, the ED stated a couple of months ago, he had given Resident #9 earplugs to use (when the roommate was yelling). He stated he had followed up with Resident #9 "about a month later" and found out the earplugs were not working. The ED stated he offered Resident #9 a larger set of earplugs, and the resident declined. He further stated no other interventions were attempted. According to the ED, staff had not notified him of the lack of sleep for Resident #9 being an on-going problem.

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F 684	Continued From page 11	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to implement the bowel protocol in accordance with physician's orders for one (1) of one (1) sampled resident for bowel management (Resident #213) out of the total sample of twenty (20) residents. The facility failed to implement the bowel protocol for Resident #213, when the resident exceeded 72 hours with no bowel movement (BM). The findings include: Review of the facility policy titled, "Bowel Protocol Guidelines," reviewed on 12/31/2023, revealed its purpose was to "provide guidance for the use of bowel stimulants for residents with constipation." Per policy review, the procedures included upon admission, an order might be obtained to 'Utilize Bowel Protocol as needed" for the newly admitted resident. Continued review revealed if the resident needed to utilize the bowel protocol, the 'Bowel Protocol' order set might be opened and	F 684	F684 Quality of Care 1. Resident #213 was discharged home as planned on 2/14/24. Resident had no adverse effects and had regular bowel movements, with none greater than 72 hours apart during the 2 weeks prior to discharge. 2. All residents had the potential to be affected. On 4/6/24, the Director of Health Services (DHS) reviewed all residents to ensure that they had a bowel movement within the last 72 hours and the bowel protocol was initiated if warranted. On 4/6/24, the DHS reviewed all resident orders to ensure there is an order to "utilize bowel protocol as needed." Nursing staff were provided education on the Bowel Protocol Guidelines and how to view the list of residents who have not had a bowel movement in the last 72 hours by the Director of Health Services (DHS) with real time discussion and questions to ensure competency on 3/28/24. Any newly	4/19/24

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F 684	Continued From page 12 orders entered from the order set for the affected resident. Review of the policy revealed the Ineffective Bowel Pattern Event should be initiated for any resident not having a BM within 72 hours (unless that had been determined to be a usual bowel pattern for the individual). Policy review revealed a progress note associated to the initiation of the Ineffective Bowel Event, was to be completed until the resident had a BM or the bowel pattern returned to normal for that resident. Further review revealed the progress note was to include (assessment for) abdominal distention, pain, and bowel sounds, and nursing staff to assess for effectiveness. Additional policy review revealed orders might be written to administer a "Natural Laxative" if a resident had no BM within 72 hours; if no results within twenty-four (24) hours after the "natural laxative," give Milk of Magnesia (MOM) q [every] day and PRN (as necessary) for constipation. Review of the policy further revealed if no BM resulted within approximately twelve (12) hours after the MOM, administer a Dulcolax suppository, and if no satisfactory BM resulted after the suppository within two (2) hours give a Fleets enema. In addition, the policy further noted nursing staff were to enter residents' bowel movements, in the resident's electronic medical record [EMR] "each shift." Review of the "Resident Face Sheet" for Resident #213 revealed the facility admitted the resident on 01/04/2024, with diagnoses that included unspecified constipation, chronic pancreatitis, unspecified severe dementia, and gastroesophageal reflux disease (GERD) without esophagitis. Further review of the Resident Face Sheet, revealed Resident #213 was discharged from the facility on 02/14/2024.	F 684	hired nursing staff will have education provided during new hire orientation by their assigned preceptor/mentor. The campus does not use agency staff. 3. As a measure of ongoing compliance, the DHS or other designated nurse leader will review al resident records weekly for 1 month, every other week for 2 months, and monthly for 3 months to ensure any resident who has gone 72 hours without a bowel movement has had effective measures taken for remedy. 4. As a quality measure, DHS will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date of compliance 4/19/24.	

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Review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/05/2024, revealed the facility assessed Resident #213 to have a Brief Interview for Mental Status (BIMS) score of six (6), indicating the resident had severe cognitive impairment. Further review of the MDS Assessment revealed the facility assessed Resident #213 as dependent upon staff for toilet use and was always incontinent of bowel.

Review of Resident #213's "Care Plan" revealed the facility developed a "Problem" area, with a start date of 01/12/2024, that noted the resident had inflammatory bowel disease and colon polyps. In addition, review of the Care Plan revealed the facility developed another "Problem" area, with a start date of 01/12/2024, regarding Resident #213 having a diagnosis of hypothyroidism and was at risk for complications. Continued review of the care plan revealed interventions which included staff to observe the resident for signs of hypothyroidism, including constipation, and to notify the physician as needed. Further review of the Care Plan revealed the facility also developed a "Problem" area, with a start date of 01/18/2024, regarding Resident #213 to receive "high risk medications," including a diuretic, with an intervention for staff to observe and report signs of dehydration, including constipation.

