STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49360 Based on observation, interview, and facility policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment. The findings include: Review of the facility's policy titled, Safe Environment Policy, effective 01/13/2021, revealed the facility was to ensure plant operations were provided daily to maintain a safe, comfortable, and clean environment for its residents. Observation during the initial tour of the facility on 06/25/2024 at 9:11 AM, revealed the flooring at the entrance to the East Wing had a yellow/black strip adhered to the floor, which had become loose and was pulled up with cracks around it. Observation during the initial tour of the facility on 06/25/2024 at 9:46 AM, revealed the flooring at the entrance to the [NAME] Wing had a yellow/black strip adhered to the floor, which also had become loose and was pulled up with cracks around it. Observation of room [ROOM NUMBER] on 06/25/2024 at 11:03 AM, revealed the sink in the room had rubber bands around the hot water knob to turn the knob off. Continued observation revealed water was observed running down into the sink. In interview with Resident #45 (R45) on 06/25/2024 at 11:03 AM, he stated he had to use the rubber bands in order to turn off the hot water in his sink. R45 stated the rubber bands did not work as you can see the water is still running into the sink. In continued interview with R45, he stated the maintenance man had been in his room quite a few times but had not been able to fix the problem. R45 further stated having to use the rubber bands did not feel homelike to him. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Maintenance Assistant (MA) person on 06/25/2024 at 2:36 PM, he stated the fall hazard tape (the yellow/black strip on the floor at the entrance to the East and [NAME] Wings) had been placed on the flooring due to there being no threshold put down when the flooring was placed in the facility. The MA person stated with no threshold being placed, the flooring would rise up which created a fall hazard, therefore, the fall hazard tape was placed as a safety precaution. He stated he walked over the tape about twenty times a day and he had not noticed the tape had become loose and pulled up. The MA further stated the current condition of the fall hazard tape created a fall hazard, for any resident, staff, or visitor, which could result in falls with injuries. In interview with the Director of Nursing (DON) on 06/27/2024 at 2:47 PM, she stated she expected all residents to have a safe, clean, comfortable, and homelike environment. The DON stated R45 would, at times, run staff out of the room when they went into his room to look at the sink. She acknowledged any refusal should be documented in R45's chart; however, there was no documentation about him refusing to let maintenance staff work on the sink. The DON stated she expected any maintenance work orders to be completed, and any issues to be discussed in the daily morning meeting with all the department heads. She stated the fall hazard tape (on the floor at the entrance to the east and west wings), which had become loose, was a fall risk to anyone walking over it. The DON further stated the risk of someone falling (over the fall hazard tape) could be an injury, such as a broken bone. In interview with the Administrator on 06/28/2024 at 10:43 AM, he stated he made rounds daily and looked at the building during those rounds. The Administrator stated the resident's room should be homelike and everything in the room should be in good condition. He stated he was not aware of any work orders regarding the flooring (with the loose fall hazard tape); however, he was aware of the rubber band situation in room [ROOM NUMBER]. The Administrator stated R45 would not let the maintenance men work on the sink and he had ran them out of his room on multiple occasions. He stated he expected any maintenance issues to be fixed as soon as possible and he expected staff to notify the appropriate department whenever there was an issue in the facility. The Administrator stated the flooring at the entrances to both the East and [NAME] wings was a potential fall hazard, and the MA was working on getting the flooring fixed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45113 Based on observation, interview, record review, and review of the facility's policies, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframe's to meet a resident's medical, nursing, mental and psychosocial needs for two of 20 sampled residents (R), (R29 and R242) 1. R29's Comprehensive Care Plan, revised 12/21/2022, revealed an intervention to utilize a mechanical lift with two (2) staff members for transfers. However, on 04/05/2023, Certified Nursing Assistant (CNA) 4 and CNA 8, transferred R29 from the bed to the wheelchair without using the mechanical lift as per the care plan, and on 04/10/2023, staff observed both the resident's upper arms had yellow/purple bruising and bruising around the clavicle. A portable x-ray was ordered and performed, and noted R29 had bilateral (left and right) humeral (upper arm bone) neck fractures. R29 was transferred to the hospital, where bilateral humeral neck fractures were diagnosed . 2. Review of R242's Comprehensive Care Plan, dated 06/19/2024, revealed the facility failed to develop a respiratory care plan for R242, which included interventions for the resident's oxygen usage. Refer to F689 The findings include: Review of the facility's policy titled, Comprehensive Care Plans revised 02/09/2024, revealed the facility was to develop and implement a comprehensive, person-centered care plan for each resident. Continued review revealed the comprehensive, person-centered care plan was to include measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs based on the comprehensive assessment of a thorough evaluation which included the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) Assessment. Per review of the policy, identified problem areas were to be incorporated into the care plan, and assessments of residents were to be ongoing. Further review revealed the care plan interventions were to be derived from thoroughly analyzing the information gathered in the comprehensive assessment. 