STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185169	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Jefferson Manor Rehab & We	1801 Lynn Way Louisville, KY 40222

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 29015 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure two (2) of 49 sampled residents (Resident (R)16 and R47) were assessed for self-administration of medications to ensure the practice was clinically appropriate. Observation on 06/03/2024 at 2:27 PM, revealed a bottle of Flonase Allergy Relief nasal spray on R16's overbed table. However, there was no documented evidence of Physician's Orders for self administration of medications. Additionally, observation, on 06/04/2024 at 12:37 PM, revealed a small yellow pill on R47's lunch tray. However, there was no documented evidence of Physician's Orders for self administration of medications. The findings include: Review of the facility's policy titled, Medication Administration Self-Administration by Resident, last reviewed on 01/2023, revealed Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, and the medications are appropriate and safe for self-administration . 1. Review of R16's Face sheet located in the electronic medical record (EMR) under the Face Sheet tab, revealed the facility admitted the resident on 04/01/2019 with diagnoses including stroke affecting the right side, congestive heart failure, and chronic obstructive pulmonary disease (COPD). Review of R16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/24/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. Review of R16's Physician's Orders included no orders for self-administration of medication. Observation on 06/03/2024 at 2:27 PM, revealed R16 was in bed reading. A bottle of Flonase Allergy Relief nasal spray was observed on the overbed table. When the resident was questioned about the nasal spray during this observation, she stated, I am allowed to keep the medication in my room and use it when I need to. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/03/2024 at 2:30 PM, revealed Licensed Practical Nurse (LPN)1, came into R16's room and stated he was going to take the resident's Flonase nasal spray and keep it on the medication cart. When LPN1 was questioned, he stated, I was told by the Director of Nursing (DON) to get the Flonase. I am not sure why. When LPN1 was asked if the resident was allowed to keep the medication at bedside, he stated, I do not know. I did not give it to her. Interview on 06/04/2024 at 5:11 PM, with the DON, revealed I asked LPN1 to retrieve the medication from the bedside table. He did not know why the resident had the medication. I saw it when I passed her room. She does not have an order for self-administration. 2. Review of R47's Face Sheet located in the EMR under the Face Sheet tab, revealed the facility admitted the resident on 11/16/2023, with diagnoses including interstitial pulmonary disease, dependence on renal dialysis, and acute respiratory failure with hypoxia. Review of R47's quarterly MDS with an ARD of 02/22/2024, revealed the facility assessed the resident as having a BIMS score of 12 out of 15, indicating moderate cognitive impairment. Review of R47's Physician's Orders included no orders for self-administration of medication. Review of R47's Progress Notes located in the EMR, dated 06/04/2024 at 1:44 PM, revealed LPN6 documented, resident states she dropped medication, this nurse verified medication as aspirin. Advanced Practice Registered Nurse (APRN) notified okay to hold dose for today, new order for nursing to ensure resident takes medication. Review of R47's Care Plan dated 06/04/2024, located in the EMR under the RAI (Resident Assessment Instrument) tab, revealed, Resident prefers to take medications from med cup independently after setup. Approaches included .Observe resident swallow medications from med cup independently, offer assistance as needed. During an observation, on 06/04/2024 at 12:37 PM, there was a small yellow pill noted on R47's lunch tray. During an interview conducted with R47 during the observation, she stated the nurse left the pills at the bedside. When questioned if the nurse stayed in the room to watch her take her medications, R47 stated, No, the nurse did not. The Registered Nurse Signature Clinical Coordinator (facility consultant), confirmed the pill left on the resident's lunch tray was aspirin. During an interview, conducted on 06/04/2024 at 12:44 PM, with LPN6, (R47's nurse), the nurse was asked if she watched the resident take her medications. LPN6 stated, Yes, I stood outside the resident's room with the door cracked. LPN6 was asked what her process was for medication administration and the nurse stated she obtained the resident's vital signs, checked medications, and watched the resident take their medications. 43050