Review of Resident #213's "Order History" revealed an order dated 01/04/2024 that specified, "May utilize bowel protocol as needed...enter bowel protocol order set." Continued review of the Order History also revealed the following orders were started on

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F 684	Continued From page 14 01/05/2024, as part of the bowel protocol order set: - "If no bowel movement within 72 hours; 2 Tablespoons (30 cc) of 'Natural Laxative' Special Instructions: assign to bowel protocol flow sheet Once A Day - PRN [as needed];" - "If no results within 24 hours, after 'natural laxative' give 30 cc of Milk of Magnesia Special Instructions: q [every] day/PRN for constipation;" - "If no results within approximately 12 hours of above MOM administration give Dulcolax suppository per rectum Special Instructions: q day/PRN if no results from MOM;" and - "If results of suppository are not satisfactory within 2 hours give Fleets enema per rectum once a day - PRN." Review of Resident #213's BM record, for the duration of his/her stay at the facility, revealed the resident had a medium BM on 01/05/2024 at 9:02 PM. Continued review of the BM record revealed the next BM recorded for Resident #213 was noted on 01/10/2024 at 8:08 AM. Per review of the documentation, Resident #213 exceeded 72 hours with no documented BM. Continued review of the BM record revealed BMs were then recorded every one (1) to three (3) days until 01/19/2024 at 2:03 PM, when a large BM was noted. Further review of the record revealed however, Resident #213 did not have another BM documented until 01/26/2024 at 9:54 PM, seven (7) days later. Review of Resident #213's January 2024 "Medication Administration History" revealed no documented evidence the bowel protocol medications were administered when the resident exceeded 72 hours with no BM, during the timeframe from 01/05/2024 to 01/10/2024 and	F 684		

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from 01/19/2024 to 01/26/2024.

Review of Resident #213's "Resident Progress Notes" for the timeframe of 01/05/2024 to 01/10/2024, when the resident first exceeded 72 hours with no BM, reflected no documented evidence of "Ineffective Bowel Pattern Event" documentation or an assessment of the resident's abdomen or bowel sounds until 01/10/2024 at 1:49 AM. Review of the 01/10/2024 at 1:49 AM documentation revealed staff noted Resident #213's abdomen was soft and non-tender and bowel sounds were active.

Review of Resident #213's "Progress Notes" for the timeframe of 01/19/2024 to 01/26/2024, when the resident again exceeded 72 hours with no BM, revealed staff documented his/her abdomen was soft and non-tender and bowel sounds were active on 01/19/2024 at 1:15 AM, 01/20/2024 at 8:47 AM, 01/21/2024 at 1:14 AM, 01/22/2024 at 8:02 PM, 01/24/2024 at 11:07 PM, 01/25/2024 at 9:37 PM, and 01/26/2024 at 8:05 PM. Further review revealed however, no documented BMs, nor documentation related to the implementation of the facility's bowel protocol.

During an interview on 03/13/2024 at 12:18 PM, Licensed Practical Nurse (LPN) #5 stated the facility utilized a BM protocol that instructed staff to initiate the protocol if a resident had no BM for three (3) days. LPN #3 stated the facility's EMR was not designed to flag the nurse after a resident had no BM for three (3) days, and the nurse would have to check the vital sign section of the EMR to know when a resident had their last BM. She further stated she remembered assisting Resident #213 to the bathroom, and as far as she knew, the resident was having regular

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BMs.

During an interview on 03/14/2024 at 11:37 AM, the Medical Director was unable to recall Resident #213. The Medical Director stated he expected staff to intervene if a resident had no BM for 72 hours unless that was the resident's normal BM routine. He stated staff should increase fluids, add fiber to the resident's diet, and implement the bowel protocol after 72 hours of no BM. He further stated if a resident had no BM for three (3) days he also expected to be notified of that information.

During an interview on 03/14/2024 at 1:35 PM, LPN #3 stated if a resident had no documented BM for three days, the nurse was expected to open a bowel pattern event in the EMR; assess for hard stool in the resident's rectum; check for nausea and vomiting; and check to make sure the resident had active bowel sounds. LPN #3 reviewed Resident #213's BM record, and stated when the resident went without a BM for five (5) days and then again for seven (7) days, the Medical Director should have been notified, an ineffective bowel pattern event opened, and the bowel protocol implemented.