1. Review of R29's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 02/29/2016, with diagnoses of adult failure to thrive, multiple sclerosis (MS), age-related physical debility, osteoporosis without current pathological fracture and dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment with the Assessment Reference Date (ARD) of 04/14/2023, revealed the facility assessed R29 as being rarely or never understood and was unable to be interviewed. Further review revealed the facility also assessed R29 as totally dependent and to require maximal assistance of two (2) for transfers. Review of the Comprehensive Care Plan (CCP), dated 12/21/2022, for R29 revealed the facility developed a focus for Activities of Daily Living (ADLs) Functional Status/Rehabilitation Potential Profile Care Guide with an intervention to use a mechanical lift, with the green lift sling for the resident's transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R29's Nurse Aide Care Plan located in the electronic medical record (EMR) under the Reports tab revealed the resident's ADL status Plan of Care (POC) specific to transfers noting the resident required total care of two (2) staff with use of a mechanical lift and the green lift sling. Review of the Nurse Aide Kardex (a quick reference for nursing staff) revealed the intervention for the mechanical lift and green lift sling were noted and tagged to it from R29's care plan intervention initiated on 12/21/2022. Review of the facility's Initial-Self-Reported Incident Form, dated 04/10/2023 at 7:38 AM, completed by the former Administrator, revealed a CNA observed R29 to have bruising of unknown origin on 04/10/2023. Continued review revealed the bruising of unknown origin was to R29's bilateral upper extremities (BUE) and left clavicle. Review of CNA7's Witness Statement, dated 04/10/2023, located in the facility's investigation revealed she cared for R29 on 04/07/2023, 04/08/2023, and 04/09/2023. Continued review revealed on Friday night (04/07/2023), CNA7 noticed R29's left arm/hand was significantly weaker. Per review, CNA7 cared for R29 on Saturday and again on Sunday night. Further review revealed when she took R29 to the shower room on Monday morning (prior to the end of her shift) she noticed bruises on both the resident's arms above the bends of her armpits. Addition review revealed CNA7 also noticed R29's shoulders were swollen and the resident cried out in pain, so she immediately notified the nurse. Review of CNA4's Witness Statement, dated 04/12/2023, located in the facility's investigation revealed the CNA was asked to assist CNA8 in transferring R29 for the resident's shower. Continued review revealed CNA4 reported assisting R29 to sit up on the side of the bed and then completed a manual transfer (of the resident). Review further revealed after R29's shower, CNA4 and CNA utilized the (mechanical) lift to assist the resident back to bed. Review of CNA8's Witness Statement dated 04/14/2023, located in the facility's investigation revealed CNA4 came to assist her with the transfer. CNA8 indicated CNA4 sat R29 up on the side of the bed and then performed a manual transfer, without using the mechanical lift (as per the resident's care plan). CNA8 further stated she showered R29, and when she was finished, CNA4 helped R29 back to bed, performing another manual transfer of the resident. Review of R29's Progress Note, dated 04/10/2023 at 12:00 PM (late entry), revealed x-rays were ordered of R29's shoulders, and (the facility was) awaiting results. Review of the facility's portable Radiology Report, dated 04/10/2023 at 6:32 PM, of R29's left and right shoulder revealed a Left and Right Humeral Neck Fracture. Review of R29's Progress Note dated 04/10/2023 at 7:36 PM, completed by Licensed Practical Nurse (LPN) 5, revealed R29's (portable) x-ray results showing left and right humeral neck fractures were called to the Advanced Practice Registered Nurse (APRN) at approximately 7:00 PM. Further review of the Note revealed LPN5 received an order to send R29 to the emergency room (ER) for evaluation and treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R29's hospital documentation revealed Radiology Impression results for x-ray imaging of the resident's bilateral shoulders which showed a comminuted (fragmented) left humeral head/neck fracture and comminuted mildly displaced right humeral head/neck fracture, with no shoulder dislocation. Continued review of R29's hospital documentation revealed Emergency Department Departure documentation dated 04/10/2023 at 8:30 PM, which noted the resident was discharged back to the facility with instructions to continue the prescription of pain medication as prescribed by the provider, and to wear the bilateral slings for comfort. Review of the facility's Final Report-Fracture Investigation documentation dated 04/15/2023 revealed on 04/05/2023, CNA8 requested help to get R29 up with the mechanical lift, and CNA4 assisted. However, even though there was a lift in R29's room, CNA4 performed a manual lift of the resident from the bed to the shower chair. Continued review revealed CNA4 also performed a manual lift of R29 upon return to the resident's room to assist her back to bed. Further review revealed the outcome of the facility's fracture investigation revealed R29's fractures occurred from CNA4's actions (of performing a manual lift). Review of the facility's Final Report-Conclusion, documentation dated 04/15/2023, revealed the facility determined R29's fractures were caused when she was moved manually and not with the mechanical lift (as per her care plan). Per review, during CNA4's interview, he acknowledged he moved R29 manually and had not used a lift (as per the resident's care plan). Additional review revealed CNA4 was suspended initially but terminated based on his personal decision to move R29 manually and not follow the resident's care plan. Review further revealed the facility acknowledged staff (CNA 4) had not followed the resident's care plan related to transfers which caused R29's fractures. During a telephonic (phone) interview with Registered Nurse (RN) 3 on 06/29/2024 at 10:20 AM, she stated R29 was nonverbal, and required complete and total care related to her debility and comorbidities. She stated R29 was care planned for and required the use of a mechanical lift with all transfers. She stated all staff, including CNA4, newly hired and agency staff, had been educated and were aware of R29's care plan requirement for the use of a mechanical lift for transfers. RN3 stated staff, especially nurses and CNAs, knew to reference residents' care plans for their ADL plan of care, which included the transfer interventions. She stated the care plan was important because it was the resident's overall assessment of the care they required, more importantly, it provided staff direction on how to ensure a resident's safety and not cause harm. During an interview with Restorative Nurse/LPN 4 on 06/29/2024 at 11:00 AM, she stated the facility's current Leadership/Management was very involved with resident care and safety to ensure staff followed residents' care plans. LPN 4 stated staff were to be routinely monitored, continuously re-educated, and the importance of care plan interventions were reinforced. She said it was a must for all staff to reference and abide by residents' care plans to ensure the residents were safe and cared for appropriately. LPN4 further stated CNA4 knew R29 was a total mechanical lift and knew the resident was care planned for the lift. She also stated CNA4 had