STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/05/2020 and concluded on 06/12/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#31821 and a COVID-19 Focused Infection Control Survey was initiated on 06/05/2020 and concluded on 06/12/2020. Complaint KY#31821 was substantiated with deficiencies cited. The facility was found was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 125.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of policy it was determined the facility failed to develop and implement a Comprehensive Care Plan (CCP) for one (1) of seventeen (17) sampled residents, Resident #1. Resident #1 reported to Registered Nurse (RN) #1 he/she had difficulty breathing on 06/01/2020 at 7:30 AM. Interviews revealed staff failed to notify the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 2	F 656		

medical provider at 06/01/2020 at 7:30 AM, and did not provide ordered and care planned respiratory medication, or continually monitor the resident when the resident showed a significant change of condition with oxygen saturations seventy to eighty (70 - 80) percent (%) while on oxygen. Further interviews revealed when a secondary assessment completed by Licensed Practical Nurse (LPN) #1 at 9:30 AM, occurred, staff did not notify the provider and provide necessary medication when the LPN assessed the resident's oxygen levels in the fifties (50's). The facility transferred the resident by nine one one (911) emergency services for respiratory distress three and a half (3.5) hours after the initial complaint and assessment. In addition, the facility failed to develop a plan of care for Resident #1's breathing support machine called BiPAP and for COVID-19 monitoring.

The findings include:

Review of the policy Care Plans, Comprehensive Person-Centered, revised 12/2016, revealed the CCP included objectives, timetables to meet the residents' physical, psychological, and functional needs. The CCP services include the services provided by staff to attain or maintain the residents' highest practical well-being. In addition, the CCP interventions provided information to aid in the prevention, reduce a residents decline, or maintain the residents' functional status.

Review of COVID-19 Resident Policy, undated, revealed the facility initiated the policy for early detection and effective triage of a potentially infectious resident. The facility monitored residents for fever and respiratory symptoms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 3	F 656		

every shift. In addition, the facility staff monitored the residents' throughout the shift for potential or actual symptoms of a respiratory infection.

Review of the clinical record for Resident #1 revealed the facility admitted the resident on 03/15/18 with the diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath (SOB), and Paraplegia. Further review revealed the physician ordered BiPAP (a supportive respiratory machine) every night for the resident's diagnosis of COPD.

Review of the Minimum Data Set (MDS) quarterly assessment, dated 04/01/2020, revealed the facility completed a cognitive assessment with the Brief Interview for Mental Status (BIMS) exam. The facility assessment revealed a score of twelve (12) out of a possible fifteen (15) and the facility determined the resident was interviewable. The facility diagnosis included the respiratory conditions of SOB and COPD.

Review of the CCP for Resident #1 revealed the CCP did not includ a developed focus care plan for Resident #1's diagnosis of COPD, the use of the BiPAP machine, and COVID-19 monitoring and or care.

Record review of the clinical recorded oxygen saturation summary revealed Registered Nurse (RN) #2, recorded Resident #1's saturation of eighty-nine (89) % while on oxygen on 5/30/2020 at 3:04 AM and 3:32 AM. Further review of the clinical record revealed staff did not document further assessments, medication administered, or notification to a provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 4	F 656		

Interview with Registered Nurse (RN) #2, on 06/10/2020 at 9:19 AM, revealed RN #2 assessed Resident #1's oxygen saturation at eighty-nine (89) % on two occasions on 05/30/2020 within thirty (3) minutes when assessed for COVID-19 symptoms. He stated at the time of the low oxygen level he did not complete an in-depth respiratory assessment, did not provide ordered respiratory treatments, and did not notify the provider or oncoming staff of the abnormal finding; nor did he review Resident #1's care plan. RN #2 stated the CCP addressed a resident's health concerns and addressed the care staff needed to follow at all times. He stated a nurses responsibilities included to follow the care plan to take care of residents.