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on interview, record review, review of the Centers for Medicare and Medicaid Services (CMS), Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, review of the CMS site, Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566 and review of facility policy, it was determined the facility failed to issue the appropriate notice for termination of Medicare part A benefits for two (2) of three (3) residents reviewed for beneficiary notification out of a total sample of 49 residents (Resident (R) 67 and R73). These failures had the potential to result in a lack of understanding of appeal rights and/or the termination of the current level of care against the resident's/representative's wishes. The findings include: Review of the Centers for Medicare and Medicaid Services (CMS), Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 accessed at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/instructions-for-notice-of-medicare-non-coverage-nomnc.pdf on 06/04/2024, revealed, The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed . CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative . If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. Review of the CMS site, Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566 accessed at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/abn-form-instructions.pdf on 06/04/2024, revealed, The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select . If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: beneficiary refused to choose an option. Review of the facility's Notice of Medicare Non-Coverage (NOMNC) policy, dated 09/01/2023 and provided on paper, revealed, All NOMNCs must be completed based on Medicate guidelines and facility policy . If the resident is unable to sign, and the SNF [Skilled Nursing Facility] is working with a legally authorized representative who is unable to be present at the facility that day, the SNF may issue the NOMNC by telephone . The facility must confirm the telephone contact by sending written notice to the authorized representative the same day the call was made by: Certified Mail, returned receipt requested. The facility did not provide a policy addressing the ABN. 1. Review of R67's Face Sheet, under the Face Sheet tab of the electronic medical record (EMR), revealed the facility admitted the resident on 03/28/2024. Family Member (F)1 was listed as her financial representative. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R67's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2024, located under the MDS 3.0 tab of the EMR, revealed the resident scored zero (0) out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of R67's Notice of Medicare Non-Coverage (NOMNC), dated 04/30/2024 and provided on paper, revealed her last covered day (LCD) of Medicare Part A services was 05/02/2024. The Social Services Director (SSD) documented F1 was provided verbal notice via telephone on 04/30/2024; however, there was no signature from F1 on the form. Review of R67's Advance Beneficiary Notice of Noncoverage (ABN), dated 04/30/2024 and provided on paper, revealed the notice was provided verbally to F1 via telephone on 04/30/2024; however, no option was checked to indicate whether F1 wanted skilled services to be continued with responsibility for payment, skilled services to be discontinued, or skilled services to continue with an appeal to Medicare for further coverage. There was no signature from F1 on the form. Review of a Progress Note, dated 04/30/2024 and located in the Progress Notes tab of the EMR, written by the Social Services Director (SSD), revealed, NOMNC/ABN issued with LCD-05/02[/2024] from therapy services, call placed to [F1]. Discussed with [F1]. [F1] is aware of ending therapy services and reviewed room [ROOM NUMBER] for LTC placement at facility. Son was agreeable. All questions answered. Social Services will continue to assist as needed. In an interview on 06/04/2024 at 10:54 AM, the SSD stated for the NOMNC and ABN, she only provided verbal notice; the written forms were not sent to F1 for signature or to keep on file. The SSD further stated she did discuss with F1 which option he wanted; however, it must have been a clerical error that the option was not documented on the form. The SSD stated she was unsure what option F1 chose and would investigate and provide further information. No additional information was provided by the SSD prior to survey exit on 06/06/2024. In an interview, on 06/06/2024 at 12:26 PM, the Administrator provided the above Progress Note written by the SSD and stated that was the only information he could locate regarding the NOMNC and ABN and no documentation could be located to indicate which option F1 chose regarding continuation of services. In a telephone interview, on 06/06/2024 at 1:39 PM with F1, he stated he did not recall receiving notice of Medicare non-coverage via telephone and stated he had not been presented with options to appeal, continue services, or end services. F1 stated he would have chosen to discontinue services had he been asked. 