STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Iroquois Park Rehab and Nursing Center	900 Gagel Avenue Louisville, KY 40216

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 - Some	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** 50442 Based on observation, interview, record review, and review of the facility's policies, the facility failed to provide a clean and homelike environment for residents. Bathrooms and hallways had a strong odor of urine. Floors were soiled, sticky, stained and/or rusted. Bathrooms were not clean. The failure to maintain a clean, homelike environment had the potential to affect Resident (R) 10, R44, and R31, as well as all other residents residing on two of the three facility halls, with 15 resident rooms on each hallway. The findings included: Review of the facility's policy titled, Landmark-Clinical Standard and Guidance: Resident Rights Guidelines, effective date 07/12/2023 and last reviewed 04/12/2024, revealed the resident's comfort, safety, and overall welfare must be promoted, protected, and enhanced at all times. Review of the facility's policy titled, Landmark-Clinical Standard and Guidance: Homelike Environment Guidance, effective date 06/20/2023 and last reviewed 04/12/2024, revealed that it is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, functional, and comfortable. All room contents to include clothes, furniture, devices, linens, bedspreads, privacy curtains, window coverings, wall hangings, wallpaper, and floors should be clean and in good repair. Review of the facility's policy titled, Landmark-Clinical Standards and Guidance: Resident Room Clean Policy, effective date 02/17/2021 and last reviewed on 02/16/2024, explained the procedure for cleaning a resident's room, which including mopping floors. (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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. a. Observation on 06/23/2024 at 12:27 PM of the facility revealed the hallway which contained Rooms 106 -116 smelled of urine. Further observation on 06/23/2024 at 12:59 PM revealed that the shared bathroom between rooms [ROOM NUMBERS] smelled like urine. At 1:04 PM on 06/23/2024 it was observed that the hallway containing Rooms 121 -135 smelled strongly of urine. At 1:06 PM on 06/23/2024 observation of room [ROOM NUMBER] revealed the room had a strong urine smell and the floors were dirty. The floors had black marks and a clear, dry, sticky substance on them. At 1:46 PM on 06/23/2024, it was observed that room [ROOM NUMBER] smelled strongly of urine. The floors were dirty. There were black smudges on the floor and a large, dried puddle of urine from a resident's indwelling catheter, which had leaked onto the floor. Paper towels and other paper debris littered the floor on the side of the room near the window. The floor in room [ROOM NUMBER] was observed on 06/23/2024 at 1:57 PM to be dirty and looked like it had not been mopped recently. b. Observation on 06/24/2024 at 11:45 AM revealed that room [ROOM NUMBER] still smelled strongly of urine; however, the dried puddle of urine had been mopped up. The hallway with Rooms 121 -135 still had a strong smell of urine. c. Observation on 06/25/2024 at 8:49 AM revealed that the hallway containing Rooms 121 - 135, smelled strongly of urine. In an interview on 06/25/2024 at 9:36 AM, Certified Nursing Assistant (CNA) 3 confirmed that the hallway with Rooms 121 -135 smelled like urine. d. Observation on 06/26/2024 at 8:31 AM revealed that the hallway with Rooms 121 - 135 once again smelled strongly of urine. Observation later at 9:05 AM on the hallway that contained Rooms 108 -116, revealed it also smelled of urine. e. An interview with R10 on 06/27/2024 at 10:25 AM revealed that she felt like the entire facility smelled like urine, especially the hallway that housed Rooms 121 -135. An interview with Housekeeper (HK) 1 at 9:58 AM on 06/25/2024 revealed that the common areas (such as the hallways and dining rooms) and residents' rooms and bathrooms were cleaned daily. A later interview with another housekeeper, HK 2, on 06/25/2024 at 1:40 PM, also revealed residents' rooms and bathrooms were cleaned daily. On 06/26/2024 at 8:31 AM, during a second interview with HK 1, he stated that it sometimes smelled bad in the morning. Although members of the survey team verified the urine smell at this time, HK1 stated that he did not think that the hallway containing Rooms 121 through 135 smelled like urine. On 06/26/2024 at 8:33 AM in an interview with CNA 2, she stated that she did not think the hallway smelled like urine even though members of the survey team verified there was a strong smell of urine. An interview with Licensed Practical Nurse (LPN) 1 on 10:27 AM on 06/27/2024 confirmed the odor of urine and added that the odor was much better today than usual. She stated that up front, when you entered the facility, it sometimes had a strong smell of urine. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 06/27/2024 at 10:29 AM revealed that R75, who resided on one of the halls which smelled of urine, refused to send her undergarments to the laundry. Instead, the resident washed them out and hung them up in her room to dry. She did not use soap on the undergarments, only water, and, per the DON, this was the reason that the hallway containing her room, continually smelled like urine. Interview with the Administrator on 06/26/2024 at 2:10 PM revealed that she was unaware of the urine smell. When asked if she felt the smell of urine constituted a homelike environment, she stated no. 47798 2. a. During an observation on 06/23/2024 at 4:01 PM, R44's bathroom had a quarter-sized brown substance on the floor beside the toilet, as well as a brown substance smeared on the wall located above the toilet paper holder. Review of R44's Quarterly Minimum Data Set (MDS) Assessment, dated 06/06/2024, revealed the facility assessed R44 to have a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. During an interview with R44 on 06/23/2024 at 4:01 PM, he stated his biggest concern at the facility was with housekeeping services. R44 confirmed his bathroom currently had stool (feces) on the floor and smeared on the wall. R44 stated the stool had been in the bathroom for at least two or three days. R44 stated the housekeeping staff was in his room every day; however, the housekeeper did not speak good English and would just look at him and not respond when he would voice his concerns. During an interview with Housekeeper (HK) 4 on 06/24/2024 at 1:53 PM, she stated she spoke limited English. The Administrator was present during the interview and assisted by using a translator app. HK4 stated she was responsible for cleaning R44's bathroom and cleaned them every day and even every hour. HK4 stated she did not see the brown substance on the floor or wall. At that time, the Administrator told HK4 to clean the brown substance from R44's bathroom floor and wall. Additional observation of R44's bathroom on 06/24/2024 at 2:25 PM revealed the brown substance had been cleaned off of the wall above the toilet paper holder; however, there was still a quarter-sized brown substance on the floor beside the toilet. The DON was made aware that R44's bathroom was not clean, and she stated she would send another Housekeeper to clean it. The DON stated rounds were done by other staff this morning and she did not think the brown spots were there. b. Review of a Quarterly MDS Assessment, dated 05/13/2024, revealed the facility assessed R31 to have a BIMS score of 15/15, indicating the resident was cognitively intact. During an interview with R31 on 06/26/2024 at 2:35 PM, she stated housekeeping does not clean well. She stated a female housekeeper that did not speak English would have to be told by residents that she needed to sweep prior to mopping. R31 further stated the housekeeper did not clean the vanity or mirrors and therefore, her roommate would often do that. During an interview with CNA12 on 06/26/2024 at 7:00 PM, she stated she did not feel like the facility was not clean or homelike for the residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA13 on 06/26/2024 at 7:30 PM, she stated the facility was very dirty, actually filthy and she did not think housekeeping staff was doing very much. CNA13 stated there had been feces in the bathroom floors and when she reported to housekeeping staff, nothing would be done. During an interview with HK3 on 06/28/2024 at 9:49 AM, he stated he would clean resident rooms and bathrooms one to two times daily depending on the condition of the rooms. He stated deep cleans were done by schedule and would be logged into a book; however, daily cleans were not logged. HK3 stated he thought the facility could be cleaner. HK3 further stated they did not have an acting manager and the Administrator oversaw the housekeeping staff. Logs referenced by HK3 were reviewed. The facility's document titled, Quality Control Inspection-Housekeeping, revealed random daily spot checks of 34 residents' bathrooms over a three-week period from 05/23/2024 through 06/12/2024. The spot checks showed nine of the inspected bathrooms had to be re-cleaned. Review of facility's Deep Clean Room Schedule and Carpet and Hard Floors Cleaning Schedule revealed that the facility only had these check off sheets for the months of January and April of 2024. Neither the Deep Clean Room Schedule nor the Carpet and Hard Floors Cleaning Schedule from January were signed or dated by the Administrator. For the month of April, the Deep Clean Room Schedule for April was not signed and dated (to indicate that it was complete.). During an interview with the Administrator on 06/28/2024 at 10:07 AM, she stated she thought the facility was clean and homelike for the most part. The Administrator stated she expected housekeeping to maintain a homelike and clean environment for the residents. 