Review of the CCP Focus for Resident #2's risk for respiratory distress, revised on 01/10/2020, revealed the resident's risks included the need for oxygen, use of the BiPAP machine, SOB, COPD and Obesity. The facility interventions included to administer ordered medications, document abnormal findings and notify provider, give aerosol, or bronchodilators (misted medication for SOB symptoms), and to observe for Signs and Symptoms (S/S) of changes in respiratory status. The S/S for respiratory status changes included increased respirations and or heart rate, decreased oxygen saturation, sweating, and changes in skin color. Further review revealed the S/S for respiratory distress included decreased oxygen saturation, increased respirations, increased heart rate, sweating, and changes in skin color. The interventions included to document abnormal findings in the residents chart and notify the provider.

Interview with the Lead Care Coordinator (LCC),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 5	F 656		

on 06/08/2020 at 1:10 PM, revealed staff verbally reported on 06/01/2020 Resident #1's pulse oximeter (a device that reads oxygen levels) at the bedside with oxygen at the level of fifty (50) percent. Normal range for oxygen included above ninety (90) % with or without oxygen.

Interview with LPN #1, on 06/09/2020 at 2:36 PM, revealed Resident #1 requested assistance, on 06/01/2020 at 9:30 AM, because the resident reported not breathing well. He stated the resident appeared sweaty and breathing heavy and fast. LPN #1 stated the resident appeared to have respiratory distress and he stated his assessment found the resident's oxygen level in the fifties (50's) while on oxygen. He stated he left the room to look for equipment to provide the ordered nebulizer but stated he did not provide respiratory medication to the resident nor did he immediately notify the provider of the resident's assessment. LPN #1 stated the Nurse Practitioner (NP) came onto the floor after 10:00 AM, assessed the resident, and requested 911 for transfer because of the resident's condition of respiratory distress. Continued interview revealed the facility required staff to review resident care plans but LPN #1 stated he did not have time to review resident care plans. He stated care plans specified the care residents required to maintain their status. He stated the facility expected all staff to follow resident care plans at all times. He further stated not following the care plan might lead to a resident's death because of what the staff did not do for the resident. Furthermore, LPN #1 stated he did not complete documentation of his assessment and findings. He stated the responsibility belonged to the assigned nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 6	F 656		

Interview with RN #1, on 06/09/2020 at 12:04 PM, revealed Resident #1 complained of SOB at the beginning of the shift at 7:30 AM. She stated she assessed the resident oxygen level while on oxygen at seventy to eighty (70 to 80) percent. She stated she did not administer the rescue inhaler and nebulizer (misted medication) ordered by the provider for SOB, but notified the provider by a text message. She stated she continued medication pass for the floor residents after the initial findings and assessment. She further stated she did not document any of the assessment findings or events with the exception of the order to send out the resident per the provider.

Review of RN #1's text message, dated 06/01/2020 at 9:53 AM, revealed RN #1 sent a message to the NP which reported Resident #1 complained of breathing difficulty.

Continued interview with RN #1, on 06/10/2020 at 12:29 PM, revealed she did not review Resident #1 care plan. She stated she knew how to access the CCP in the computer and she stated the reason to follow a CCP included to help the resident feel better and to prioritize the care to meet resident goals. She stated a nurse's responsibilities included to follow the CCP daily. She stated resident health may decline if the CCP was not followed. She further stated care of the resident included the care plan and all nurses knew to follow the care plan.

Interview with the UM #1, on 06/10/2020 at 9:05 AM, revealed she did not compare the care staff provided the the care specified in the CCP to insure the CCP was followed. She stated she expected staff to review resident care plans and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 7	F 656		

she stated staff followed resident care plans to provide proper care to each resident at all times. UM #1 stated staff who did not follow the resident care plan might cause the resident condition to change. She further stated the clinical team, which included the UM, reviewed the clinical chart to ensure staff followed, reacted, and completed all required components for a discharged resident. She further stated the clinical team did not identify issues for 06/01/2020 for Resident #1's care or required documents before discharged to the emergency room. However, review revealed the clinical chart did not include both clinical nurse's findings and observations, the time reported, medications provided or the events around the resident's decline and emergent transfer. Therefore, a clinical team completed inaccurate review for care and services provided by the staff as indicated by the residents CCP.