During an interview on 03/14/2024 at 3:17 PM, Registered Nurse (RN) #19 stated the BM protocol was initiated if a resident had no BM for three (3) days. RN #19 stated the protocol started with use of MiraLAX (a laxative), and if the resident had no BM within four (4) hours, the resident was to be given MOM. She stated if the resident still had no BM within twelve (12) hours of the MOM; a suppository was to be given; and if the resident continued to have no BM within two (2) hours of the suppository; an enema was

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administered. RN #19 stated if the resident still had no BM the physician was called. She stated prior to starting the bowel protocol for a resident, an abdominal assessment was needed to listen for bowel sounds and to determine if the resident's abdomen was hard or distended. She stated if a resident had no BM for a period of five (5) days or seven (7) days, she would ask the physician for an X-ray to rule out a bowel obstruction or ileus (inability of the intestines to contract normally). RN #19 reviewed Resident #213's BM record and then further stated the resident should have been assessed and the bowel protocol should have been implemented.

During an interview on 03/15/2024 at 8:25 AM, LPN #2 stated the bowel protocol was to be initiated when a resident had no BM for 72 hours. LPN #2 said the facility's bowel protocol had been approved by the Medical Director and was included in the orders for a newly admitted resident. She stated that before she would initiate the bowel protocol, she assessed the resident and listened for bowel sounds and notified the Medical Director. LPN #2 reviewed Resident #213's BM documentation and stated based on the documentation, the bowel protocol should have been initiated for the resident. LPN #2 acknowledged she had cared for Resident #213 and had no reason or explanation for why she had not started the bowel protocol for him/her. She further stated the Director of Health Services (DHS), who used to run the BM report and post it for staff to review, had stopped posting the BM report about a year ago.

During an interview on 03/15/2024 at 9:53 AM, the DHS stated if a resident had not had a BM for three (3) days nurses were expected to follow the

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F 684	Continued From page 18 facility's bowel protocol. The DHS said that prior to the initiation of the bowel protocol, she expected nurses to assess the resident and document their findings in the nurse's notes of the resident's medical record. She stated the Certified Registered Care Associates (CRCAs) were responsible for documenting BMs and informing the nurses if a resident had no BM for three (3) days. The DHS stated however, the CRCAs were unable to review BM documentation and would be unable to determine how long it had been since a resident had a BM. She stated nurses were also expected to communicate from shift to shift if a resident had not had a BM during their shift. The DHS stated she was responsible for generating residents' BM reports and notifying the nurses if a resident had not had a BM for three (3) days. The DHS reviewed Resident #213's BM record, and stated the bowel protocol should have been implemented when the resident had no BM for five (5) days and longer. During an interview on 03/15/2024 at 1:50 PM. The ED stated he expected nurses to follow the facility's bowel protocol for any resident when the resident had no BM for three (3) days.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making	F 687		4/19/24

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F 687	Continued From page 19 appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide necessary foot care for one (1) of seven (7) residents sampled for activities of daily living (ADLs), (Resident #3). Observation revealed Resident #3's toenails extended half an inch to one (1) inch beyond the tips of his/her toes. The findings include: A policy was requested regarding nail care on 03/15/2024 at 4:45 PM; however, the Assistant Vice President of Clinical Operations stated the facility did not have a policy that addressed toenail care. Review of Resident #3's "Resident Face Sheet" revealed the facility admitted the resident on 03/25/2022, and most recently readmitted the resident on 12/24/2022, with diagnoses that included unspecified dementia, chronic respiratory failure with hypoxia (low oxygen level in the blood), chronic kidney disease with heart failure, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/21/2023, revealed a Staff Assessment for Mental Status (SAMS) determined Resident #3 had short- and long-term memory problems and was moderately impaired cognitively. Further review of the MDS revealed	F 687	F687 Foot Care 1. Resident #3 was affected by the alleged deficient practice. Resident #3 was provided foot care. Resident is scheduled to see the podiatrist on 4/12/24. Resident has new physician's orders for a treatment to the right heel; protective, moisturizing and healing ointment for bilateral feet; and an emollient for bilateral lower legs. 2. All residents who require assistance with foot care had the potential to be affected. On 3/28/24, the Director of Health Services (DHS) observed all residents' feet to ensure foot care was provided, and to identify if they had elected podiatry services. Those who had not were offered the services. On 3/28/24, the Director of Social Services (DSS) provided the Podiatry provider with a current list of residents requesting services. On 3/28/24, the DHS provided education to nursing staff with real time discussion and questions to ensure competency on foot care, Guidelines for Pressure Prevention, and communicating need for podiatrist referral to the Director of Social Services (DSS). On 3/28/24, the Executive Director (ED) provided education to the Director of Social Services and admissions staff regarding offering podiatry services to all	