been trained/educated and knew better. In interview on 06/29/2024 at 11:28 AM, LPN 6 stated R29 required use of a mechanical lift for transfers as she was total care with all ADLs and was care planned for the lift. LPN 6 stated nursing assessments were performed to ensure residents' care plans were accurate and updated related to their needs and transfer requirements. She said management ensured staff were trained and educated to follow the residents' care plan interventions, and indicated harm could occur easily and quickly if the care plan was not followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	In interview on 06/29/2024 at 11:46 AM, Unit Manager (UM)/LPN7 stated R29 required total assistance with all ADLs and care plan interventions guided staff on how to provide proper care for the resident and ensure her safety. She stated staff,, including CNA4 were trained upon hire, re-educated, and provided constant communication of any new and/or updated care plan interventions for residents. UM/LPN7 stated that all new employees were educated with emphasis on residents' care plans, and therefore, she felt CNA4 had been trained/educated and was fully aware that R29 required a mechanical lift for all transfers (as per the care plan). During an interview with a former SDC on 06/29/2024 at 9:05 AM, she stated she had been very involved with the investigation process of the incident involving R29, regarding CNA4 not using a mechanical lift with the transfer of the resident, as care planned. She stated CNA4 knew the facility's process and was very aware that referencing the resident's care plan was a must to ensure resident safety. In interview on 06/29/2024 at 1:50 PM, the Director of Nursing (DON) stated she had actively been involved in the facility's investigation of the incident involving R29. She stated the facility's root cause analysis (RCA) determined R29's fractures were due to CNA4's failure to use the mechanical lift as R29 had been care planned. The DON stated CNA4's actions went against facility policy and procedure and was not tolerated so, CNA4 was terminated. In interview on 06/29/2024 at 2:35 PM, the current Administrator stated resident safety, transfers, ensuring the care plan was followed, and accidents/hazards were discussed at every meeting, to include the morning meeting. The Administrator stated not following the residents' care plans was not an exception and was not tolerated. In interview on 06/30/2024 at 9:55 AM, the Medical Director stated he was actively involved with the facility and was made aware of the incident involving R29. The Medical Director stated he was informed the CNA had not followed the resident's care plan. He further stated he expected staff to provide for the safety and well-being of the facility residents and follow their care plans. 49360 2. Review of R242's face sheet revealed the facility admitted the resident on 06/18/2024, with diagnoses of type 2 diabetes mellitus, hypoglycemia, hypothyroidism, and hypertension. Review of R242's Admission History and Physical, dated 06/20/2024, revealed the resident had an additional diagnosis of chronic obstructive pulmonary disease (COPD). Review of R242's Physician Orders dated June 19, 2024, revealed R242 was to be on oxygen therapy at 2 liters per minute (LPM) continuously via nasal cannula. Review of R242's Admission Minimum Data Set (MDS) Assessment with an ARD of 06/25/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Continued review of the Admission MDS Assessment revealed oxygen was not listed under Section O for special treatments, procedures, and programs. Review of R242's Comprehensive Care Plan, dated 06/19/2024, revealed the facility had not developed a respiratory care plan for R242, nor had the resident's oxygen usage and oxygen ancillary orders been placed on the care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Observation of R242 on 06/25/2024 at 2:40 PM, on 06/26/2024 at 9:42 AM, on 06/27/2024 at 3:16 PM, and on 06/28/2024 at 2:48 PM, revealed the resident wearing the ordered oxygen via nasal cannula, and her oxygen concentrator was set on 2 liters. In interview with R242 on 06/25/2024 at 2:40 PM, she stated she had been on oxygen therapy for about three years now and had been on home oxygen as well. In interview with the Director of Nursing (DON) on 06/27/2024 at 2:47 PM, she stated she expected residents' oxygen orders to be placed on their care plans. The DON stated any physician order should be noted on the care plans. She stated she was not aware of any residents who had continuous oxygen therapy who did not have a care plan for it. The DON stated new admissions were discussed in the next clinical meeting and the clinical team reviewed admission orders, which included oxygen therapy orders. In interview with the Administrator on 06/28/2024 at 10:43 AM, he stated he attended the daily morning meetings, but did not develop or implement care plans for residents. The Administrator stated he expected all oxygen orders to be placed on the resident's care plan and any changes should be updated on the care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974 Based on observation, interview, record review and review of the facility's policies, the facility failed to have an effective system in place to ensure each resident received adequate supervision and assistive devices to protect them from accidents and injury for 2 of twenty sampled residents (R) (R29 and R41). 1. On 06/25/2024, R41 stated he had fractured his right leg two times since residing at the facility, once in 2020, and again in 2022. Per R41, the first time occurred when he was being transported in his wheelchair to be weighed without the right foot pedal being on the wheelchair. He stated his leg got tired and dropped and was pulled under the wheelchair. The first incident resulted in R41 sustaining a fracture to his right distal femur. The second incident happened during a transfer from his bed to the wheelchair when he was going to a physician's appointment. He stated the two (2) Certified Nurse Aides (CNA) assisting him did not use a gait belt and rushed him during the transfer. He stated as he transferred, the wheelchair brakes were not on and he was only sitting on the edge of the seat and the wheelchair kept going backwards. The resident stated his leg twisted during the incident. The second incident resulted in a right tibial fracture. 