2. Review of R73's Face Sheet under the Face Sheet tab of the EMR, revealed the facility readmitted the resident on 12/13/2023. F2 was listed as her financial representative. Review of R73's Significant Change of Status MDS, with an ARD of 12/17/2023 and located under the MDS 3.0 tab of the EMR, revealed she scored 12 out of 15 on the BIMS, indicating moderate cognitive impairment. Review of R73's NOMNC, dated 12/27/2023 and provided on paper, revealed her LCD of Medicare Part A services was 12/29/2023. The SSD documented F2 was provided verbal notice via telephone on 12/27/2023; however, there was no signature from F2 on the form. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R73's ABN, dated 12/27/2023 and provided on paper, revealed the notice was provided verbally to F2 via telephone on 12/27/2023; however, no option was checked to indicate whether F2 wanted skilled services to be continued with responsibility for payment, skilled services to be discontinued, or skilled services to continue with an appeal to Medicare for further coverage. There was no signature from F2 on the form. Review of a Progress Note, dated 12/27/2023 and located in the Progress Notes tab of the EMR, written by the SSD, revealed, NOMNC/ABN issued with LCD-12/29[/2024] from therapy services. Resident notified and preferred to review with [F2] instead. SSD notified [F2]- Spoke with [F2], voiced understanding. No issues or concerns voiced. In an interview, on 06/04/2024 at 10:54 AM, the SSD stated for the NOMNC and ABN, she only provided verbal notice; the written forms were not sent to F2. The SSD also stated she did discuss with F2 which option she wanted; however, it must have been a clerical error that the option was not documented on the form. The SSD stated she was unsure what option F2 chose and would investigate and provide further information. No additional information was provided by the SSD prior to survey exit on 06/06/2024. In an interview, on 06/06/2024 at 12:26 PM, the Administrator provided the above Progress Note written by the SSD and stated that was the only information he could locate regarding the NOMNC and ABN and he was unable to find documentation to indicate which option F2 chose regarding continuation of services. In a telephone interview, on 06/06/2024 at 5:52 PM with F2, she stated she did not remember receiving a phone call to explain the NOMNC and ABN and was never asked whether she wanted skilled services to continue, to end, or to appeal the decision. F2 stated she would not want skilled services to continue.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 28306 Based on interview, record review and review of the Kentucky Board of Nursing AOS #09 - Wound Assessment, Staging, and Treatment published in December 2023, it was determined the facility failed to ensure services provided or arranged by the facility meet professional standards of quality for two (2) of 49 sampled residents (Resident (R)71 and R1). The facility failed to have qualified wound care staff and physician oversight related to wound care. The findings include: Review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #09 - Wound Assessment, Staging, and Treatment published in December 2023, provided by the facility revealed, .It is within the scope of licensed practical nursing practice for a licensed practical nurse who is educationally prepared and clinically competent to assist the qualified healthcare provider in wound assessment, staging, and treatment including debridement. This includes the application of wound dressings and wound vacs, the removal of wound drains, and the application of Unna boots . Review of the job description provided by the facility, for a Charge Nurse (LPN or RN) [Licensed Practical Nurse or Registered Nurse] under Essential Duties and Responsibilities revealed, .Administer professional services such as: catheterization, tube feedings, suction, applying and changing, dressings/bandages, packs, colostomy, and drainage bags, taking blood, giving massages and of motion exercises, care for the dead/dying, etc., as required . Review of the Director of Nursing's (DON) job description provided by the facility, revealed, .Review and verify that documentation procedures for nursing are met . Review of the Medical Director Services - Rules and Responsibilities provided by the facility revealed, The Medical Director will coordinate medical care .and provide clinical guidance and oversight . 