STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185029	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Post Acute and Rehabilitation Center	920 South Fourth Street Louisville, KY 40203

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 - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to implement care plan interventions to prevent falls for two of three sampled residents, Resident (R)1 and R2. Both R1 and R2 falls prevention interventions included colored tape on the resident's call light, however the call lights did not have colored tape for multiple days of the survey. The findings include: 1. Review of the facility policy Fall Prevention & Management Program not dated, revealed if a high fall risk was identified, the facility would develop a care plan to address the risk. Interventions would be monitored for effectiveness. Review of the facility policy Post Fall Management Guidelines not dated, revealed the Program would provide applicable interventions to prevent falls. If a fall occurred other interventions would be executed to prevent another fall as much as possible. The program included implementation of person-centered interventions to decrease the incidence of falls. Review of the clinical record for Resident (R)1 revealed the facility admitted the resident on 01/22/2021 and readmitted the resident on 04/10/2024. Diagnoses included dementia, depression, impulse disorder, and repeated falls. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) score of nine out of 15 and determined the resident was cognitively intact. Review of facility care plan for R1 revealed after the resident fell on [DATE] a new falls intervention added for bright orange tape to call light, dated 10/10/2024. Observation of R1 on 10/16/2024 at 10:16 AM and 10/17/2024 at 9:48 AM, revealed no colored tape on the resident's call light. In interview on 10/16/2024 at 10:20 AM with R1, he stated the call light never had colored tape on it. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview on 10/17/2024 at 11:02 AM, with Licensed Practical Nurse (LPN)1 revealed colored tape on R1's call light was to keep the call light more visible, for the resident to see it. The LPN stated if the resident did not have tape on his call light according to the care plan, the resident could fall. On 10/17/2024 at 11:35 AM, interview with Certified Nurse Aide (CNA)4 revealed she was unsure when she last saw the tape on the R1's call light, however there was no tape on the call light today. She stated she was unsure who put the tape on the call light. She stated the colored tape was to get the resident's attention to use the call light. The CNA stated if the tape was not on the call light, the resident would not use the call light and try to get up by himself. In interview on 10/17/2024 at 1:38 PM, with CNA6 revealed the tape on R1's call light was so the call light would stand out. She stated if the tape was not on the call light the resident might not see the call light. She stated she did not receive in report when she came on duty the resident was to have tape on his call light. On 10/17/2024 at 3:47 PM, interview with the MDS Coordinator revealed if a resident fell the intervention put in place at the time of the fall was completed by the Unit Manager (UM) and entered into the care plan. She stated the bright tape helped identify the call light and if the tape was not present the call light would not stand out to the resident. In interview on 10/18/2024 at 8:43 AM, UM1 stated when R1 fell on [DATE] she placed the orange tape on the resident's call light as a new fall intervention. She stated the tape was for R1 to see the call light more and as a reminder to use the call light. She stated although she rounded on residents she was not able to look at every resident's interventions and relied on the nurses to catch if the tape was missing. She stated she was informed yesterday by staff the tape was not on the call light, which increased R1's risk for falls. The UM further stated the tape was put in place to prevent a fall or reduce the risk of falling. In interview on 10/18/2024 at 9:41 AM, the Director of Nursing (DON) stated after R1 fell on [DATE] tape was placed on his call light so the resident could see the call light and prompt him to use it before getting up. She stated if the tape was not on the call light, the intervention would not be effective as the resident would not have the prompt to use the call light. She stated the tape was a care plan intervention to prevent a fall and was the nurse's responsibility to ensure the intervention was in place. The DON stated the Unit Managers completed rounds to check falls interventions were in place, although the rounds were not documented. The DON further stated R1 was impulsive and hoped the tape prompted him to use the call light. In interview on 10/17/2024 at 10:41 AM, the Executive Director stated if the tape was not on the resident's call light, the resident may not see the call light and may not use it. He stated the resident's care plan included interventions to try to prevent falls. 2. Review of the facility policy Fall Prevention & Management Program not dated, revealed the facility would develop a care plan to address a high fall risk if identified. Interventions would be monitored for effectiveness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Post Fall Management Guidelines not dated, revealed the Program provided interventions to prevent falls. If a fall occurred, other interventions would be used to prevent another fall. The program included implementation of person-centered interventions to decrease the incidence of falls. Review of the clinical record for Resident (R)2 revealed the facility admitted the resident on 02/28/2024 with diagnoses of pain in left hip, low back pain, urinary tract infection (UTI), and weakness. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) of 13 out of 15, and determined the resident was interviewable. Review of the facility investigation for a fall on 06/20/2024 revealed a new intervention for bright tape to call light. Review of the care plan for falls revealed an intervention for bright tape to call light, dated 07/25/2024. Observation of Resident (R)2, on 10/16/2024 at 10:20 AM, 10/17/2024 at 10:57 AM and 2:56 PM, revealed the resident's call light did not have colored tape on it. In interview on 10/16/2024 at 10:20 AM and 2:56 PM, R2 stated his call light never had tape on it. In interview on 10/17/2024 at 1:21 PM, Certified Nurse Aide (CNA)5 stated she never saw colored tape on R2's call light in the several weeks she was working at the facility. She stated no one informed her R2 should have tape on his call light. She stated if the tape was not on the resident's call light the resident would not be able to see the call light. On 10/17/2024 at 2:14 PM, interview with Licensed Practical Nurse (LPN)2 revealed R2's care plan intervention for bright tape to his call light was for the resident to easily find the call light. She stated if the resident did not see the call light he could not use it and would not be able to notify staff when he needed assistance. In interview on 10/17/2024 at 3:11 PM, LPN3 stated she did not recall seeing tape on R2's call light. She stated the care plan intervention for tape was for the resident to see it easily. She stated if the call light did not have the tape, the resident might not see the call light as easily and would not be able to use it when he needed something. She stated she could not recall if she was told in report if the resident had the tape on his call light. In interview on 10/17/2024 at 3:47 PM, the MDS Coordinator stated residents who fell were discussed in the clinical meeting. She stated she could not recall if R2 was discussed after his fall. She stated the interventions were also discussed in the clinical meeting. The MDS Coordinator also stated if a resident fell a new intervention was put in place at the time of the fall and placed on the resident's care plan. She stated bright tape was to help identify the resident's call light. She further stated if the tape was not on the call light, the call light would not stand out to the resident to use. On 10/18/2024 at 9:41 AM, interview with the Director of Nursing (DON) revealed the tape was placed on R2's call light in June so the resident would see the call light to use it. She stated the facility did not have any audits regarding resident's call lights and the tape on it. She stated if the tape was not on the call light the resident the intervention would not be effective to prevent another fall. She also stated the nurses were responsible to ensure the tape was in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview on 10/18/2024 at 10:41 AM, the Executive Director stated the facility did not have a procedure in place to ensure the tape was on R2's call light. He stated if the tape was not on the call light the resident might not see the call light and could not use it. In interview on 10/18/2024 at 11:11 AM, Unit Manager (UM)2 stated after the resident fell an intervention for color tape to the call light was to make the call light more visible to the resident so he would not try to just get up and walk. She stated if the tape was not on the call light, it would not be as visible to the resident as intended. She also stated once an intervention was in place and added to the care plan, we assume once the intervention was in place there would not be a reason for the intervention to not be in place unless removed. UM2 stated she did not know why the tape was not on the resident's call light.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to ensure access to complete resident clinical records for two of three sampled residents (Residents (R)2, and R3). The facility transitioned 07/01/2024 to a new computer software system and did not have the residents' prior clinical information available for R1 and R2 for information in their electronic health records from the time of their initial admission to the facility until 07/01/2024. The findings include: 1. Review of the facility policy titled Fall Prevention & Management Program not dated, revealed upon admission the nurse would complete a fall risk assessment with the admission assessment to determine the resident's level of fall risk. The nurse would document the resident's fall risk in the resident's records and initiate interventions on the resident's baseline care plan. Review of the facility policy titled Post Fall Management Guidelines not dated, revealed a fall was documented in the clinical record. Review of the clinical record for Resident (R)1 revealed the facility admitted the resident on 01/22/2021 and readmitted the resident on 04/10/2024. R1's diagnoses included Dementia and repeated falls. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) of nine out of 15 and determined the resident was cognitively intact. Review of the care plan for R1, dated 07/25/2024, revealed falls interventions were initiated on 06/23/2024. Review of the resident's electronic health record revealed the earliest documentation in the resident's progress notes began 06/26/2024. Observation of R1 on 10/15/2024 at 8:34 AM revealed the resident sat on the side of the bed, with non-skid strips on the floor at the side of the bed. In interview on 10/15/2024 at 8:34 AM, R1 stated he had a few falls at the facility and did not want to discuss them further. In interview on 10/17/2024 at 3:32 PM, the Medical Records (MR) Specialist stated she was not involved in the computer switch over and was not provided any instruction to prepare for the change. She stated the facility was told resident records and information would be available after 05/01/2024 when the facility switched over to another computer system. She further stated the facility was not told they would not have access, otherwise she would have printed information to enter into the new system. She stated any resident who was at the facility before June would not have prior information in the current clinical record. She further stated the medical record was not complete without access to the old system. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/17/2024 at 3:47 PM, interview with the MDS Coordinator revealed nothing the facility had in the prior computer system carried over to the new clinical records. She stated she thought records were supposed to carry over to the new system when the facility transitioned. She further stated when the facility transitioned to the new system, there were some resident records that were incomplete and did not have the documentation necessary to complete the MDS during the look- back period, although she could not recall specific residents who were affected. The MDS Coordinator stated the resident's clinical record was incomplete if the information did not carry over from the older system. She stated the medical record's purpose was for the resident's ongoing care. She stated she was not involved to prepare for the transition from one system to another and was not instructed what to do in preparation for the transition. In interview on 10/18/2024 at 8:38 AM, interview with Unit Manager (UM)1 revealed R1's care plan prior to the transition was not copied and uploaded into the new computer system when the facility transitioned from the prior clinical record. She stated R1 admitted to the facility in 2021, however with the transition she was not able to access the record prior to the transition and the record was then incomplete. UM1 also stated if the clinical record was not complete, all the resident's risks and every intervention the facility tried to put into place specialized to the resident was not available and could be harmful to the resident. In interview on 10/17/2024 at 9:41 AM, the Director of Nursing (DON) stated the facility did not have a way to find previous information for a resident prior to the transition to a new computer system. She stated the medical record ensured staff knew what a resident's care was and was provided. She stated if the record was not complete resident care may not be correct or safe. The DON also stated R1's care plan prior to the transition did not transition to the new system and his medical record was not complete. The DON stated the facility was not involved with the transition as it was completed by a third party. On 10/17/2024 at 10:41 AM, interview with the Executive Director revealed the corporate office had the contracts and negotiations for the transition from one computer record to another. He stated the facility was supposed to have information needed to perform their jobs. He stated R1's care plan did not carry over and the facility no longer had access to the prior system. 2. Review of the facility policy titled Fall Prevention & Management Program not dated, revealed upon the nurse would complete a fall risk assessment with the admission assessment to determine the resident's level of fall risk on admission of a resident. The nurse would document the resident's fall risk in the resident's records and initiate interventions on the resident's baseline care plan. Review of the facility policy titled Post Fall Management Guidelines not dated, revealed a fall was documented in the clinical record. Review of the clinical record for Resident (R)2 revealed the facility admitted the resident on 02/28/2024 with diagnoses of pain and weakness. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) of 13 out of 15 and interviewable. Review of the resident care plan revealed the resident at risk of falls with interventions noted. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview on 10/17/2024 at 3:11 PM, Licensed Practical Nurse (LPN)3 stated the purpose of the resident's medical record was for the facility to know correct dates, documentation, and multiple information for resident safety. She stated there was no way to look back before the change in computer systems to know what the resident may need for care. In interview with the Medical Records (MR) Specialist on 10/17/2024 at 3:32 PM. She stated she was not involved in the computer switch to a new system for resident clinical records. She stated the facility was not told they would no longer have access to the prior records. She further stated R2 had 3 months of records in the prior system and his clinical record was not complete without it. On 10/17/2024 at 3:47 PM, interview with the MDS Coordinator revealed she was not aware the clinical records from the prior system would not be available with the new system. She also stated the purpose of the clinical record was for a resident's ongoing care. She stated if the information did not carry over, the resident's clinical record was not complete. In interview on 10/18/2024 at 9:41 AM, the Director of Nursing (DON) stated R2's clinical record was not complete. She stated there was no way to find previous information when the facility transitioned from one computer system to another. The DON stated the purpose of the medical record was to ensure care was provided to the resident. She also stated if the record was not complete, resident care could be incorrect, or unsafe. In interview on 10/18/2024 at 10:41 AM, the Executive Director stated the current company hired another company to assist in the transition from one record system to another. He stated the system changed on 07/01/2024 to the current computer system. He further stated the facility needed items from the previous record and should be available to the facility. On 10/18/2024 at 11:11 AM, interview with Unit Manager (UM)2 revealed resident clinical records in the prior system included previous doctor appointments and continuation of the resident's care plan. She stated she expected to have access to the resident's notes. The UM stated if the clinical record was not complete the facility would not be able to reference previous falls, see previous progress notes, care plan, or have a baseline of how the resident came to the facility.