2. On 04/05/2023, R29 was transferred from the bed to a shower chair and back to bed after the shower without using a mechanical lift as per the resident's care plan. On 04/10/2023, staff were getting R29 ready for a shower and noticed both of the resident's upper arms had yellow/purple bruising and bruising. A portable X-ray report noted R29 had bilateral (left and right) humeral (upper arm bone) neck fractures. The resident was transferred to the hospital, where the bilateral humeral neck fractures were confirmed. Refer to F656 The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 06/29/2024 at 9:31 AM, alleging removal of the Immediate Jeopardy (IJ) on 04/18/2023, prior to the State Survey Agency's (SSA's) survey and investigation. The SSA validated the facility's IJ Removal Plan, on 06/29/2024 at 4:00 PM, and determined the deficient practice was corrected as alleged on 04/18/2023, prior to the initiation of the investigation. Therefore, the IJ was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy titled, Resident Rights, revised 09/15/2023, revealed all residents had the right to be treated with respect and dignity. Continued review revealed the facility was to promote and protect the rights of the residents. Further review revealed resident rights included providing all residents with a manner and environment that promoted maintenance or enhancement of quality of life. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's, Certified Nursing Assistant (CNA) Job Description, revised December 2011, revealed the CNA was to perform direct care duties under the supervision of licensed nursing personnel and assist with promoting a compassionate physical and psychological environment for the residents. Continued review of the CNA's performance standards in the following areas, such as Essential Duties and Responsibilities, included the CNA to ambulate and transfer residents, utilizing appropriate assistive devices and body mechanics. 1(a). Review of R41's admission record revealed the facility admitted the resident on 12/18/2017, with diagnoses of acquired absence of left leg above knee, diabetes mellitus with diabetic neuropathy, muscle weakness, and limitation of activities due to disability. Review of R41's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/26/2020, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 of 15, which indicated intact cognition. Continued review of R41's MDS Assessment revealed the resident's functional status for locomotion on the unit revealed the facility assessed that activity to have not occurred. Per the MDS Assessment review the facility assessed R41's (ADL) support as family and/or non-facility staff provided care 100% of the time over the entire 7-day period. Further review revealed the facility assessed R41's locomotion off the unit for self-performance as the activity occurred once or twice with one-person physical assist (with self-sufficiency once in wheelchair). Review of R41's Care Plan, dated 08/31/2020, revealed the facility added an intervention to place the right foot petal on the wheelchair prior to transportation needs for right leg. Review of R41's Care Plan revealed the facility added a problem for ADL functional status on 02/01/2023, for transfers for the resident to have extensive assist X2 (times two) staff with use of a sliding board. Continued review revealed after the first incident in 2020, the facility added the right foot pedal to the wheelchair at all times intervention. Review of the facility's Event Report dated 08/29/2020, noted by Registered Nurse (RN 5) revealed an incident occurred at 2:45 PM (on that date) involving R41. The resident sustained an injury to the right knee while being transported. Continued review revealed the leg was extended during transportation under the wheelchair. The Certified Nursing Assistant (CNA) had stated the resident was being wheeled down the hall, and resident had been asked to keep the leg up and to let the CNA know if his leg became tired. Further review of the Event Report revealed the CNA said the resident did not say anything but suddenly let the leg fall causing the leg to jerk back under the wheelchair, overextending the right leg. Further review revealed the Physician was contacted and an order was obtained for an x-ray and to add the right leg pedal to the wheelchair. Review of R41's Progress Note dated 08/29/2020 at 4:04 PM, documented by RN 5, revealed awaiting mobile x-ray of right knee. Further review revealed the resident had been given pain medication with effective relief for right leg pain. Review of the mobile x-ray report of R41's right leg dated 08/29/2020 at 7:59 PM, revealed no acute fracture or dislocation seen. However, a small joint effusion and diffuse osteopenia were noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Progress Note dated 09/01/2020 at 2:55 PM, revealed R41 had complaints of right knee pain. Continued review revealed the physician was notified and an order for Tramadol (medication for moderate to severe pain) every six hours and an order for a Computed Tomography (CT) scan. Review of the CT imaging report dated 09/08/2020, revealed R41 had an insufficiency fracture of the distal right femur, and recommendations for an x-ray to confirm the results. Continued record review revealed a progress note dated 09/08/2020, documenting R41 was sent to the Emergency Department (ER) for the x-ray to be performed. Review of the hospital x-ray report dated 09/08/2020, revealed R41 had a fracture of the distal right femur meta-diaphysis (shaft portion of the long bone) above the prosthesis with impaction, a 2-centimeter gap between the fracture fragments and medial subluxation (partial dislocation) of the proximal femur. Review of the hospital nursing progress note dated 09/08/2020, revealed the resident was placed in a right knee immobilizer and new medications were prescribed. During interview with R41 on 06/25/2024 at 11:25 AM, the State Survey Agency (SSA) Surveyor asked about the resident's right leg fracture and he stated, Which time? They broke my leg twice. R41 stated the first time the CNA, (whose name started with A), came to get him from the day room on the East Wing to weigh him. He stated his wheelchair would not go through the door to the area where the scale was located due to the anti-tippers (device to keep a wheelchair from tipping over backwards) on his wheelchair. R41 said the CNA proceeded to take him over to the [NAME] Wing to weigh him there. In continued interview, R41 stated after being weighed when the CNA was taking him back to his room his leg became tired and before he could tell the CNA, his leg dropped. He stated when his leg dropped it resulted in the leg being pulled under the wheelchair. During an interview on 06/27/2024 at 4:04 PM, LPN 4 stated CNA3 had informed her that while pushing R41 in the wheelchair, the resident's leg dropped and went backwards under the wheelchair. LPN4 stated she contacted LPN 3, who was the Unit Coordinator at that time, and the resident's representative (RP). LPN4 further stated she could not recall if CNA3 was placed on leave after the incident. During interview with the Director of Nursing (DON) on 06/27/2024 at 4:10 PM, she stated CNA3 was the staff person transporting R#41 during the first incident. The DON stated RN5, who had written the progress note, passed away. She stated no investigation or report was made to the State Survey Agency (SSA) or any other entity due to the fact the facility knew how the incidents involving R41 happened and it had not been a reportable incident. However, later in another interview on 06/29/2024 at 2:50 PM, the DON stated the facility had completed an investigation, but that information was to be in the IJ Removal Plan to be provided to the SSA. Review of CNA3's employee file revealed the facility hired the CNA on 10/11/2019, and had performed a background check and completed an Adult Caregiver Misconduct Registry review with no issues. Further review revealed no documented evidence of education provided or of any reprimands. A telephonic (phone) interview was attempted to contact CNA3 on 06/22/2024 at 9:42 AM. However, she was unsuccessful as the person who answered stated the SSA Surveyor had the wrong number. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1(b). Review of the facility's policy titled, Gait Belts, dated 03/2011 revealed staff providing direct care to residents might use a gait belt during ambulation, transfer, or movement of residents. Further review of the policy revealed all CNA's, licensed nurses and therapists received education related to gait belt use during their schooling related to their licensure or certification. In continued interview on 06/25/2024 at 11:25 AM, R41 stated the second time his leg was broken two male CNAs were transferring him from his bed to the wheelchair as he was going out to a physician's appointment. The resident said with the assistance of two persons he could use a slide board to transfer. R41 stated the two male CNAs who were assisting him were rushing him to transfer that day and did not use a gait belt. He stated during the transfer the one CNA was behind the wheelchair, with the other in front of him and his wheelchair wheels were not locked. Per R41, as he was transferred he was only sitting on the edge of the seat, and the CNA behind him put his arms around R41's chest to try to pull him back, but the wheelchair kept moving. He stated the CNA in front of him was trying to hold him (R41) by his wrists to get him back onto the wheelchair, and his leg twisted somehow during the incident. Review of R41's Progress Note, dated 04/22/2022 2:42 PM, documented by LPN 8 revealed the resident returned from an appointment with complaints of discomfort to the right knee. Continued review revealed R41 stated he pivoted wrong this am when getting into w/c. MD notified, awaiting orders. Review of the physician's order, dated 04/22/2022, revealed at order to send R41 to the hospital for evaluation of discomfort to the right knee. Review of the Hospital Discharge Summary, dated 04/23/2022 revealed R41 arrived at the ED on 04/22/2022 at 10:22 PM, and was discharged back to the facility on [DATE] at 12:35 AM. Per review of the Summary, the mechanism of trauma was noted as a fall or jump, and under the comment section, Patient arrived from facility via Emergency Medical System (EMS) with chief complaint of no pulse in right foot and blue toes on right foot per facility nurse. Continued review revealed patient (R41) stated his right foot has had purple appearance with petechiae on right great toe like this for about 1 week. Further review revealed patient stated he was going to an appointment this morning from the nursing home, and the aides who had been assisting him transferred him to the wheelchair too quickly and he went backwards. Review of the hospital x-ray report dated 04/22/2022, revealed a fracture of R41's anterior right tibial (bone in the lower leg) tubercle measuring 2 1/2 by 0.7 centimeters. Additional review of the Hospital Discharge Summary dated 04/23/2022, revealed the final diagnosis for R41 was a displaced fracture of the right tibial tuberosity. Review of the Interdisciplinary Team (IDT) note dated 04/23/2022 at 3:11 PM, revealed the IDT met to review R41's plan of care. Per review of the IDT note, R41 was transferred to the wheelchair yesterday via two person assist with a gait belt and transfer board to go out to an appointment. Continued review revealed when R41 returned from the appointment, he stated his knee was hurting and he thought something was wrong. Review revealed R41 stated when the two CNA's transferred him yesterday, his leg caught on the floor and twisted. Per review of the IDT note, R41 had no initial complaints of pain; however, the knee was noted to be swollen and the resident later complained of pain in the knee. Review revealed R41 was sent to the Emergency Department (ED) for evaluation, and treatment, and was diagnosed with right tibial fracture. The review of the IDT note revealed Physical Therapy (PT)/Occupational Therapy (OT) were to evaluate and treat. Additional review revealed care plan interventions were added for a pain assessment every four hours, and new pain medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Event Report dated 04/23/2022 at 3:09 PM, completed by prior DON, revealed an incident occurred on 04/22/2022 at 10:06 AM, in which R41 sustained a right tibia fracture during transfer when preparing to go to an appointment. Continued review revealed R41 was sent to the hospital for evaluation. Review of CNA1's witness statement located in the facility's investigation documentation, dated 05/03/2022, revealed the CNA noted, We were transferring the resident very gently and slowly because he likes to move slowly with transfers. Then just out of nowhere during the transfer he just dropped his weight. We didn't do anything to him, he just dropped down like he was trying too purposely. Review of CNA2's witness statement, dated 05/05/2022 revealed, During a transfer of a man, I was helping CNA 1 [sic]. We were just transferring the guy and in the middle of it he kind of jerks and sits down in the air. We kept ahold of him though. He just out of nowhere tried to sit down, but we were doing good and had a good transfer. . Review of the employee file for CNA1 revealed his date of hire was 09/14/2021 as a CNA. Further review revealed the facility performed a background check and a check of the Adult Caregiver Misconduct Registry with no issues. Review of the employee file for CNA2 revealed he was hired as a Hospitality Aide on 12/01/2020, and on 03/07/2022, he became a Personal Care Assistant (PCA). Further review revealed the facility performed a background check and a check of the Adult Caregiver Misconduct Registry with no issues. Review of the facility's Personal Care Aide (PCA) job description, undated, revealed the PCA could assist with transfers from bed to chair or wheelchair with use of a gait belt, for one person standby assist/transfer. Further review revealed for anything beyond a one-person transfer, the PCA might only assist and must be directed by a certified/licensed staff member. During an telephonic (phone) interview on 06/27/2024 at 9:20 AM, with CNA 1 he stated that