1. Review of R71's undated Face Sheet located in the electronic medical record (EMR), under the Face Sheet tab, revealed the facility admitted R71 on 04/13/2024, with diagnoses including stroke, type 2 diabetes mellitus, malnutrition, and unstageable pressure ulcer to sacral area. Review of R71's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/19/2024, located in R71's EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of zero (0) out of 15, indicating severe cognitive impairment. R71 was also coded for an unstageable pressure ulcer that was known, but not stageable due to coverage of the wound bed by slough and/or eschar. Review of R71's Physician's Orders located in the EMR under the Orders tab, revealed clean sacrum wound with normal saline, pack with normal saline wet to dry dressing, and apply boarded dressing daily and as needed for dislodgement. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R1's undated Face Sheet located in the EMR, under the Face Sheet tab, revealed the facility admitted the resident on 10/31/2014, with diagnoses including cerebral palsy. Further review of the EMR revealed R1 developed a Stage IV pressure ulcer in August 2023. Review of R1's Annual MDS with an ARD of 03/16/2024, located in R1's EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Review of R1's Physician Orders, dated 05/15/2024, located in the EMR, under the Orders tab, revealed clean right ischium wound with normal saline, place betadine-soaked gauze loosely in the wound, and cover with an ABD (abdominal) pad using no tape twice a day and as needed for dislodgement . An interview was conducted with Wound Care Nurse (WCN)1/Licensed Practical Nurse, on 06/05/2024 at 1:26 PM. WCN1 was questioned if she was a certified wound care nurse and she stated, I have only had on the job training. I'm not certified. I am supposed to get the training at some point. Review of WCN1's employee file revealed she was hired on 02/06/2024 and the job application and resume revealed she was not a certified wound care nurse. Review of WCN1's competencies included online classes of Skin Integrity for 0.50 hour with a completion date of 04/01/2024, Infection Control and Prevention for 1.00 hour with a completion date of 02/07/2024, and Pressure Injuries: Assessment, Interventions, Prevention for 1.25 hours with a completion date of 02/08/2024. During a phone interview, on 06/06/2024 at 4:30 PM, Wound Care Certified Nurse (WCCN)1 stated, I worked with WCN1 on 03/13/2024 showing WCN1 the different types of wounds, staging of wounds, measuring of wounds, and some of the best treatments used for the different types of wounds. WCCN1 stated she worked at a sister facility of the corporation where this was education was completed with WCN1. During an interview with the Signature Clinical Coordinator (SCC) Registered Nurse (RN) who was Wound Care Certified, on 06/05/2024 at 2:29 PM, she stated she only provided support to the wound care nurse and did not review her documentation regularly nor did she make observations of the residents that had wounds that were being treated by WCN1. During an interview with the Nurse Practitioner (NP), on 06/06/2024 at 9:10 AM, the NP stated, I will visualize the wounds on admission and then if the wound care nurse sees a wound worsening, but I don't measure the wounds. The wound care nurse does this. During an interview with the Medical Director, on 06/06/2024 at 10:09 AM, he stated he did not visualize the wounds and he was not a board-certified wound care doctor. The Medical Director confirmed the Nurse Practitioner would call if there were any problems she was made aware of, but it was a consult type of occurrence. During an interview with the Director of Nursing (DON), on 06/06/2024 at 10:45 AM, she confirmed she was not a certified wound care nurse, and she did not regularly review the documentation nor observe the wound care nurse during dressing changes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/06/2024 at 3:00 PM, the Administrator stated the facility did not have a job description for a Wound Care Nurse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 12679 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure that adequate assistive devices were implemented to prevent accidents for one (1) of four (4) sampled residents reviewed for falls out of a total sample of 49 residents, Resident (R)76). R76 was found on the floor on 04/20/2024, and the Interdisciplinary Team (IDT) conducted a root cause analysis and determined the resident attempted to get out of his bed and fell . A new fall intervention dated 05/04/2024, revealed the resident's bed was to be in a low position, when he was in bed. However, observations on 06/04/2024 revealed staff failed to ensure the bed was in the lowest position while the resident was in bed. The findings include: Review of the facility policy titled, Falls, dated 09/15/2023, indicated, .The intent of this policy is to ensure the facility provides an environment that is as free from accident hazards, as possible, over which the facility has control to prevent avoidable falls.All residents will have a fall risk assessment on admission/readmission, quarterly, annually, and with a significant change of condition to identify risks for falls.A Comprehensive Care Plan will be implemented based on the resident's risk