3. Observation at 1:20 PM on 06/23/2024 an observation of the bathroom shared between rooms [ROOM NUMBERS] revealed the floors of the bathroom had rust stains on them from the rusting door jamb of the bathroom door. Observation on 06/23/2023 at 1:28 PM revealed the floors in the bathroom shared by rooms [ROOM NUMBERS] also had rust stains from the rusting door frames of the bathroom door. It was observed on 06/23/2024 at 1:39 PM and 1:43 PM that the flooring under the window in rooms [ROOM NUMBERS] were stained with rust and discolored with water stains. At 1:46 PM on 06/23/2024, observation of the floor under the window and in the bathroom shared by rooms [ROOM NUMBERS] revealed rust stains from the rusting bathroom door's door jamb. On 06/23/2024 at 1:57 PM, the bathroom for room [ROOM NUMBER] and 131 had rust stains on the floor and rust on the door jamb leading into the bathroom. On 06/26/2024 at 8:55 AM, interview with the Maintenance Director revealed that he was unaware of the rust on the floors in the rooms and bathrooms in Rooms 121,123, 125, 127, 128, and 129 and was unaware of the rust on the door jambs for these rooms. He stated that the facility was in the process of repainting and remodeling. An outside company had been hired to do the remodel; however, they had only done part of the remodel prior to quitting. He also stated that there were no plans to replace the flooring, but housekeeping could try and remove the rust. During an interview with the DON on 06/27/2024 at 10:29 AM, she was asked about the rust on the flooring and on the door jambs and stated that maintenance was in the process of remodeling, and both were to be replaced.

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F 0656 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37031 50000 Based on interview, record review and review of the facility policy, the facility failed to develop a comprehensive person-centered care plan for one (Resident (R) 85) of 76 sampled residents. that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. Care Area Assessments (CAA) that triggered for care planning, as well as other areas such as medical needs, goals, and discharge planning, were not included in R85's comprehensive care plan by the required completion date (no later than 21 days from admission). The findings include: Review of the facility policy titled Baseline, comprehensive, resident centered care plan guideline dated 09/01/2017 and reviewed 04/12/2024, revealed the comprehensive care plan expands on resident's baseline care plan to include risks, goals and interventions using person centered plan of care approach to meet the medical, physical functioning, nursing, mental and psychosocial needs of a resident. Further review of the policy revealed the comprehensive care plan should be finalized with seven days of completion of the full comprehensive minimum data set (MDS) assessment and will include discharge planning. Review of the face sheet for R85 revealed she was admitted to the facility on [DATE] with pertinent diagnoses of adult failure to thrive, malfunction of tracheostomy stoma, and history of blood clots. A baseline care plan for R85, dated 05/05/2024, was completed within 48 hours of admission to facility and addressed the resident's initial goals, functional status, health conditions, dietary, therapy and social services. Review of the comprehensive Minimum Data Set (MDS) for R85, dated 05/09/2024, revealed a brief interview of mental status (BIMS) score of 14/15, meaning intact cognition. The Care Area Assessments (CAA) triggered for the following areas of concern: The Communication trigger revealed R85 had impaired ability to make herself understood through verbal and non-verbal expression of ideas/wants. The Functional Ability trigger revealed R85 needed partial/moderate assistance with showering and bathing, and supervision or touching assistance with lower body dressing, personal hygiene, chair/bed to chair transfer, sub/shower transfer, walking 10 feet, and partial/moderate assistance with walking 50 feet with two turns, and walking 150 feet. The Fall trigger revealed R85 was at fall risk related to received antidepressant medications on one or more of the last seven days. The Nutritional status trigger revealed R85 had a low body mass index (BMI). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Psychotropic drug use trigger revealed R85 received antidepressant medications on one or more of the last seven days. The Urinary incontinence trigger revealed R85 had occasional urinary incontinence. The Pressure Ulcer/injury trigger revealed R85 had frequent bowel incontinence. The MDS documented that all CAA triggers were reviewed and addressed in the care plan on 05/16/2024 and signed by the facility's MDS nurse, who also signed as the person completing the care plan decision process on 05/23/2024. Based on the resident's date of admission, the comprehensive care plan was scheduled to be completed no later than 05/23/2024. Review of the care plan on 06/25/2024 revealed that it did not address the triggered areas of Communication, Functional Ability, Falls, Psychotropic Drug Use, Urinary Incontinence, or Pressure Ulcer/Injury. The care plan also failed to address medical needs related to the resident's care related to the tracheostomy/stoma. In addition, it failed to address the resident's goals and/or plans for discharge. Interview conducted with R85 on 06/24/2024 at 8:58 AM revealed she has been in the facility for about six weeks, and in that time, had a swallow study, received tracheostomy care, and reported that staff often had a hard time understanding what she says due to having a tracheostomy and use of a speaking valve. R85 stated she was unaware of what her plan of care is, did not know how long she will be in the facility, and did not know plans for discharge. Interview conducted with the Assistant MDS Coordinator on 06/26/2024 at 3:00 PM revealed that she has been in her current position for about six weeks and received training from the facility's MDS Coordinator and a nurse from the corporate office and attended a few training seminars. The Assistant MDS Coordinator was unable to recall the time frame requirements for completion of comprehensive care plans. Interview conducted with the facility MDS Coordinator on 06/26/2024 at 3:13 PM revealed that she has been in her current position for 13 months. The MDS Coordinator stated she completes the MDS assessment within five to seven days of admission and then has a total of 14 days from admission to complete the comprehensive care plan. The MDS Coordinator stated she is responsible for the completion of the nursing portion of the comprehensive care plan and other department heads complete their portion. In further interview, the MDS Coordinator stated she prints a list monthly of new residents and does a check list to ensure all care plans have been completed. When asked to produce R85's comprehensive care plan (addressing all areas noted above), she stated that it was not there, adding, I take full responsibility on the comprehensive not being there, it should have been done by the end of May.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37031 Based on observation, interview, record review and policy review, the facility failed to provide the necessary care and services to ensure that two (Resident (R) 49 and R 58) of two sampled residents reviewed for activities of daily living/communication did not decline in their ability to communicate. The residents were not provided communication tools in accordance with their plans of care. The findings include: 1. Review of R49's face sheet revealed he was admitted to the facility on [DATE] with diagnoses which included parkinsonism, dysarthria and anarthria (slurred and raspy speech and inability to articulate words), occlusion and stenosis of right middle cerebral artery, cognitive communication deficit, and hemiplegia and hemiparesis (paralysis and/or weakness on one side of the body). Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 2/15, which indicated a severe cognitive deficit. Per the MDS, the resident had unclear speech, but was usually understood. Review of the Comprehensive Care Plan for Impaired Communication dated 02/19/2024, revealed a goal that, I will be able to communicate with staff daily and as needed. Interventions included to utilize appropriate augmentative devices like communication boards/cards, large print signs, and writing pad. The intervention also stated to help the resident acquire and learn to use appropriate devices. Review of the Speech Therapist Evaluation and Plan of Treatment, dated 03/01/2024, revealed the resident has reached his maximum level of potential and been verbally educated and trained on word retrieval strategies. Per this Plan of Treatment, communication picture pages were left in the resident's room in help the resident communicate basic wants/needs to family/staff. The resident verbalized understanding of what had been discussed. Observation on 06/23/2024 at 2:30 PM revealed R49 and the resident's sister (F49) were playing a game of Yahtzee when the survey team entered the resident's room. Observation of the resident's room revealed no evidence of communication picture pages or a communication board in the resident's room. Although the MDS had documented the resident was severely cognitively impaired, during an interview on 06/23/2024 at 2:30 PM, the resident was able to answer questions by nodding and saying yes or no. Interview with both R49 and the resident's sister revealed they had not seen anything left in the room for communication. During an additional interview with R49 in the resident's room on 06/25/24 at 1:31 PM, he appeared to have awareness/cognition of the conversation. When asked if he could understand the questions, he stated yes. When asked if he could write, he stated yes. The resident was observed to have flaccid paralysis to the left side. When asked if he was right or left-handed, R49 raised his right hand, and stated yes when asked if he would benefit from a dry erase board for communication. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R58's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses which included dysarthria following cerebral infarction, dysphagia following cerebrovascular disease, and major depressive disorder. Review of the annual MDS, dated [DATE], revealed the resident had a BIMS score of 9/15, which indicated moderate cognitive decline. Per the MDS, the resident had unclear speech, but was usually understood. Review of the Comprehensive Care Plan, dated 02/09/2024, revealed the resident had an alteration in ability to communicate related to impaired speech. Per the care plan, the problems were evidenced by: ability with transmission of information. Resident is able to communicate via steno pad in order to clarify his needs, but reports speech was affected by stroke occurring last year. The resident will communicate through verbal/non-verbal means through the next review. Intervention included for staff to Assess the resident's communication strengths and deficits. Emphasize abilities. Utilize appropriate augmentative devices, i.e., eyeglasses, magnifying glass, hearing aid, listen aider (power ear), communication board/cards, large print signs, writing pad, etc. Help the resident acquire and learn to use appropriate devices. Make sure augmentative devices are in good working order. Review of a therapy discharge note, dated 03/01/2024, revealed the resident was discharged due to reaching maximum functional potential. Per this note, the resident, understands yes/no questions at 60% accuracy with moderate cues with training on auditory processing strategies to increase comprehension for the communication of basic wants/needs to family/staff. Resident discriminates pictures in a field of 4 with moderate cues with training on word retrieval strategies in increase communication of basic wants/needs to family/staff. States goals not met due to the resident reached maximum level of potential. During an interview on 06/24/24 at 12:38 PM, R58 was difficult to understand. Observation of the resident's room at this time revealed no evidence of a communication board or pen and paper in the room. R58 motioned to use the surveyor's pen and pad to write a note with. The resident had legible writing skills and was able to communicate this way throughout the interview. An additional observation and interview on 06/25/24 at 10:53 AM in R58's room revealed no communication aids at bedside. When asked if the facility had ever had any aids to help him communicate with (including a board to write on), he said No. When asked if it benefit him to have something in his room to communicate with, he responded. Yes. An interview on 06/25/2024 at 2:38 PM with the Speech Therapist revealed she has worked with both R49 and R58. She stated she had placed large picture signs and communication boards in each resident's room and did not know why the communication aids were not in the rooms now. During an interview with Licensed Practical Nurse (LPN) 5 on 06/27/2024 at 10:30 AM, she stated she is able to understand R58 pretty good but sometimes, she has to have him write something down. LPN5 added, I know I have to take something into the room for him to write on since nothing seems to stay in his room. LPN5 was also familiar with R49 and stated that, If I ask [R49] a question, the answer has to be written down since he says yes sometimes and means no. She stated the communication boards as well as paper and pencils are never in the rooms. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Rehabilitation on 06/28/2024 at 12:56 PM, he stated each of the therapists tries hard to keep devices and tools for each resident who requires them for communication. However, he added, they have a hard time keeping the communication devices/tools in the residents' room as, things disappear and are hard to replace at times. The Director of Rehabilitation added that after the resident is discharged from therapy, he is not sure when or where the devices go. He stated he expects the nursing staff to make sure those communication devices are in the resident rooms and to communicate with the therapist if something needs to be replaced. The Director of Rehabilitation stated after the resident has been discharged from therapy service, We do not usually see the resident again unless a referral is completed. Then we evaluate the resident for further services. An interview with the Director of Nursing on 06/28/2024 at 1:26 PM revealed she expects the nursing staff to make sure