Interview with the MDS coordinator, on 06/10/2020 at 2:16 PM, revealed the facility collected data from several sources to complete a resident's CCP. She stated the CCP followed interventions from a select sub type and individual interventions to meet the goal of the residents' focus. She stated the facility reviewed CCP's and updated quarterly and the facility instructed staff to review the residents' care plans. She state the CCP directed resident care to improve or maintain the health of a resident. She stated the facility expected all staff to follow resident care plans at all times. She further stated a poor outcome for the resident may occur when staff did not follow the care plan.

Interview with the Director of Nursing (DON), on 6/10/2020 at 2:52 PM, revealed resident care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 656	Continued From page 8	F 656		

plans provided information for how to provide care of the resident. She stated the basics identified the problem and the facility completed interventions specific to the resident needs. She stated she expected staff to follow the CCP because the interventions provided specific care for a resident and care of a resident with a change of condition included close monitoring and communication with the provider because the resident might decline quickly. She further stated she and the UM had not completed any CCP audits on the floor. She stated she expected staff to provide care per the CCP at all times. She stated the facility did not review the resident's care plan; this occurred when the resident returned. However, record review revealed staff failed to document, provide interventions, administer medication, and notify the provider with a change of condition after staff identified S/S of respiratory changes and distress. Therefore, the staff failed to follow the resident's CCP and clinical staff failed to identify a root cause of the resident's emergent discharge.

Interview with the Administrator, on 06/11/2020 at 8:29 AM, revealed the clinical nursing team reviewed residents' unplanned discharges the next day. He stated he did not receive a report from the DON of identified issues with the response, care, clinical chart documentation or following the care plans for Resident #1. He stated he expected facility staff to provide competent nursing care to meet the needs for each resident. He stated competent care included attentiveness, monitored changes of conditions, completed assessments, documentation, and following provider orders and care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 9	F 695		
F 695 SS=G	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 respiratory care and services for one (1) of seventeen (17) sampled residents, Resident #1. Record review revealed Resident #1's physician ordered daily and as needed (PRN) respiratory aerosols treatments for COVID-19 and the facility instructed staff to be on a heightened alert for COVID-19 respiratory symptoms. Resident #1 presented over a three (3) day period with low-grade fevers and a low oxygen level while on oxygen. Furthermore, on the morning of the fourth day, Resident #1 presented with a Change of Condition (CoC) and the complaint of difficulty with breathing. A staff's assessment reported oxygen saturations of between seventy (70) and eighty (80) percent (percentage) on oxygen at 7:30 AM on 06/01/2020. Staff did not administer respiratory treatments, left the resident in the room without supervision, and the resident continued to decline. At 9:53 AM, staff sent a text message to the Nurse Practitioner (NP) with the first notification of Resident #1's complaint of	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 10	F 695		

Shortness of Breath (SOB) after another staff assessed Resident #1's oxygen level at fifty-six (56) % and now in respiratory distress. The NP did not respond and arrived later to the floor. The NP's assessment revealed an oxygen saturation of fifty-four (54) % on oxygen and in respiratory distress. The facility activated 911, and the resident was transported to an Emergency Room (ER) with the admission recorded at 10:59 AM, three and a half (3.5) hours after the identified CoC. The ER diagnosed Resident #1 with Respiratory Failure and Pneumonia with Sepsis with a venous oxygen saturation level of seventy-one point seven (71.7) percent.

The findings include:

The facility failed to provide a policy of Respiratory Care and Services upon request.

The facility failed to provide a policy for Re-Assessment of a Resident.

Review of the policy Departmental (Respiratory Therapy) Prevention of Infection, dated 11/2011, revealed therapy services documentation included date, time, type of therapy, and staff who completed the respiratory therapy. In addition, all assessment data obtained or refusals of care which included why and what was done when the resident refused by the person who recorded the information.