for falls with an individual goal and interventions specific to each resident to attempt to reduce the risk of avoidable falls, to the extent possible. The care plan will be reviewed following each fall, quarterly, annually, and with a significant change in condition.The Interdisciplinary Team (IDT)/which includes the Director of Nursing (DON) or their designee reviews during the At-Risk Meeting as applicable. Review of R76's Resident Face Sheet, in the electronic medical records (EMR), located under the Resident tab, revealed the facility admitted the resident on 04/18/2024 with post-surgical diagnosis of traumatic subdural hematoma. Review of R76's Progress Notes, dated 04/20/2024, located in the EMR under the Progress Notes tab, revealed the resident was found when the nurse was coming out of another resident room. The nurse found the resident on the floor and the resident stated he was trying to get up. The progress notes further revealed the resident was transported to the local hospital, per resident representative (RR)1's request, for evaluation and treatment. Review of R76's Progress Notes, dated 04/22/2024, located in the EMR under the Progress Notes tab, revealed the Interdisciplinary Team (IDT) conducted a root cause analysis and determined the resident attempted to get out of his bed and fell , and determined the cause of the fall as self-transfer of the resident. Review of R76's Care Plan, dated 05/04/2024, located under the RAI (Resident Assessment Instrument) tab, revealed an intervention for the resident's bed to be in a low position, when he was in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R76's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/10/2024, located under the RAI tab, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of nine (9) out of 15 indicating moderate cognitive impairment. The MDS assessment further revealed the resident had a history of falls prior to admission and during his admission to the facility. Under the Care Area Assessment (CAA), falls triggered and directed the staff to develop a care plan. During an observation, on 06/04/2024 at 1:10 PM, R76 was in bed, and the bed was not in a low position. During this observation, RR1 was present and stated the bed was not in the low position and she lowered it. RR1 stated when she would find the resident in bed, the bed was typically not in the low position. During an observation, on 06/04/2024 at 4:41 PM, R76 was observed to be in bed, and the bed was not in a low position. During an interview on 06/06/2024 at 8:58 AM, Certified Nursing Assistant (CNA) 3 stated she had provided care for R76 and stated the resident's bed was to be in a low position when he was in the bed. During an interview, on 06/06/2024 at 10:45 AM, the Director of Nursing (DON) stated it was her expectation for staff to implement fall precautions to prevent major injury of a resident. The DON stated the facility had placed a soft touch call light for R76 and the bed was to be lowered to the low position. The DON further stated the positioning of the resident's bed would be in a Certified Nurse Aide (CNA) guide.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 29015 Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure drugs and biologicals were stored appropriately, without being expired, for one (1) of two (2) medication storage rooms, and two (2) of five (5) medication carts. A tour of the blue medication room, on 06/04/2024 at 11:45 AM, revealed a tube of Iodosorb with an expiration date of 02/2022, a tube of Medihoney with expiration date of 12/11/2022, and a tube of HydrofaraBlue with expiration date of 02/01/2021. Additionally, observation on 06/04/2024 at 12:50 PM, of the [NAME] Unit, Medication Cart #1, revealed the following expired medications: a bottle of nitroglycerine 0.4 milligram (mg) with an expiration date of 11/16/2023; Atrovent 17 micrograms (mcg) hydrofluoroalkane (HFA) inhaler with an opened date of 04/24/2024; and a Miralax bottle opened on 01/29/2023. Furthermore, observation on 06/04/2024 at 1:35 PM, of the [NAME] Unit, Medication Cart #3, revealed the following expired medications: Breyna expired on 04/25/2024; and Glycopyrolate 1 milligram (mg)/5 milliliters (ml) opened on 04/08/2024. The findings include: Review of the facility's policy titled Medication Storage, undated, revealed Medications and biologicals are stored properly .to maintain their integrity and to support safe effective drug administration .Outdated, contaminated, discontinued, or deteriorated medications, and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. Review of the facility's policy titled Medication Administration dated 01/2023, revealed The nurse shall place a date opened sticker on the medication if one is not provided at the dispensing pharmacy and enter the date opened Certain products or package types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating, once opened, to ensure