the resident has the aids needed for communication, adding that she takes pencils and pads of paper back to the residents if they are running low. During an interview on 06/27/2024 at 10:48 AM with the facility administrator, she stated the facility had no policy on activities of daily living regarding communication devices for residents with communication deficits with speech communication tools. An additional interview with the Administrator on 06/28/2024 on 2:34 PM revealed she expects the staff to follow the rehabilitation care plans to provide communication devices to ensure residents can communicate with staff, friends, family, and other residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32635 Based on observation, interview, record review, and review of facility policy and food storage reference material, the facility failed to store food in accordance with facility policy and accepted standards of food service/management. Foods were not dated and/or labeled when opened. The deficient practice had the potential to affect 85 of 89 residents who consumed food stored and /or used in this kitchen. The findings include: A review of the facility policy titled Food Storage, dated 03/25/2012, revealed food is stored and prepared in a clean safe sanitary manner that will comply with state and federal guidelines. Per the policy, containers for bulk items are leakproof, non-absorbent, and sanitary, with tight-fitting lids. In addition, the policy stated that containers are labeled with their content and date. A review of the website www.Servesafe.com revealed a poster titled How to Store Food, dated 2019, which stated to label and date all food. The poster noted that safe food handling practice was: First in and first out (FIFO). Review of a Roster/Matrix form provided by the facility during the survey revealed that four of 89 residents received nutrition via a tube, with the other 85 residents consuming their food orally. Observation of the kitchen on 06/23/2024 at 12:35 PM during the initial tour revealed a shelf in the walk-in refrigerator contained a steam table pan covered in foil with no date or label. Observation of the dry storage revealed a clear container with a red top and white particle substance with no open date or label. Observation of open oatmeal and farina packages revealed they were not dated when opened. In addition, there were two saran-wrapped packages of elbow noodles with no open date, two open packages of buttermilk mix, and two open brown sugar in saran wrap with no open date. Five containers of seasonings in dry storage had no open date. In an interview with the [NAME] on 06/28/2024 at 9:30 AM, she stated that she was Servesafe certified. The [NAME] stated that when food was opened, staff were to label the food with the current date and then, throw it away in three days. The [NAME] stated that food without a label and/or date was to be thrown away because it is not known how long the food was opened and this can make residents sick. In an interview with Dietary Aide (DA) 1 on 06/28/2024 at 9:37 AM, she stated opened food item were to have the current date and item. Food without a label and no date was to be thrown out because it is not known how long it had been on the shelf. In an interview with DA 2 on 06/28/2024 at 9:39 AM, she also stated that food was to be dated and labeled when opened, and discarded if there was no label or date. (continued on next page)

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	185096	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Iroquois Park Rehab and Nursing Center	900 Gagel Avenue Louisville, KY 40216

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Dietary Manager on 06/28/2024 at 10:07 AM, she stated all food in dry storage must have a label and open date. If a food item does not have a label or open date, it must be thrown out because the food can be spoiled, and they do not know the length of time it was on the shelf. In an interview with the Director of Nursing (DON) on 06/28/2024 at 10:59 AM, she stated her expectation was for dietary staff to label, date, and rotate food based on its date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37031 Based on observation, interview, record review and policy review, the facility failed to implement an infection prevention and control program designed to prevent the development and transmission of communicable disease and infections for two of 76 sampled residents (Resident (R)11 and R35). Staff failed to perform hand hygiene when indicated, as well as failed to handle and dispose of a soiled dressing in a manner to prevent the possible spread of infection. In addition, the facility failed to ensure that required Personal Protective Equipment (PPE) was readily available and worn by staff when providing care for a resident who was on Enhanced Barrier Precautions (EBP). The findings include: 1. Review of the