Review of COVID-19 Resident Policy, undated, revealed the facility initiated the policy for early detection and effective triage of a potentially infectious resident. The facility monitored residents for fever and respiratory symptoms every shift. In addition, the facility monitored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 11	F 695		

residents throughout the shift for potential symptoms of a respiratory infection.

Review of the policy Change in a Resident's Condition or Status, dated 5/2017, revealed notification of the provider occurred promptly when the resident's condition changed. A significant change included a decline to which the change in condition will not resolve without intervention by staff and clinical measures. Staff notification information to the provider included detailed observations and findings, which the staff documented on a Situation-Background-Assessment-Recommendation (SBAR) communication form. Further review revealed staff documented information of the residents' change of condition in the residents' record.
Review of the facility document Communication/How to Notify Provider, undated, revealed when staff identified a CoC requiring attention; the staff contacted the provider on the phone. The "Urgent Needs included in a list on the document, which the facility determined warranted a call to the provider, included a CoC.

Review of the facility COVID-19 Preparedness Checklist, undated, revealed the facility completed plans for the training and education of staff to help the providers understand the implications of prevention and control measures for COVID-19. The facility education plan included to educate staff on the Signs and Symptoms (S/S) of the COVID-19 virus and how to monitor residents for respiratory illnesses. The facility's education and training plan included education to staff for infection control measures to prevent the spread of COVID-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 12	F 695		

Review of the Centers for Disease Control and Prevention (CDC), dated 5/13/2020, revealed adults with medical conditions for lung diseases remained at a high risk for the development of serious complications. The CDC list for symptoms to monitor included a fever of unknown origin and shortness of breath. Furthermore, emergency warning signs for COVID-19 included trouble breathing to which the person needed to seek or transfer to emergent medical services.

Review of the clinical record for Resident #1 revealed the facility admitted the resident on 03/15/19 with the diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath (SOB), and Paraplegia. Further review revealed the physician ordered a BiPaP (a supportive respiratory system) every night for the resident's diagnosis of COPD.

Review of the Quarterly Minimum Data Set (MDS), dated 04/01/2020, revealed the facility assessed Resident #1 as not having shortness of Breath under Section J. The facility assessed Resident #1's cognition with the Brief Interview for Mental Status (BIMS) exam and scored the resident with twelve (12) out of a possible fifteen (15) total score and determined the resident as able to convey his/her needs and cognitively intact.

Review of the Physician Order (PO) Sheet for Resident #1 revealed ordered medications and treatments for the resident's condition of COPD included Advair (inhaler for the treatment of COPD) twice a day. The resident's physician ordered PRN medications for episodes of SOB, which included a rescue inhaler of Albuterol (used to treat breathing issues) every four (4) hours. In

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 13	F 695		

addition, a second PRN medication included Ipratropium-Albuterol inhaled (used for wheezing, difficulty breathing, chest tightness, and coughing) through a nebulizer (a treatment which mists the medication to allow inhalation) every 4 hour for SOB. Further review revealed the PO did not include bedside and self-administrative orders for medications by Resident #1.

Interview with the Lead Care Coordinator (LCC), on 06/08/2020 at 1:10 PM, revealed facility staff reported a resident presented with wheezing on 06/01/2020 at about 10:00 AM. The LCC stated the NP arrived to the floor and went to the resident's room. The LCC stated the NP reported the resident's low oxygen saturations in the fifties (50's). The LCC stated Emergency Medical Services (EMS) arrived and the resident left the facility on a stretcher with the EMS staff providing respiratory support to the resident.

Review of the clinical record, oxygen saturation summary, revealed Registered Nurse (RN) #2 recorded Resident #1's saturation of eighty-nine (89) % while on oxygen on 05/30/2020 at 3:04 AM and 3:32 AM. Review of recorded levels from 01/01/2020 to 05/29/2020 revealed Resident #1's documented oxygen levels were between ninety-two (92) to ninety-eight (98) % with and without oxygen. Further review revealed staff did not document interventions or care provided to Resident #1 for the oxygen below ninety (90) % in a progress note; nor record administration of ordered PRN medications on the resident's Medication Administration Record (MAR) or Treatment Administration Record (TAR) for 05/30/2020.