medication purity and potency. When the date open expiration dating is not available from the manufacturer, the following may be considered in determining facility policy: Position statements from the American Society of Ophthalmic Registered Nurses and American Society of Cataract & Refractive Surgery (ASCRS) state that the multi-use eye drops and ointments should be disposed of 28 days after initial use. Manufacturer recommendations for beyond use dating should take precedence, taking into consideration not to exceed limitations. All other ophthalmic drops are to be considered expired after 60 days from the date opened. During a tour of the blue medication room, on 06/04/2024 at 11:45 AM, with the Director of Nursing (DON) and Signature Clinical Consultant (SCC), observation revealed the following: a tube of Iodosorb with an expiration date of 02/2022, a tube of Medihoney with expiration date of 12/11/2022, and a tube of HydrofaraBlue with expiration date of 02/01/2021. These items were confirmed as expired by the DON, and SCC during the tour of the medication room. (continued on next page)

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	185169	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Jefferson Manor Rehab & We	1801 Lynn Way Louisville, KY 40222

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation conducted on 06/04/2024 at 12:50 PM, of the [NAME] Unit, Medication Cart #1, accompanied by Unit Manager (UM)1, the following medications were noted to be expired: a bottle of nitroglycerine 0.4 milligram (mg) with an expiration date of 11/16/2023; Atrovent 17 micrograms (mcg) hydrofluoroalkane (HFA) inhaler with an opened date of 04/24/2024; and Miralax bottle opened on 01/29/2023. These items were confirmed as expired by UM1 during observation of the medication cart. During an observation conducted on 06/04/2024 at 1:35 PM, of the [NAME] Unit, Medication Cart #3, accompanied by Licensed Practical Nurse (LPN)5, the following medications were noted to be expired: Breyna expired on 04/25/2024; and Glycopyrolate 1 milligram (mg)/5 milliliters (ml) opened on 04/08/2024. These items were confirmed as expired by LPN5 during observation of the medication cart. During an interview conducted on 06/04/2024 at 1:00 PM, with LPN5, the nurse was questioned concerning how long a medication was good after the opened date. LPN5 stated she thought it was 30 days, but she was not positive and would have to look it up. During an interview conducted on 06/04/2024 at 2:24 PM, with LPN4, she stated she thought medications were good for 28 -30 days after opened , but she wasn't sure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 28306 Based on observation, interview, and record review, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) of two (2) sampled residents observed for wound care out of a total sample of 49 residents, Resident (R)1 and R71. During observation of wound care for R71, on 06/04/2024, Wound Care Nurse (WCN)1 failed to implement infection control procedures as evidenced by failure to clean/disinfect the table top prior to placing a barrier in which to place wound supplies; failure to clean/disinfect scissors before using them to cut the Kerlix which she packed in the resident's wound; failure to wash hands and don new gloves after wound care and prior to cleaning/disinfecting the dirty scissors; and failure to wait three (3) minutes after disinfecting the scissors prior to placing them back into the treatment cart. Additionally, during observation of wound care for R1 on 06/06/2024 at 9:30 AM, WCN1 failed to provide incontinence care to remove stool before she started the wound care. Also, during wound care, the nurse cleaned the wound with a gauze saturated with normal saline, wiping down the center of the wound, and then wiped the same area again with the same gauze. The findings include: Review of the facility policy titled Skin Integrity, dated 09/15/2023, revealed it is recommended that a nursing leader does a follow-up visualization of skin integrity concerns that were present upon admission. Recommend ongoing observation of skin integrity by licensed nursing staff. The licensed nurse shall initiate applicable Skin Integrity documentation if a new area of impairment is identified. The Nurse Leader/Wound Nurse shall document all impaired skin integrity areas such as: pressure, stasis, surgical incision, or diabetic ulcers in the Electronic Medical Record (EMR) on an ongoing basis or until closed or the resident has been discharged . In addition to ongoing observations of skin integrity impairments mentioned above, nursing stakeholders shall observe the skin for areas of impairment during bathing, dressing, and peri care. Nursing stakeholders will notify the nurse if a new area is identified. The facility utilizes either a pressure reducing, pressure relieving, or pressure redistributing mattress on each resident bed. However, the policy