he did recall transferring R41 from the bed to wheelchair using a slide board. CNA 1 stated, I gave my report to them during their investigation He stated he had not used a gait belt during the transfer because I didn't have to, it wasn't called for. CNA 1 further stated he was not aware R41's leg was injured initially, and then stated, I need to hang up now and ended the call. A phone attempt was made to contact CNA 2 on 06/27/2024 at 9:29 AM. However, it was unsuccessful as the number provided by the facility was a wrong number. No other number was provided by the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/27/2024 at 10:30 AM with the Director of Rehabilitation (DOR), she stated she was not at the facility during the first incident in 2020, but did recall the 04/22/2022 incident. She stated R41 was a slide board transfer with minimal assistance from 01/22/2022 through 04/22/2022. The DOR stated after the incident on 04/22/2022, and returning from the hospital stay R41 had been a (mechanical) lift transfer for a short time. She stated when Physician's Orders were received for R41 to be weight bearing on the right leg, Physical Therapy (PT) saw the resident from 05/31/2022 through 09/15/2022. According to the DOR training/education was provided to all staff in 05/2022 that consisted of transfer training. The DOR further stated gait belts were usually not specified on the resident's care plan, but gait belts were a standard of care when transferring residents. 45113 3. Review of the facility's policy titled, Mechanical Lifts, dated 06/01/2015, and revised on 12/07/2023, revealed the policy was regarding safely transferring residents with mobility limitations using a mechanical lift to prevent falls and injuries from transfers. Continued policy review revealed provisions for general guidelines and procedural steps, including staff being alert for any resident requiring or needing a mechanical lift device upon admission and throughout the resident's stay for transfer needs. Further review of the policy revealed each certified nurse aide, licensed nurse, or licensed therapist utilizing a mechanical lift was to receive training on the proper use of the mechanicals as part of their schooling, during which they received certification or licensure. Review of the facility's guidelines and procedures revealed the mandatory training module titled, Day 1: New Hire Orientation: All Aides Competency-Full Body Lift Bed to Wheelchair undated, revealed Guideline #1, which instructed all aides to check the care plan and make sure to transfer a resident in accordance with the care plan. Review of R29's electronic medical record (EMR) Face Sheet revealed the facility admitted the resident on 02/29/2016, with diagnoses to include dementia, adult failure to thrive, multiple sclerosis (MS), age-related physical debility and osteoporosis without current pathological fracture. Review of R29's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/14/2023, revealed the facility assessed the resident as being unable to interview and as rarely or never understood. Continued review of the MDS Assessment revealed the facility also assessed R29 as totally dependent on two staff for transfers. Review of R29's Comprehensive Care Plan (CCP) dated 12/21/2022, revealed the facility developed a focus on Activities of Daily Living (ADLs) Functional Status/Rehabilitation Potential Profile Care Guide for the resident. Continued review revealed for transfers the interventions included the resident requiring total dependent care from two staff assistants, using a mechanical lift, staff to use the green lift sling. Review of the Mechanical Lift Evaluation dated 12/21/2022, revealed the facility assessed R29 for the correct sling size to use: the green lift sling with mechanical lift, referenced in the care plan for staff awareness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Nurse Aide Care Plan found in R29's EMR under the Reports tab for the resident's ADL status on the Plan of Care (POC), specific to transfers revealed the resident required total care with two (2) staff assist, a mechanical lift with the use of a green lift sling for transfers. Further review revealed that intervention was noted and tagged to the Kardex (Nurse Aide Care Plan) from R29's comprehensive care plan intervention initiated on 12/21/2022. Review of the facility's Stop and Watch documentation revealed a change in R29's skin color or condition, dated 04/07/2023 at 9:54 PM, completed by Registered Nurse (RN) 3. Further review revealed the resident's skin color was lighter on the left arm/hand and very weak. Review of R29's Progress Note, dated 04/07/2023 at 11:37 PM, completed by RN3, revealed CNA 7 reported the resident's left arm was weaker. Continued review revealed RN 3 observed R29 and noted it appeared the resident was not using the left arm. In addition, review of the Note revealed RN3 notified the physician and received an order for Occupational Therapy (OT) to evaluate and treat R29. Review of R29's Progress Note, dated 04/10/2023 at noon (late entry), revealed the nurse (RN4) was told by staff that R29 was in pain. Continued review revealed x-rays were ordered for R29's shoulders, and the results were pending. Further review revealed the nurse gave R29 650 mg of acetaminophen for pain with some relief noted. Review of the facility's Initial-Self-Reported Incident Form, dated 04/10/2023 at 7:38 AM, completed by the former Administrator, revealed on that date stakeholder (CNA7) observed at approximately 6:00 AM-7:00 AM, during R29's bathing, bruising of unknown origin to the resident's bilateral upper extremities (BUE) and left clavicle. Continued review of the Form revealed nurses completed a full skin assessment and a pain assessment and identified no further issues. Review further revealed immediate notification was made to the physician, resident's responsible party (RP), State Agencies and an investigation was initiated. Review of RN3's Witness Statement dated 04/10/2023, located in the facility's investigation documentation, revealed the Nurse Aide (CNA7) called the RN to the shower room on 04/10/2023 at approximately 5:00 AM. RN3 noted she observed R29 in the shower chair and observed discoloration to the resident's bilateral upper arms. Continued review revealed RN3 documented on 04/10/2023 at 5:08 AM, she notified the Assistant Director of Nursing (ADON) of her observation of R29, and the ADON stated she was on her way to the facility to assess the resident. Per review of RN3's Witness Statement, at approximately 6:49 AM, she received a physician's order for bilateral shoulder x-rays related to her observation and assessment of R29's shoulders which were swollen. Further review revealed RN3 also noted she left a message with R29's RP to call the facility. Additional review revealed after R29's shower, CNA7 and CNA9 transferred the resident back to bed