Interview with RN #2, on 06/10/2020 at 9:19 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 14	F 695		

revealed RN #2 assessed Resident #1's oxygen level on 05/30/2020 at 3:04 AM and 3:32 AM for the COVID-19 shift assessment. RN #2 stated he acquired the second reading to re-evaluate the first low reading as the resident wore oxygen with the first reading. RN #2 stated he did not complete a further assessment to Resident #1 when the second reading remained below ninety (90). Additionally, RN #2 stated he did not administer or offer ordered PRN medications. RN #2 stated staff responsibilities included resident assessments, providing treatments, documenting each, and report to the next shift.

Interview with LPN #2, on 6/11/2020 at 3:22 PM, revealed he provided care to Resident #1 on the weekend of 05/30/2020 to 05/31/2020. LPN #2 stated he performed blood draws for serum laboratory levels on 05/30/2020 instead of 06/01/2020 as ordered because of a reported low-grade fever. LPN #2 stated the labs came back unremarkable and the NP did not order further tests. LPN #2 stated he did not receive report in the AM of 05/30/2020 regarding the resident's oxygen saturation of eighty-nine (89) percent. LPN #2 stated the resident's normal oxygen levels as mid-nineties (90's). He stated if RN #1 relayed a low oxygen level, and the return of the low-grade fever on 05/31/2020 he would have called the NP. However, he stated report at the change of shift from night to day provided limited information because staff wanted to get out and home to sleep. Furthermore, LPN #2 stated when the resident presented with the fever again; he did not complete a thorough assessment of the resident including lung sounds, and general status. He further stated the TAR instructions included to notify the provider of two (2) or more symptoms. LPN #2 stated he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 15	F 695		

not consider the symptoms possibly COVID-19 related

Interview with LPN #1, on 06/09/2020 at 2:36 PM, revealed Resident #1 requested assistance from the LPN around 9:30 AM on 06/01/2020. The LPN stated Resident #1 stated the RN did not come back to the room after completion of medication pass and that upon entry into the resident's room he observed the resident to be in respiratory distress because he/she breathed heavily, wheezing was audible without a stethoscope, and the resident sweated profusely. The LPN stated the resident wore oxygen and he obtained an oxygen saturation level in the fifties (50's). The LPN stated he attempted to locate the rescue inhaler, could not find the inhaler, and attempted to find a nebulizer machine unsuccessfully. The LPN stated after the failed attempts to find a machine himself, the NP arrived to the floor sometime after 10:00 AM and he immediately asked the NP to see Resident #1. The LPN stated the NP assessed the resident and requested 911 activation. The LPN stated responsibilities of the nurse providing resident care included detailed documentation. The LPN stated he did not notify a provider or the Unit Manager (UM) of his assessment and findings at the time of the initial observation.

Review of the Registered Nurse (RN) Position Summary, dated 8/2019, revealed essential responsibilities included assessment and documentation of residents' condition and nursing needs, to accurately and promptly implement orders, provide report, record observations, and assist or activate emergency measures for sudden adverse developments with a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 16	F 695		

Review of the clinical progress noted, dated 06/01/2020 at 7:43 AM, revealed RN #1 documented the administration of the residents ordered insulin. Review revealed the presence of RN #1 at the resident's bedside with the resident's initial report of breathing difficulties and need for respiratory care.