did not identify infection control measures to be utilized related to wound care. 1. Review of R71's undated Face Sheet located in the electronic medical record (EMR), under the Resident tab, revealed the facility admitted the resident on 04/13/2024, with diagnoses including stroke, type 2 diabetes mellitus, malnutrition, and unstageable pressure ulcer to sacral area. Review of R71's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/19/2024, located in R71's EMR under the MDS tab, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0) out of 15, indicating severe cognitive impairment. R71 was also coded as having an unstageable pressure ulcer that was present on admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R71's Physician's Orders, dated 05/09/2024, located in the EMR under the Orders tab, revealed orders to clean sacrum wound with normal saline, pack with normal saline wet to dry dressing, and apply boarded dressing daily and as needed for dislodgement. During an observation of Wound Care Nurse (WCN)1 providing wound care to R71 on 06/04/2024 at 1:48 PM, the following was noted: 1) WCN1 did not clean and disinfect the overbed table before placing the barrier down which would hold the wound care supplies. 2) WCN1 brought scissors from the treatment cart into R71's room and did not clean/disinfect the scissors before using them to cut the Kerlix which she packed in the resident's wound. 3) After providing wound care, WCN1 then took off her gloves and failed to wash hands and don new gloves before cleaning the the dirty scissors with soap and water, and then with alcohol preps. She then with bare hands cleaned/disinfected the scissors with a Clorox wipe and placed the scissors on top of the laptop. 4) The WCN1 only waited two (2) minutes before placing the scissors into the treatment cart. During an interview with the Director of Nursing (DON), on 06/05/2024 at 1:57 PM, the DON stated, The nurse should have cleaned the overbed table with a Clorox wipe and then placed her barrier down. And then she should have worn gloves to clean her scissors When asked what the dry time for the Clorox wipes was, the DON stated, I don't know. I will have to get back in touch with you about this. During an interview with Registered Nurse/Signature Clinical Consultant/ Wound Care Nurse Certified Nurse (RN/SCC/WCCN), on 06/05/2024 at 2:29 PM, she confirmed the overbed table should have been cleaned/disinfected with a Clorox wipe before the barrier was placed on it. Further, she stated the scissors should have been cleaned/disinfected before using them to cut the Kerliz and the dry tine for the Clorox wipes was three (3) minutes before the scissors were to be placed back into the treatment cart. During an interview with WCN1, on 06/06/2024 at 1:30 PM, the nurse confirmed she should have cleaned/disinfected the over the bed table prior to placing the barrier to hold the wound care supplies. In further interview, she stated she should have cleaned/disinfected the scissors before using them to cut the kerlix to pack in the resident's wound. In continued interview, WCN1 stated she should have ensured she cleaned and disinfected the scissors after providing wound care while wearing clean gloves and should have waited the dry time of three (3) minutes before placing the clean scissors back into the treatment cart. 2. Review of R1's undated Face Sheet located in the EMR, under the Resident tab, revealed the facility admitted the resident on 10/31/2014, with a diagnosis of cerebral palsy. R1 developed a stage IV pressure ulcer in August 2023. Review of 1's annual MDS with an ARD of 03/16/2024, located in R1's EMR under the MDS tab, revealed the resident had a BIMS score of 14 out of 15, which indicted the resident was cognitively intact. R1 was also coded for having a Stage IV pressure ulcer. Review of R1's Physician's Orders, dated 05/15/2024, located in the EMR under the Orders tab, revealed orders to clean the right ischium wound with normal saline, place betadine-soaked gauze loosely in the wound, and cover with an ABD (abdominal) pad using no tape twice a day and as needed for dislodgement. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of WCN1 providing wound care to R1, on 06/06/2024 at 9:30 AM, the following was noted: 1) When R1 was moved to the side lying position for wound care, the resident had a small bowel movement. The nurse did not provide incontinence care to remove the stool before she started the wound care. 2) While cleaning the wound with a gauze saturated with normal saline, WCN1 wiped down the center of the wound, then wiped the same area again with the same gauze. During continued interview with WCN1, on 06/06/2024 at 1:30 PM, the nurse confirmed she should have provided incontinence care by cleaning the stool from R1 prior to providing wound care. Further, she stated she should not have cleaned R1's wound using the same gauze as she had previously used.