facility policy, Clinical Standard and Guidance Infection Prevention and Control Guidelines, dated 08/25/2019 and reviewed 01/26/2024, revealed, It is the policy of the facility that a comprehensive system is in place that prevents, identifies, investigates reports, records and controls infections and prevent the development and transmission of communicable disease processes for residents/care providers, staff, visitors and others within the facility. Review of the Hand Hygiene Guidance policy, dated 02/10/2024, revealed that, Hand hygiene is the single most efficient means of preventing the spread of infection. Wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water when hands are visibly dirty or are visibly soiled with blood or other body fluids such as urine or feces. Wash hands before eating, after eating and after using the restroom with a non-anti-microbial soap and water or an anti-microbial soap and water. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Review of the Electronic Medical Record (EMR) revealed that R11 had a Stage IV pressure ulcer to the sacrum which was identified on 04/22/20/24. On 06/24/2024, the Wound Care Physician gave an order for treatment of the sacral wound, with staff to Cleanse wound with normal saline, apply alginate and cover with medi-honey. Cover with silicone foam border dressing every day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation, during a wound care observation for R11 on 06/24/2024 at 2:11 PM, revealed the Infection Control Registered Nurse (IC/RN) placed her large set of keys and a clean dressing on a PPE box inside the door of the room. She then put on clean gloves without first performing hand hygiene. The IC/RN next removed R11's soiled dressing and threw it in the resident's trash can. The IC/RN then failed to perform hand hygiene after degloving. She then took a pen out of her pocket and wrote a date on the dressing. The IC/RN next picked up the clean dressing off of the PPE container and opened the dressing on the resident's bed with no barrier underneath. The IC/RN proceeded to spray the wound with cleanser; however, as she was holding the resident on his side, she let go of him to wash her hands, allowing the resident to roll back onto his wound, and contaminate it. She then put gloves on again, picked up the dressing from the bed and placed it on the wound. The IC/RN then contaminated the brief and bedding as she pulled up the brief and bedding without removing her soiled gloves. After pulling up the brief and linens, she then degloved without performing hand hygiene. The nurse then left the room, leaving the soiled dressing in the trash in the resident's room. After the dressing change, an interview with the IC/RN revealed there was nothing she would do differently. The IC/RN stated that at another facility, she used wax paper as a barrier; however, there was nothing here to use. She stated she considered the resident's bed linens and the PPE storage box were clean and thought putting the clean dressing on those areas was OK. An interview with the Director of Nursing (DON) on 06/27/2024 at 2:43 PM revealed she expects all staff to follow the infection control policy and hand hygiene policies as written. Per the DON, hands are to be washed before, during, and after any dressing changes. Also, a barrier is to be used on the overbed table in resident's rooms to prevent contamination of supplies, and this can be a plastic bag or a clean towel. She further stated she expected staff to keep any personal items, like keys, in the staff's pockets. The DON stated that all soiled dressings are to be bagged and removed from the resident's room after wound care and if the resident cannot stay in any position for wound care, staff should get another staff member to assist them. An interview with the Administrator on 06/28/2024 at 2:34 PM revealed she expected staff to follow the policies and procedures of infection control regarding correct hand hygiene. 47798 2. Review of a facility policy titled, Enhanced Barrier Precautions Guideline, dated 07/12/2022 and reviewed 04/12/2024, revealed the facility would ensure that additional and appropriate PPE was utilized, when indicated, to prevent the spread of Multidrug-resistant organisms (MRDOs). Per the policy, EBP was defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDROs in the form of blood or body fluids, onto the hands and/or the clothing of the rendering care giver. Record review of a face sheet revealed the facility admitted R35 on 03/15/2024. Per the face sheet, the resident's diagnoses included Ogilvie syndrome and colostomy status. Review of R35's comprehensive care plan, dated 10/30/2023, revealed the resident was on EBP due to the colostomy. Observation of R35's room on 06/23/2024 at 1:04 PM revealed a sign on the wall at the head of the bed stating the resident was on EBP. However, there was no PPE container (which