Interview with RN #1, on 06/09/2020 at 12:04 PM, revealed the RN cared for Resident #1 on 06/01/2020 for day shift. The RN stated she did not know the resident presented with low levels of oxygen, low-grade fevers or had labs recently drawn. The RN stated the resident activated the call bell as she arrived to the room and complained of not being able to breathe. The RN stated the time was around 7:30 AM and during medication pass. The RN stated she assessed the resident oxygen level while the resident wore oxygen and noted the level between seventy (70) to eighty (80) percent. The RN stated the resident kept Albuterol and Advair inhalers in the room but she was only able to locate the box for the inhaler, but not the actual inhaler. The RN stated she looked at the list of medications for the resident and the resident did not have an order for a nebulizer treatment. The RN stated a re-assessment ten (10) minutes later revealed the resident remained SOB, the oxygen levels had not improved and her observations noted the resident "was breathing heavily". The RN stated she attempted to look for the resident's nebulizer in the room and could not find it and did not ask about an Emergency Drug Box for the facility. The RN stated she notified the Unit Manager (UM) of the resident's complaint. However, she did not notify the UM of the need for a nebulizer machine nor her inability to locate the resident's rescue inhaler. The RN stated she continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 17	F 695		

with medication pass and assisted taking residents to the desk for COVID-19 screening. The RN stated the NP came to the unit, requested the resident go to the ER, and ordered a nebulizer treatment before the resident left. The RN stated she did not complete a treatment because she could not find the machine. RN #1 stated she did not know about SBAR forms. The RN stated the nurses' responsibilities included complete documentation of events with a resident, and providing care as ordered. Review of RN #1's text message, dated 6/01/2020 at 9:53 AM, revealed RN #1 texted to the NP that Resident #1 had SOB. The RN stated the facility provided one and half days (1 ½) of orientation four (4) weeks ago when she started.

Review of Resident #1's ER admission record, dated 6/01/2020 at 10:59 AM, revealed the ER room received the resident in respiratory distress with oxygen levels on arrival in the seventies (70's) per transport staff. The resident received immediate CPAP (continuous air pressure) and labs. The ER physician diagnosed the resident with Respiratory Failure, Pneumonia, and Sepsis. The resident COVID-19 screen returned with positive results.

Interview with the UM #1, on 06/10/2020 at 9:05 AM, revealed RN #1 notified her Resident #1 complained of SOB about 8:30 AM. The UM stated she did not assess the resident or inquire for relevant information. The UM stated she left the unit to check on another area, returned and discussed the resident treatment orders with the RN. The UM stated the RN "thought" the resident had orders for respiratory treatments but neither checked PO's. The UM stated she instructed the RN to notify the NP but did not follow-up. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 18	F 695		

UM stated the resident went to the ER per the NP request when the NP arrived to the unit. The UM stated staff did not report the lack of equipment to provide treatments. The UM stated when a respiratory CoC occurred she expected staff to complete a full assessment, notify the provider immediately, follow orders, provide treatments, and stay with the resident to monitor for distress. The UM stated she expected staff to complete detailed documentation and a SBAR on the event with the provided care and resident's response. The UM stated if staff delayed care and services to a with resident breathing issues the resident's breathing could become impaired and the resident could experience a body system shut down. In addition, the UM stated the Intra-Department Team (IDT) reviewed the residents chart and events on 6/02/2020 with the clinical team. The UM stated the IDT did not identify issues with care before transfer and staff documentation. However, the UM stated the IDT team did not interview staff to obtain details of the events on shift, and did not review the clinical chart.

Interview with the NP, on 6/10/2020 at 9:47 AM, revealed facility staff did not call to report a respiratory CoC for Resident #1 but sent one (1) text message to her phone, which she did not notice. The NP stated she became aware of the CoC when she arrived after 10:00 AM and LPN #1 reported Resident #1 needed an immediate assessment because of respiratory distress. The NP stated she found the resident in respiratory distress, heard the resident wheezing upon entering the resident's door, and assessed his/her oxygen at fifty-six (56) % on two (2) liters of oxygen per nasal cannula. The NP stated staff did not inform her of a continued low-grade fevers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 19	F 695		

or of the low oxygen levels while on oxygen. Furthermore, the NP stated staff should have called because of the unknown source of the fevers and with COVID-19 residents in the building, the resident needed further assessment.

