STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185455	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valhalla Post Acute	300 Shelby Station Drive Louisville, KY 40245

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** 37182 Based on observation, interview, and record review, it was determined the facility failed to provide a safe environment for residents. The facility's deficient practice had the potential to affect 24 of 24 residents who resided on the English Oak Terrace Unit. On 05/01/2024 a staff member was arrested under suspicion of arson after a fire occurred in Resident (R14) and R466's room. The facility failed to protect residents when a staff member, the Social Services Assistant (SSA), voiced frustration and threatened Resident (R) 14. On 05/01/2024 at approximately 4:45 PM, the Social Services Assistant (SSA) exited an elevator and stated to Certified Nursing Assistant (CNA) 2 he was going to get rid of R14. Subsequently, on 05/01/2024 the SSA was arrested for suspicion of arson after a fire occurred in the room of R14 and R466. Additionally, the fire was set while R14's roommate was in the room, R466. It was determined the facility's non-compliance with one or more requirements of participation caused or was likely to cause serious harm, serious impairment and/or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care were identified at 483.25 Free of Accidents, Hazards, or Supervision, F689. The IJ was identified on 05/10/2024 and was determined to exist on 05/01/2024 at approximately 4:45 PM when the SSA threatened to harm R14. The facility was notified of the IJ and provided a copy of the IJ template on 05/10/2024 at 5:34 PM. An amended IJ template was delivered to the facility on [DATE] at 4:03 PM. An acceptable IJ Removal Plan was received on 05/16/2024. The State Agency validated removal of the IJ on 05/17/2024 at 5:00 PM following the facility's plan for removal of the IJ. The findings include: Review of facility policy Safety and Supervision of Residents, revised July 2017, revealed the facility made resident safety, supervision, and assistance priorities. Review of facility policy Accidents and Incidents, dated July 2017, revealed it was the facility's responsibility to monitor its employees to ensure the safety of its residents. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Kentucky Handbook, revised July 2020, revealed in Section 1.4 General Safety and Security Policy, all company employees are responsible to maintain a healthy and safe work environment. Additionally, employees were to advise their supervisor of any known or potential security risks and/or suspicious conduct of employees, customers, or guests. Review of the Long Term Care Facility - Self-Reported Incident Form initial report to the State Survey Agency, received on 05/01/2024, revealed a fire occurred on 05/01/2024 at 4:57 PM, in the room of Residents (R) 14 and R466. Resident 14 was not in the facility when the fire occurred and R466 was in the room. Resident 466 required total assistance for mobility and ambulation. Continued review of the report revealed the facility's fire alarm was activated, the fire extinguished, and R466 was removed from the room and was evaluated by an emergency medical technician with no injury identified. Review of the facility's Long Term Care Facility - Self-Reported Incident Form final report/5-day follow-up revealed the fire department personnel initially stated the fire began from a power-wheel chair cord; but, upon further inspection discovered suspicious items in the room and contacted a fire investigator who cleared all facility personnel from the room and secured the room. After the investigation, the local police were notified. The local police then arrested the SSA on 05/01/2024, and charged him with arson. Further review of the facility's final report/5-day follow-up revealed immediately prior to the fire, Certified Nursing Assistant 2 noted suspicious behavior from the SSA, including SSA entering and exiting the room where the fire occurred. Review of the facility's video footage of the incident revealed on 05/01/2024, the SSA entered R14 and R466's room at 4:59:20 PM and exited the room at 5:00:18 PM. The SSA was in the resident room for approximately 58 seconds, and after exiting the room, the SSA walked away from the room, turned around and walked past the closed door and glanced at the residents' door at 5:00:52 PM. The fire alarm then sounded at 5:01:33, approximately 41 seconds later. Review of the facility's Admission Record revealed the facility admitted Resident (R) 14 on 06/28/2023 with diagnoses including generalized anxiety disorder, schizophrenia, adjustment disorder with mixed anxiety and depressed mood, and post-traumatic stress disorder, unspecified. The facility assessed R14 on the quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) 03/19/2024, as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15. Additionally, the facility's functional assessment from the facility's MDS revealed R14 was independent regarding mobility with use of a motorized scooter. Review of the facility's Admission Record revealed the facility admitted R466 on 06/20/2023 with a diagnosis of stroke, hemiparesis and hemiplegia on left side, and unspecified dementia. Review of R466's quarterly MDS, with an ARD of 03/29/2024, revealed the facility assessed him with a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. Review of the facility's functional assessment from the facility's MDS of R466 revealed he was dependent on care regarding turning, repositioning, toileting, hygiene, and mobility. Review of the facility investigation form Investigation Interview Question and Responses (Employee), (IIQR) undated, revealed Certified Nursing Assistant (CNA) 2, noted on 05/01/2024 at approximately 4:45 PM, she observed the SSA getting out of the elevator and per CNA2, the SSA stated I'm going to get rid of this old fucker. When CNA2 asked the SSA to clarify who, the SSA stated [R14]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the IIQR for Licensed Practical Nurse (LPN) #4, dated 05/02/2024, revealed R14 approached her earlier in the day upset as the SSA had not yet taken R14 to an area store. Additionally, LPN #4 stated when she informed the SSA about R14 waiting for the SSA to take him to the store, the SSA responded by displaying his middle finger and saying fuck [R14] and cussed profusely. Observation of the room of R14 and R466, on 05/09/2024 at approximately 8:20 AM, revealed no discernable effects of a fire other than fire extinguisher residue. Interview with R14, on 05/09/2024 at 9:01 AM, revealed on the morning of 05/01/2024, R14 asked the SSA to escort him to the store and the SSA agreed; however, the SSA did not show. R14 then stated he asked the SSA again and the SSA responded he had an emergency and was not able. Further interview revealed R14 stated maybe he [the SSA] got tired of me asking to do this, the [store] thing. Interview with CNA1, on 05/09/2024 at 10:31 AM, revealed approximately two to three weeks prior to the fire the SSA asked her which residents had cameras in their rooms. CNA1 stated she then escorted the SSA to the room of R14/R466 and pointed out the four cameras installed in the room. CNA1 stated she thought this was an odd question to ask but gave it no further thought. Interview with CNA2, on 05/08/2024 at 10:40 AM, revealed she observed the SSA enter and exit R14's room and shut the door a few minutes prior to the fire alarm sounding. Interview with Certified Medication Technician (CMT) 3 on 05/09/2024 at 11:17 AM, revealed that during the immediate aftermath of the fire, the SSA told her not to worry about R14 as the SSA had a feeling [R14] won't be around here much longer. CMT3 further stated she thought the comment odd but did not question it further. Interview with the Administrator in Training (AIT), on 05/09/2024 at 3:00 PM, revealed he could not recall when the SSA informed him that R14 was getting on him a lot about going to the store. Additionally, he stated the SSA told him that R14 was driving him crazy and the SSA could not get his work done because of assisting R14. Interview with the Administrator, on 05/08/2024 at 2:34 PM, revealed the facility was responsible for keeping residents safe, but it was difficult to predict when an employee may start a fire. Further, the Administrator stated he did not have a formal type of staff monitoring in place, prior to this incident (the fire on 05/01/2024). Since this incident, however, he stated he has provided education to all staff, including agency staff, regarding being aware of their surroundings and suspicious behaviors, from a resident or fell ow staff member. Further, staff were provided education related to reporting any suspicious behaviors. In an additional interview with the Administrator on 05/09/2024 at 12:47 PM, he stated he was not present at the time of the fire on 05/01/2024. Further, he stated local law enforcement had already taken the SSA into custody by the time he returned to the facility.