included gowns) in the room, behind the resident's door, or in the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of colostomy care provided to R35 by Licensed Practical Nurse (LPN) 9 on 06/26/2024 at 2:45 PM, LPN9 did not wear a gown during the procedure. In addition, LPN9 failed to perform handwashing after the care was provided, prior to exiting R35's room. During an interview with LPN9 on 06/26/2024 after the 2:45 PM care was completed, she stated she did not know she was supposed to wear a gown when she did colostomy care. LPN9 further stated she thought she had washed her hands when she finished providing care but if she didn't, she should have. During an interview with Certified Nursing Assistant (CNA)10 on 06/24/2024 at 1:55 PM, she stated if a resident was on any type of precautions, there would be a sign posted above the bed or on the door. CNA10 stated she would need to wear a gown and gloves for residents on EBP and there should be a PPE cart in the hallway. Interview on 06/24/24 2:23 PM with the DON revealed that all EBP care plans are kept in a binder at the nursing station, and she is currently trying to get all the care plans scanned into the EMR. Per the DON, residents on EBP or any precautions should have a sign up at the head of their bed or on their door, The DON stated staff would need to wear a gown and gloves to provide care for these residents. The DON stated there should be a cart in the hall or on the back of the resident's door stocked with PPE. At this time, the DON went to the rooms of two resident (R16 and R31) who were on EBP, and confirmed there was no PPE tray on those resident's doors. The DON stated that, Maybe it [the PPE tray] fell down and I'll check with maintenance to see if they have an order to put one back up. The DON stated she did not know why there was not a PPE available for staff use. During an interview with CNA10 on 06/26/2024 at 7:00 PM, she stated she was not sure what EBP was. CNA10 further stated she received a report from the off going shift and that is how she would know how to care for a resident. CNA10 stated if a resident was in isolation, she would wear a gown and gloves. Additionally, CNA10 stated gowns were usually in a clear box outside of the resident's room with other types of PPE. During an interview with CNA13 on 06/26/2024 at 7:30 PM, she stated she would suit up prior to entering a room for a resident on EBP. CNA13 stated there should be a sign on the resident's door and PPE should be placed outside the resident's room. CNA13 further stated she had not been educated on EBP and thought this meant that a resident would need more barrier cream applied. During an interview with LPN11 on 06/26/2024 at 7:51 PM, she stated she did not know what EBP was and there were no signs posted that she was aware of. LPN11 further stated that PPE was in bins outside of the resident rooms. During an interview with Registered Nurse (RN) 6 on 06/28/2024 at 10:00 AM, she stated she had received education related to EBP approximately two weeks ago and again this morning, after the issue with a lack of EBP was identified during the survey. RN6 stated staff was required to wear gown and gloves when providing direct contact care for resident's on EBP. RN6 stated there was usually a cart with PPE in the hall or in the resident room and it was always accessible. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Assistant Director of Nursing (ADON) on 06/27/2024 at 3:15 PM, she stated was responsible for training staff on EBP and would train based on facility policy. The ADON stated when a resident was on EBP, there would be a sign posted on the resident's door or over their bed. The ADON further stated if the resident was on EBP, a PPE bin or cart would be placed outside of the doorway or in an over the door bin. The ADON stated she expected PPE to be readily accessible and for staff to be aware and knowledgeable of what PPE to use and what they were using it for. During an additional interview with the DON on 06/28/2024 at 10:15 AM, she stated she was also the acting Infection Preventionist (IP). The DON stated EBP education was provided as well as skills check offs quarterly and as needed. The DON stated the expectation that PPE was always accessible and available for staff to use. The DON again stated PPE should be on the halls in a cart or bin or behind the resident's door. The DON further stated staff was expected to follow facility policy, be knowledgeable of what EBP were and to wear the appropriate PPE when a resident was on barrier precautions. During an interview with the Administrator on 06/28/2024 at 10:07 AM, she stated the ADON was responsible for staff education, which was weekly, monthly, and quarterly and was ongoing. She further stated her expectation was that PPE would always be available for staff, who would follow policy and wear the appropriate PPE when providing care.