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F 687	Continued From page 20 Resident #3 had expressed no rejection of care during the assessment period. In addition, MDS review revealed Resident #3 was dependent on staff to put on or take off footwear and to shower/bathe and required substantial/maximal assistance from staff with personal hygiene. Review of Resident #3's "Care Plan," revealed the facility identified a "Problem" area, started on 12/10/2021 and revised on 02/26/2024, that indicated the resident had impairment in his/her ADLs in regard to bed mobility, transfers, toileting, and eating. Further review revealed an intervention dated 12/10/2021, which directed staff to encourage Resident #3 to be "as independent as safely possible." Review further revealed there were no documented interventions that addressed toenail care. Review of an untitled document dated 12/06/2021 and signed by Resident #3 revealed the resident declined a variety of outside resources, including dental, vision, and auditory services. However, further review of the document revealed it did not address podiatry services. During an observation on 03/13/2024 at 11:00 AM, Resident #3 was observed lying on his/her bed with Certified Resident Care Assistant (CRCA) #14 and CRCA #16 present in the room to provide care for the resident. Continued observation revealed Resident #3's toenails were observed to extend a half an inch to one (1) inch beyond the tips of his/her toes. During an interview on 03/13/2024 at 11:20 AM, CRCA #12 stated she was assigned to care for Resident #3, and confirmed the resident's toenails needed to be cut. CRCA #12 stated she	F 687	residents upon admission with real time discussion and questions to ensure competency. Any newly hired nursing staff will have education provided during new hire orientation by their assigned preceptor/mentor. The campus does not use agency staff. 3. As a measure of ongoing compliance, DHS or other designated nurse leader will observe 3 random residents who require assistance with foot care weekly for 1 month, every other week for 2 months, and monthly for 3 months to ensure feet are clean and treatment is being provided for any skin conditions. The Executive Director will review 3 new admission records weekly for 1 month, every other week for 2 months, and monthly for 3 months to ensure podiatry services are offered. 4. As a quality measure, the DHS and ED will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date of compliance 4/19/24.	

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reported the need for toenail care for Resident #3 a few months ago; however, was unable to recall who she reported the information to.

During a concurrent observation and interview on 03/13/2024 at 11:25 AM, Registered Nurse (RN) #10 observed Resident #3's toenails and stated the resident's toenails needed to be trimmed.

During a follow-up interview on 03/13/2024 at 12:38 PM, RN #10 stated podiatry services was last in the facility either in January 2024 or February 2024. RN #10 stated Director of Social Services (DSS) #38 was responsible for arranging podiatry services for residents. She further stated she was responsible for Resident #3's care on 03/13/2024; however, additionally stated no one had reported Resident #3's long toenails to her.

During a concurrent observation and interview on 03/14/2024 at 10:23 AM, CRCA #13 and CRCA #14 were observed providing Resident #3 a shower. Per observation, Resident #3's toenails had not been trimmed, and his/her right great toenail extended approximately one (1) inch beyond the tip of the toe and curved under the right second toe. Continued observation revealed Resident #3's third toenail on his/her right foot extended approximately a quarter inch to a half inch beyond the tip of the toe, and the left great toenail extended approximately one (1) inch beyond the tip of the toe and curved left, resting under the left second toe. CRCA #13 stated the CRCAs were not allowed to cut residents' toenails, further stated a podiatrist visited the facility every three (3) months. CRCA #13 stated if a resident required podiatry services, the facility placed the resident's name on a list, and the

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resident was seen when the podiatrist came to the facility.

During an interview on 03/15/2024 at 9:24 AM, the Director of Health Services (DHS) stated the podiatrist visited the facility every three (3) months, but added that recently the podiatrist had canceled a few visits. The DHS stated DSS #38 was the person who coordinated all ancillary services, including podiatry services. She stated she had observed Resident #3's toenails and stated the toenails should not have been that long. The DHS further stated no one had reported the condition of Resident #3's toenails. She additionally stated she expected Resident #3's toenails to be cut to the proper length.

During an interview on 03/15/2024 at 10:50 AM, DSS #38 stated the podiatrist came to the facility every two (2) to three (3) months and the podiatry service was who sent her the list of residents to be seen. She further stated she was unsure when Resident #3 had last been seen.

During a follow-up interview on 03/15/2024 at 11:24 AM, DSS #38 said Resident #3 had not received podiatry services since his/her admission to the facility and agreed podiatry care should have been provided for the resident. DSS #38 also stated she had reviewed Resident #3's admission paperwork, and the resident had declined some outside resources but she confirmed podiatry services had not been discussed with the resident.

During an additional interview on 03/15/2024 at 3:46 PM, DSS #38 stated she called the facility's podiatry provider, and they confirmed Resident #3 was not receiving their services and they had

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F 687	Continued From page 23 never seen the resident. During an interview on 03/14/2024 at 11:53 AM, the Medical Director stated if a resident's toenails extended half an inch to one (1) inch beyond the tips of their toes, he expected the facility to arrange with an outside source to have the resident's nails trimmed.	F 687		