using a mechanical lift, as ordered, and a head-to-toe assessment was completed by the ADON and an investigation initiated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of CNA7's Witness Statement, dated 04/10/2023, located in the facility's investigation revealed she cared for R29 on Friday, 04/07/2023, Saturday, 04/08/2023, and Sunday, 04/09/2023. Continued review revealed on Friday night (04/07/2023), CNS7 noticed R29's left arm and hand were significantly weaker; therefore, she filled out a Stop and Watch with the nurse. Per review of the witness statement, CNA7 noted she did not notice any skin discoloration, bruising, or swelling, nor had the resident exhibited any signs of pain. Per review of the Witness Statement, she cared for R29 on Saturday (04/08/2023), and did not notice anything out of the resident's baseline. Further review of the Witness Statement, revealed on Monday morning, (prior to the end of her shift) when she took R29 to the shower room to bathe the resident she observed bruises on both R29's arms above the bends of her armpits. In addition, she stated she also noticed R29's shoulders were swollen, and the resident cried out in pain, so she immediately notified the nurse. Review of CNA4's Witness Statement, dated 04/12/2023, located in the facility's investigation revealed the CNA reported having been asked to assist CNA8 in transferring R29 for the shower task to be completed. Continued review of the Witness Statement revealed CNA4 reported assisting R29 to sit on the side of the bed and then completed a manual (without the use of the mechanical lift) transfer. Further review revealed following R29's shower, CNA4 noted he and CNA8 utilized the (mechanical) lift to assist in getting the resident back to bed. Review of CNA8's Witness Statement dated 04/14/2023, revealed she had been assigned to shower R29 on 04/05/2023, which she performed closer to the end of her shift. Continued review of the Witness Statement revealed CNA4 came to assist her with R29's transfer from the bed and CNA4 sat the resident up on the side of the bed and performed a manual transfer, without using the mechanical lift. Further review revealed CNA8 reported she showered R29, and when she was finished, CNA4 helped the resident back to bed, doing another manual transfer. Review of the facility's Final Report-Incident Summary dated 04/15/2023, revealed on 04/10/2023, between 5:30 AM and 6:00 AM, CNA (7) was getting R29 ready for a shower and noticed both upper arms had yellow/purple bruising and bruising around the clavicle. Continued review revealed a portable x-ray revealed left and right humeral neck fractures, and R29 was sent to the hospital, where they confirmed bilateral humeral neck fractures. Further review revealed R29 was sent back to the facility with a sling and to continue on the pain medications. Additional review revealed the Administrator reported the injury of unknown origin to all State Agencies and parties timely. Review of the facility's Final Report-Fracture Investigation dated 04/15/2023 revealed that on 04/05/2023, CNA8 requested help to get R29 up with the lift, and a CNA (CNA 4) assisted CNA 8. Per review, although the lift was in the room, CNA 4 manually lifted R29 from the bed to the shower chair and returned the resident to the bed after the shower the same way. Contiuned review revealed the outcome of the facility's fracture investigation revealed the fractures occurred from the actions performed by CNA4. Additionally, R29 was not gotten up any other time until 04/10/2023 when staff observed the bilateral bruising to upper arms and clavicle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Final Report-Conclusion, dated 04/15/2023, revealed the facility determined R29's fractures were caused when she was moved manually and not with the mechanical lift as required. Per review, during CNA 4's interview, he acknowledged he moved R29 manually and had not used the mechanical lift. Continued review revealed CNA4 was suspended initially, but terminated after that based on his personal decision to move R29 manually and not follow the resident's care plan. In addition, however, the facility acknowledged staff (CNA4) did not follow the care plan related to transfers caused R29's fractures. Review of R29's facility portable Radiology Report, dated 04/10/2023 at 6:32 PM, completed on the resident's left and right shoulder revealed Recent Left and Right Humeral Neck Fracture. Further review of R29's Progress Note dated 04/10/2023 at 7:36 PM, completed by Licensed Practical Nurse #5 (LPN5), revealed the x-ray results of the left and right shoulders were called to the Advanced Practice Registered Nurse Practitioner (APRN) by the dayshift nurse at approximately 7:00 PM. Further review revealed the results reported to the APRN showed recent left and right humeral neck fractures. Additional review revealed an order was received to send R29 to the emergency room (ER) for evaluation and treatment and the ADON and RP were notified. Review of R29's Medical Decision Making/Emergency Department Course (MDM/ED) documentation dated 04/10/2023 at 8:24 PM, revealed the ER Physician assessed the resident and found scattered bruising to the proximal (point closer to the point of attachment) medial (center of the body) aspect of the bilateral upper arms which appeared yellowish/purple. Continued review revealed the ER Physician noted a similar yellow/purple bruise was noted on R29's left clavicle/lateral neck region. Review of the MDM/ED course also revealed the ER Physician considered neglect or abuse within the facility as a reason for R29's fractures, as the resident was bedbound. Further review revealed the ED nursing staff filed an Adult Protective Service (APS) report related to R29's bilateral humeral fractures with no reported trauma/injury. Review of the hospital Radiology Impression results for R29 revealed x-ray imaging of the resident's bilateral shoulders revealed a comminuted (broken in two or more areas) left humeral head/neck fracture and comminuted mildly displaced right humeral head/neck fracture, with no shoulder dislocation. Review of R29's Emergency Department Departure dated 04/10/2023 at 8:30 PM, revealed the resident was discharged back to the nursing home facility with instructions to continue taking the prescription of Norco (narcotic pain medication) 7.5/325 mg (milligram) as prescribed by the provider; wear the bilateral slings for comfort and supportive care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physician Progress Note, dated 04/11/2023, for R29 revealed the resident was seen for a follow-up assessment after an ER visit and resident's condition reported by the nurse and Interdisciplinary Team (IDT). Per review, the Physician assessment revealed R29 was reported to have increased weakness starting on Friday (04/07/2023), and a stop and watch was put into place by the nurse, and an