Review of the NP visit, dated 06/01/2020, revealed the NP documented Resident #1's chest assessment with wetness, crackles, and wheezes. The resident complained of thick yellow sputum, cough, and reported to the NP he/she "cannot breathe". The NP documented a diagnosis of respiratory distress and the resident's oxygen level at fifty-six (56) %, a respiratory rate of thirty-six (36), and a temperature of ninety-nine point seven (99.7) degrees. The NP plan included sending the resident to the ER and an immediate nebulizer or inhaler treatment as ordered before transfer. Record review and interview revealed staff did not provide the ordered nebulizer,

Interview with the Staff Development Coordinator, on 06/09/2020 at 10:39 AM, revealed all staff received education of the S/S and care of a COVID-19 resident. Education to staff included S/S, assessments, care, monitoring and reporting. She stated staff received respiratory care education for residents in the facility and the facility provided extra information on pre and post assessments, documentation, and the process of providing respiratory care and treatments. She stated she expected staff to document findings in the chart of assessment findings and interventions. She further stated normal oxygen levels included ninety (90) % to one hundred (100) %, and a low reading included 89% with or without oxygen. She stated staff responsibilities included notification of the provider with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 20	F 695		

assessments, which identified condition changes.

Interview with the Director of Nursing (DON), on 06/10/2020 at 2:52 PM, revealed the facility provided education for COVID-19 related S/S and care for the residents for all staff and new employees. The DON stated the facility owned nebulizer machines and is able to provide the equipment for residents who need treatments, including seventeen (17) residents who required respiratory care. The DON stated she expected nurses to respond to resident needs, report to the provider, notify nursing administration, and continually monitor the resident until transferred or stable, and complete all required documentation. The DON stated she became aware of Resident #1's condition when staff transferred the resident. The DON stated the clinical team at the IDT meeting reviewed the transfer of a resident the next day and did not identify issues in the clinical chart. The DON stated she knew the resident left in respiratory distress; however, she stated she did not have knowledge of the staff's inability to locate equipment, or medications for treatments. Additionally, the DON stated she was unaware of the clinical findings of staff, which included oxygen saturations in the fifties (50's) two (2) hours after an assessment of oxygen saturations in the seventies to eighties (70-80's) while on oxygen, and the decline of the resident's respiratory status after the initial complaint and assessment at 7:30 AM. The DON stated it concerned her to learn of the findings of the resident's course of care and response by staff and stated residents with CoC in their respiratory status usually decline quickly, which is why staff response remained important.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(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
F 695	Continued From page 21	F 695		

Interview with Resident #1's Physician, on 06/12/2020 at 11:10 AM, revealed he identified the resident as a high-risk patient because of his/her diagnoses and previous respiratory failures. He stated with COVID-19 residents in the building and risk factors when the resident initially complained of respiratory issues staff should have called a provider. He stated the resident's decline to the point of the documented findings by the NP may have been avoidable with early notification of the CoC. He stated as a provider his expectations of staff further included complete, accurate, and informative documentation, especially when in a crisis mode.

Interview with the Administrator, on 06/11/2020 at 8:29 AM, revealed the facility admitted and cared for residents with respiratory diseases without previously identified issues for care and services. He stated new nurses received extensive training and the facility previously "ramped" up the training to ensure staff orientation received proper training by the facility. He stated the IDT clinical team did not report issues after record review of the transfer of Resident #1. He stated his expectation for staff included to provide competent care to the residents. He stated he expected the administrative team, which include himself, to have proactive responses for the continuation of quality resident care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	**1705 STEVENS AVENUE LOUISVILLE, KY 40205**

(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
F 695	Continued From page 22 .	F 695		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100218	A. BUILDING: _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING AND REHABILITATION	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An Abbreviated Survey investigating KY#31821 was initiated 06/05/2020 and concluded 06/12/2020. The complaint was substantiated and deficient practice was cited pursuant to 42 CFR 483.10 - 483.95. In addition a COVID-19 Focused Infection Control Survey was conducted and the facility was found to be in compliance pursuant with 42 CFR 483.80. Total census 125.	N 000		

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