OT evaluation was ordered. Continued review revealed on Monday (04/10/2023), the nurse notified the physician before the physician arrived at the facility and reported R29 had swelling to the bilateral upper extremities (BUE), bruising, and appeared to be in pain. Review of the Note revealed an x-ray was ordered at that time and completed later that evening with the physician notified of the results showing a right humeral neck fracture. The physician documented orders were given to send R29 to the ER for further evaluation, and the resident returned from the ER evaluation with orders for a sling to the bilateral arms with a neck strap in place when the resident was sitting up related to bilateral humeral neck fractures. Further review revealed no surgical intervention was recommended. During a phone interview with RN3 on 06/29/2024 at 10:20 AM, she stated R29 was nonverbal and required complete total care related to her debility, chronic diagnoses and comorbidities; therefore, the resident required a mechanical lift with all transfers. RN3 stated all staff, including CNA6, agency staff, and newly hired staff, were all educated and aware of R29's requirement for a mechanical lift with transfers. She stated staff, especially nursing staff including CNAs, knew to reference the care plan for a resident's ADL plan of care, including their transfer interventions. RN3 emphasized the importance of referencing the care plan because it was the resident's overall assessment of what they required, and stated more importantly, it provided staff direction to ensure the resident's safety and not cause harm. In continued interview on 06/29/2024 at 10:20 AM, RN3 stated she had worked the weekend shift starting on Friday evening (04/07/2023) through Monday morning (04/10/2023). She stated on that Friday night, at approximately 9:30 PM, CNA7 informed her that R29's left arm/hand appeared significantly weaker. RN3 stated after completing her assessment of R29, she filled out a Stop and Watch form. RN3 stated she did not notice any bruising, or swelling, and the resident was not exhibiting any signs of pain and/or discomfort. She stated she recalled obtaining an order for the OT evaluation. RN3 stated that early on Monday morning (04/10/2023) at approximately 6:00 AM, while the CNAs were performing their morning showers, they requested she go look at some areas of bruising/discolorations they had found on R29's arms and clavicle area. She said she immediately assessed R29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49360 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice for one of two residents (Resident 242). The findings include: Review of the facility's policy titled, Oxygen Administration Policy, revised 05/30/2024, revealed oxygen therapy was to be administered as ordered by a physician. Review of the facility's policy titled, Comprehensive Care Plans, revised 02/09/2024, revealed the facility was to develop and implement a comprehensive person-centered care plan (CCP) for each resident. Per review the care plan was to include measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs as identified on the comprehensive assessment. Review of the facility's policy titled, Policies and Practices-Infection Control, revised October 2018, revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Continued review of the policy revealed the objectives of the facility's infection control policies and practices were to provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. Review of R242's Face Sheet revealed the facility admitted the resident on 06/18/2024, with diagnoses of type 2 diabetes mellitus. Review of the Admission History and Physical, dated 06/20/2024, revealed an additional diagnosis of chronic obstructive pulmonary disease (COPD). Review of the Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/25/2024, revealed the facility assessed R242 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident had intact cognition. Further review of the Admission MDS Assessment revealed under Section O for special treatments, procedures, and programs oxygen was not listed. Review of R242's Physician's Order, dated June 19, 2024, revealed an order for oxygen therapy at two (2) liters per minute (LPM) continuously via nasal cannula. Review of R242's Comprehensive Care Plan (CCP) dated 06/19/2024, revealed the facility failed to develop and implement a respiratory care plan for the resident's oxygen usage which included the oxygen ancillary orders. Observation of R242 on 06/25/2024 at 2:40 PM; on 06/26/2024 at 9:30 AM; on 06/27/2024 at 11:42 AM; and on 06/28/2024 at 2:48 PM, revealed the resident wearing oxygen via a nasal cannula at 2 LPM. Observation of R242's oxygen concentrator revealed the filter was covered in dust. In interview on 06/25/2024 at 2:40 PM, R242 stated the (oxygen concentrator) filter had not been cleaned since she was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockcastle Health and Rehabilitation Center	371 West Main Street Brodhead, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with Licensed Practical Nurse #5 (LPN5) on 06/28/2024 at 2:56 PM, she stated the oxygen company was responsible to change the filters on the oxygen machines. LPN5 stated, to her knowledge, the nurses did not touch oxygen filters on the oxygen concentrators. She stated if they found a dirty one (dirty filter) they notified the oxygen company. LPN5 further stated the risk for not having a clean filter on an oxygen machine was it could cause the residents to have more respiratory distress and could spread germs. During an interview with Registered Nurse #1 (RN1) on 06/28/2024 at 3:14 PM, she stated the oxygen company was responsible to come in and to check the filters on the oxygen equipment. RN1 stated if she found a dirty filter, she notified the Director of Nursing (DON), or the Unit Manager (UM) and they would in turn notify the oxygen company. She further stated if the filter was dirty, it could cause the machine to not run properly, which could cause the resident to not get all the oxygen needed, and could cause more respiratory issues for the resident. In interview with the DON on 06/27/2024 at 2:47 PM, she stated she expected oxygen filters to be clean and without dust. The DON stated the oxygen tubing change and cleaning of the oxygen filter was completed on night shift weekly and as needed. She stated filters could be cleaned anytime a nurse saw a dirty filter. The DON further stated the filter's job was to keep debris out of a resident's lung field, so a dusty filter posed no risk to the resident. In interview with the Administrator on 06/28/2024 at 10:43 AM, he stated he expected all oxygen filters to be clean, which included having no dust on it. The Administrator stated he expected all nurses to be observant and to clean the filters as needed whenever there was a dirty filter observed during routine rounds.